113TH CONGRESS
1st Session

COMMITTEE PRINT

S. PRT.
113–16

JOINT STAFF REPORT ON THE CORPORATE PRACTICE OF DENTISTRY IN THE MEDICAID PROGRAM

PREPARED BY THE STAFF OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

MAX BAUCUS, *Chairman*

AND

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

CHUCK GRASSLEY, *Ranking Member*

JUNE 2013

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
81–510 WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON FINANCE

MAX BAUCUS, Montana, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia
RON WYDEN, Oregon
CHARLES E. SCHUMER, New York
DEBBIE STABENOW, Michigan
MARIA CANTWELL, Washington
BILL NELSON, Florida
ROBERT MENENDEZ, New Jersey
THOMAS R. CARPER, Delaware
BENJAMIN L. CARDIN, Maryland
SHERROD BROWN, Ohio
MICHAEL F. BENNET, Colorado
ROBERT P. CASEY, Jr., Pennsylvania

ORRIN G. HATCH, Utah
CHUCK GRASSLEY, Iowa
MIKE CRAPO, Idaho
PAT ROBERTS, Kansas
MICHAEL B. ENZI, Wyoming
JOHN CORNYN, Texas
JOHN THUNE, South Dakota
RICHARD BURR, North Carolina
JOHNNY ISAKSON, Georgia
ROB PORTMAN, Ohio
PATRICK J. TOOMEY, Pennsylvania

AMBER COTTLE, *Staff Director*
CHRIS CAMPBELL, *Republican Staff Director*

COMMITTEE ON THE JUDICIARY

PATRICK J. LEAHY, Vermont, *Chairman*

DIANNE FEINSTEIN, California
CHARLES E. SCHUMER, New York
DICK DURBIN, Illinois
SHELDON WHITEHOUSE, Rhode Island
AMY KLOBUCHAR, Minnesota
AL FRANKEN, Minnesota
CHRISTOPHER A. COONS, Delaware
RICHARD BLUMENTHAL, Connecticut
MAZIE HIRONO, Hawaii

CHUCK GRASSLEY, Iowa
ORRIN G. HATCH, Utah
JEFF SESSIONS, Alabama
LINDSEY GRAHAM, South Carolina
JOHN CORNYN, Texas
MICHAEL S. LEE, Utah
TED CRUZ, Texas
JEFF FLAKE, Arizona

BRUCE A. COHEN, *Chief Counsel and Staff Director*
KOLAN DAVIS, *Republican Chief Counsel and Staff Director*

CONTENTS

I. Preface

The United States Senate Committee on Finance has jurisdiction over the Medicare and Medicaid programs. As the Chairman and a senior member and former Chairman of the Committee, we have a responsibility to the more than 100 million Americans who receive health care coverage under these programs to oversee their proper administration and ensure the taxpayer dollars are appropriately spent. This report describes the investigative work, findings, and recommendations of the Minority Staff of the Senate Committee on the Judiciary and the Majority Staff of the Senate Committee on Finance regarding the corporate practice of dentistry in the Medicaid program. The issues are analyzed primarily in the context of one company, Small Smiles. We received whistleblower complaints about the company, it has been the subject of a False Claims Act lawsuit, and it has been under a corporate integrity agreement with independent monitoring by the Department of Health and Human Services Office of Inspector General since January 2010. In addition, we briefly examined complaints received regarding ReachOut Healthcare America (ReachOut).

At the outset of this investigation, Church Street Health Management (CSHM), the parent company of Small Smiles, cooperated with Committee staff until it emerged from bankruptcy. After emerging from bankruptcy and hiring new counsel, CSHM ceased cooperating. Under the old ownership, Committee staff was able to obtain reports by the Independent Monitor, a private, independent oversight entity whose services were mandated as part of CSHM's settlement agreement with the U.S. Department of Justice (DOJ). However, the new owners and counsel refused to give Committee staff access to on-going reports from the Independent Monitor. ReachOut cooperated with the Committees' investigation. More than 10,000 pages of documents were obtained from CSHM, ReachOut, whistleblowers, and Federal entities. The Committee staff conducted six meetings with Small Smiles, six meetings with the U.S. Department of Health and Human Services Office of Inspector General, one site visit, and various stakeholder meetings throughout the course of the investigation. Likewise, the Committee staff met with ReachOut three times in addition to meeting with various stakeholders.

II. Executive Summary

Across the country, there are companies that identify themselves as dental management companies. These organizations are typically organized as a corporation or limited liability company. They work with dentists in multiple states and purport to provide general administrative management services. In late 2011, whistleblowers and other concerned citizens came forward with information that some of these companies were doing more than providing

management services. In some cases, dental management companies own the dental clinics and have complete control over operations, including the provision of clinical care by clinic dentists.

While there is no Federal requirement that licensed dentists, rather than corporations, own and operate dental practices, many states have laws that ban the corporate practice of dentistry. In those states where owners of dental practices must be dentists licensed in that state, the ownership structure used by some dental management companies is fundamentally deceptive. It hides from state authorities the fact that all rights and benefits of ownership actually flow to a corporation through contracts between the company and the "owner dentist." These contracts render the "owner dentist" an owner in name only.

Notably, these clinics tend to focus on low-income children eligible for Medicaid. However, these clinics have been cited for conducting unnecessary treatments and in some cases causing serious trauma to young patients; profits are being placed ahead of patient care.

In one case, the corporate structure of a dental management company appears to have negatively influenced treatment decisions by over-emphasizing bottom-line financial considerations at the expense of providing appropriate high-quality, low-cost care. As a consequence, children on Medicaid are ill-served and taxpayer funds are wasted.

Our investigation into these allegations began by examining five corporate dental chains which were alleged to be engaged in these practices:

- Church Street Health Management (CSHM), which at the time owned 70 Small Smiles dental clinics in 22 states and the District of Columbia;
- NCDR, LLC, which owns 130 Kool Smiles clinics in 15 states and the District of Columbia;
- ReachOut Healthcare America (ReachOut) which operates mobile clinics that treat children at schools in several states;
- Heartland Dental Care, Inc. (Heartland), which operates more than 300 clinics in 18 states; and
- Aspen Dental Management, Inc., (Aspen) which operates more than 300 Aspen Dental clinics in 22 states.

While we initially looked broadly at all five companies, the focus shifted primarily to CSHM and ReachOut, due to similarities between the patient populations of these two companies. Both treat Medicaid-eligible children almost exclusively and therefore are reimbursed using taxpayer dollars.

A. CSHM

CSHM has management services agreements with dental clinics which extend far beyond providing typical management services. Through its agreements, CSHM assumes significant control over the practice of dentistry in Small Smiles clinics and is empowered to take substantially all of a clinic's profits.

CSHM has management services agreements with "owner dentists" who typically work at one of the Small Smiles clinics and also "own" several clinics nearby. These "owner dentists" are paid a sal-

ary by CSHM as well as a flat fee when they sign state paperwork declaring that they own other clinics. In a glaring departure from industry practice, some "owner dentists" have never visited clinics that they purport to own, are not allowed to make hiring decisions, and do not even control the scheduling of patients. Moreover, Small Smiles dentists are required by their parent company, CSHM, to treat a high volume of patients daily, which subsequently has a significant impact on the quality of care delivered.

Defenders of this corporate structure are quick to claim that without their organizations, the under-served Medicaid population would not have access to dental care. Countless news reports cite low Medicaid reimbursement rates as the principal cause for the lack of access to dental care for low-income families. However, if states and Medicaid are having difficulty recruiting good dentists to serve such a vulnerable population due to lack of reimbursement, how are private investors so successful at producing huge profits from those allegedly inadequate Medicaid reimbursements? Do short-term profits come at the cost of quality care and a sustainable business model in the long run? Local dentistry practices should be able to provide quality care to the Medicaid population and still be profitable. Fortunes should not be made on Wall Street by sacrificing proper care for the underprivileged.

B. ReachOut Healthcare America

The troubling case of Isaac Gagnon illustrates the concerns relating to the quality of ReachOut's care and a pattern of treatment without parental consent. A then 4-year-old "medically fragile" boy, Isaac received invasive dental work in October 2011 from a mobile services unit that held a contract with ReachOut Healthcare America.[1] Notably, Isaac's mother said that while she permitted ReachOut to review dental hygiene education with Isaac, she also expressed her wishes that no procedures be performed.[2]

On the day treatment was provided, the mobile dental unit visited Isaac's special needs preschool. During treatment that lasted approximately 40 minutes, three adults held down a screaming, kicking, and gagging Isaac.[3] This disturbing conduct violated ReachOut's own internal policy that a patient is never to be physically restrained in any manner, except by holding a patient's hands when the patient "presents [an] imminent danger of harm to themselves."[4] In the aftermath, Isaac was severely traumatized, and according to his mother, a "complete mess, emotionally."[5] Moreover, since the treatment, Isaac has exhibited increasingly aggressive behavior—namely, kicking, screaming, and punching.[6]

Ultimately, after Isaac's mother informed the school superintendent, the school board voted to sever contractual ties with ReachOut, and issued a cease and desist order.[7] Isaac's mother was referred to a pediatric dentist who concluded after examining Isaac

---

[1] Interview with Stacey Gagnon, by Moriarty Leyedecker, PC at 2 (Nov. 11, 2011) (Exhibit 36).
[2] *See id.*
[3] *See id.* at 3.
[4] Letter from Reginald Brown, Attorney at WilmerHale, to Senators Baucus and Grassley at 5 (Feb. 23, 2012) (Exhibit 31).
[5] Interview with Stacey Gagnon, by Moriarty Leyedecker, PC at 4 (Nov. 11, 2011) (Exhibit 36).
[6] *See id.* at 5.
[7] *See id.* at 4.

that the two pulpotomies (root canals) and two silver crowns administered were both unnecessary, and in the case of the former, performed incorrectly.[8]

Another troubling case occurred in December 2011. Nevada's Clark County School District, with a student population of almost 400,000, severed contractual ties with ReachOut after receiving complaints from parents who alleged ReachOut did not give proper notification before proceeding with serious procedures such as fillings and crowns.[9] According to Amanda Fulkerson, spokesperson for the Clark County School District, "They [ReachOut] were going well beyond what we consider preventive care." [10]

The allegations against ReachOut that its dental practices were abusing children and billing Medicaid for unnecessary procedures were serious and disturbing, but we found that those practices were not necessarily widespread. Unlike CSHM, ReachOut's management services agreements truly provide only administrative and scheduling support, and do not constitute *de facto* ownership and control of its mobile dental clinics.[11]

In its Administrative Agreements with dentists, ReachOut uses language similar to the following example, which ensures that the sole authority to practice dentistry remains with the licensed dentist:

> *Sole Authority to Practice.* Notwithstanding any other provision of this Agreement, Provider shall have exclusive authority and control over the healthcare aspects of Provider and its practice to the extent they constitute the practice of a licensed profession, including all diagnosis, treatment and ethical determinations with respect to patients which are required by law to be decided by a licensed professional.[12]

ReachOut maintains administrative services agreements with local dentists, or principal shareholders (PCs), who largely provide mobile services to schools, but also the military and in some states, nursing homes.[13] At the time of this report, ReachOut has contracts with 23 dental practices in 22 states. The contracts between ReachOut and dental practices relate only to nonclinical aspects.[14] ReachOut is paid set fees by the dentists for facilitating the mobile dentistry services. These services include providing equipment and supplies, maintaining inventory, and providing information systems, financial planning, scheduling, reporting, analysis, and customer service.[15]

---

[8] *See id.*

[9] *See* Ken Alltucker, *Mobile dental clinics drawing scrutiny,* AZCentral.com (Aug. 18, 2012) *http://www.azcentral.com/business/articles/20120810mobile-dental-clinics-scrutiny.html.*

[10] *Id.*

[11] *See, e.g.,* Administrative Agreement between ReachOut and [REDACTED] DDS, PC (July 2, 2006) (bates RHA 0000007–0000021) (Exhibit 32).

[12] Administrative Agreement between ReachOut and [REDACTED], DDS at 9 (Apr. 23, 2009) (bates RHA 0000030) (Exhibit 33). Small Smiles has what is arguably similar language to that found in ReachOut's administrative agreement. However, ReachOut's language appears to be focused more on limiting its liability. Moreover, our investigation found that Small Smiles' contractual language is at odds with actual practice. *See* report Section IV(a); *see* Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 2 (Oct. 1, 2010) (Exhibit 6).

[13] *See* Administrative Agreement between ReachOut and Big Smiles Colorado at 2–3 (July 1, 2009) (bates RHA 0000051–0000065) (Exhibit 34).

[14] *See* Letter from Reginald Brown, Attorney at WilmerHale, to Senators Baucus and Grassley at 2 (Feb. 23, 2012) (Exhibit 31).

[15] *See id.*

The basic plan behind the Administrative Agreement between ReachOut and the mobile dentists is "to provide *administrative and financial services* as set forth herein, *so that the PC can focus on furnishing high-quality dental care* directly and through third-party dentists to needy, primarily low-income, children in schools and out-of-home placement agencies needing mobile dentistry through the services of the PC's dentist(s)." [16] The compensation for ReachOut is divided into two categories: direct expenses and administrative services. Administrative services are billed at a fee of $500 per visit for all services provided.[17] Direct expenses are billed at the actual cost plus 15% of the entire professional corporation (PC)'s employee salaries and expenses paid from the PC's account.[18]

Before children can receive treatment during school hours, they must obtain parental approval. ReachOut America maintains that all offered services must be pre-approved by the child's parents or legal guardians. Verification of the legal guardianship of the child is the responsibility of the school. However, per contractual agreement, ReachOut facilitates the delivery of the Provider consent forms and coordinates the completion of the consent forms:

- Arrange for the delivery of the Provider consent forms to the proper school employee in each school for each student to take home.
- Coordinate that each school obtains completed consent forms by the students and that they are provided to the Administrator [ReachOut].[19]

In ReachOut's case, the reported problems of unnecessary procedures, lack of parental consent, and patient abuse appear to be the result of ReachOut having management agreements with several unscrupulous dentists. Given the administrative nature of their arrangement, ReachOut lacks ability to police such bad actors. As of last year, the company had no standards for dentists with whom they contract to obtain parental consent for treatment—leaving each mobile clinic to devise its own forms and procedures. While these factors appear to have contributed to many of the problems reported to us involving the company, it is also evidence that ReachOut does not significantly control the operations of clinic dentists, and simply contracts with dentists to provide support services.

---

[16] Administrative Agreement between ReachOut and [REDACTED] DDS, PC at 1 (July 2, 2006) (bates RHA 0000007–0000021) (emphasis added) (Exhibit 32).
[17] *See id.* at 9.
[18] *See id.*
[19] Administrative Agreement between ReachOut and [REDACTED] D.D.S., Big Smiles Maryland PC, at 5 (Apr. 1, 2009) (bates RHA 0000246) (Exhibit 35).

III. Key Findings

1. Through management services agreements with dentists, CSHM is the *de facto* owner of all Small Smiles clinics. It retains all the rights of ownership, employs all staff, recruits all staff, makes all personnel decisions, and receives all income from each Small Smiles clinic.

2. CSHM entered into a Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) as part of the company's settlement with the U.S. Department of Justice (DOJ). As part of the agreement, an Independent Monitor (IM) conducts extensive audits of CSHM's clinics. During the last 3 years, the IM has found massive amounts of taxpayer dollars being recklessly spent on unnecessary procedures on children in the Medicaid program by Small Smiles clinics.

3. After 2 years of intense scrutiny by HHS OIG through the CIA, and attempting to follow newly prescribed rules, CSHM went bankrupt.

4. After 3 years of monitoring by the HHS OIG and emerging from bankruptcy with new ownership and leadership changes, CSHM has repeatedly failed to meet quality and compliance standards set forth in the CIA with HHS OIG. Breaches in quality and compliance include: (1) unnecessary treatment on children; (2) improper administration of anesthesia; (3) providing care without proper consent; and (4) overcharging the Medicaid program.

5. Despite CSHM's repeated violations of the CIA, resulting in both monetary fines and an HHS OIG-issued Notice of Intent to Exclude the company from Medicaid, HHS OIG has allowed Small Smiles to continue to participate in the program.

6. Despite state laws against the corporate practice of dentistry, numerous states have allowed companies such as CSHM to operate dental clinics under the guise of management services agreements. These practices appear contrary to the purpose of state law requiring clinics to be owned and operated by licensed dentists. The result is poor quality of care, billing Medicaid for unnecessary treatment, and disturbing consumer complaints.

7. Access to dental care is a problem in certain parts of the country, particularly rural areas for the dual reasons of fewer employment opportunities and lower reimbursement rates than urban counterparts. It is also a problem for some patients served by the Medicaid program due to the number of dentists who are unwilling to accept patients on Medicaid. Access is complicated by the burden of extremely high student loans of dentists graduating from dental school that makes serving rural or Medicaid populations problematic.

IV. Church Street Health Management and Small Smiles Dental Centers

Church Street Health Management was the successor company of an organization called FORBA (For Better Access). FORBA was founded in Pueblo, Colorado on February 9, 2001 by Dan DeRose.[20] At the time of incorporation, FORBA operated only a handful of Small Smiles clinics in Colorado and New Mexico.[21] Eventually, the company grew and expanded to a nationwide chain with more than 60 clinics, and benefitted from an influx of private equity dollars, including investments by The Carlyle Group and Arcapita.[22] Today, Small Smiles' mission is "to provide the highest quality dental care to low-income children in the Medicaid and [S]CHIP populations."[23]

An investigative report in 2008 by the ABC–7 I–Team in Washington, DC revealed serious abuses at Small Smiles clinics. Featured clinics prohibited parents from accompanying their children during treatments and excessively used a device called a papoose board, which is used to strap down young patients and immobilize them during treatment. The clinics performed a high number of crowns and pulpotomies on children who did not require such aggressive treatment and engaged in improper X-ray billing. The quality of care was significantly below any recognized medical standard according to independent pediatric dentists interviewed by ABC–7.[24]

This explosive report was triggered by several *qui tam* actions[25] initiating the investigations by the Department of Justice and the Department of Health and Human Services Office of Inspector General.[26] Acting Associate Attorney General Tony West went so far as to describe the conduct of Small Smiles as "really horrific stuff," and further stated, "[T]he behavior in that [clinic] was so egregious that we had to—I think we were compelled to be very aggressive about going after [the] fraud in that case."[27] The company eventually settled with the government and entered into a CIA, which provided for extensive audits by an Independent Monitor.[28] On February 20, 2012, after struggling to comply with the CIA, Church Street Health Management filed for Chapter 11 Bankruptcy protec-

---

[20] Articles of Incorporation of FORBA, Inc., Secretary of the State of Colorado, signed by Dan DeRose (Feb. 9, 2001) (Exhibit 1).

[21] *See* Small Smiles History, *http://www.smallsmiles.com/small-smiles-history.php* (last visited Mar. 22, 2013).

[22] Press Release, Arcapita, Arcapita Completes Largest US Corporate Transaction (Jan. 15, 2007) (*http://www.arcapita.com/media/press_releases/2007/01–15–07.html*); Sydney P. Freedberg, *Dental Abuse of U.S. Poor Dodges Ejection from Medicaid*, BLOOMBERGBUSINESSWEEK, June 26, 2012, *http://www.businessweek.com/printer/articles/268590?type=bloomberg;* Dr. Steven Adair Joins FORBA Dental Management as Chief Dental Officer, BUSINESS WIRE, Sept. 19, 2008 (on file with author).

[23] *See* Small Smiles FAQs, *http://www.smallsmiles.com/faqs.php* (last visited Mar. 22, 2013).

[24] I–Team: Small Smiles Investigation, *http://www.youtube.com/watch?v=pIoMaw4zC9Q* (last visited Mar. 22, 2013).

[25] *See* BALLENTINE'S LAW DICTIONARY (2010) ("An action to recover a penalty brought by an informer in the situation where one portion of the recovery goes to the informer and the other portion to the state").

[26] Civil Settlement Agreement, FORBA and Dep't of Justice (Jan. 15, 2010) (Exhibit 2).

[27] Interview with Tony West, Acting Associate Attorney General, Department of Justice, in Washington, D.C. (Mar. 18, 2013) (on file with authors).

[28] Corporate Integrity Agreement, Department of Health and Human Services and FORBA Holdings, LLC (Jan. 15, 2010) (Exhibit 3).

tion.[29] The company emerged from bankruptcy under the moniker CSHM, which is how we will generally refer to the company in this report.

A. Corporate Structure

CSHM argues that it does not own any dental clinics, but rather that it has management services agreements with dentists who own the clinics.[30] However, courts have voided management services agreements with similar characteristics to the agreements between CSHM and their dental clinics.[31] Based on our review of several management services agreements, employment contracts, and the payment structure, it appears that these arrangements are designed to give the appearance of complying with state laws requiring that dental clinics be owned by licensed dentists.[32] However, in practice, dental clinics are not owned by dentists in any meaningful sense.

Typically, an agreement between the owner of a business and a third-party management company would simply involve the business owner paying a fee to the management company in return for services. The arrangements between CSHM and its dental centers, however, are much more complex. Like traditional third-party management agreements, dental clinics are obligated to pay CSHM a management fee under the terms of their management agreements. However, in that the benefits of the dental operations are heavily weighted toward CSHM, this fee is unlike traditional agreements on account of the sheer asymmetry benefitting CSHM. Specifically, each calendar month, a dental clinic must pay CSHM *the greater of:* (i) $175,000; *or* (ii) 40% of the "Gross Revenues";[33] *or* (iii) **100% of the "Residual."**[34] "Residual" is defined as "the Gross Revenues and income *of any kind derived, directly or indirectly, from the Business* . . . based on the net amount actually collected after taking into account all refunds, allowances, and discounts." Notably, "residual" excludes "owner dentist" or staff compensation and benefits (and other expenses).[35] Therefore, at a minimum for any given month, CSHM is collecting a $175,000 management fee from dental clinics, even if the clinic loses money. However, for banner months CSHM is poised to reap 100% of a clinic's gross revenues and income, minus "owner dentist" and staff salaries and benefits.

---

[29] Bankruptcy Filing, Case 3:12–bk–01573 (Feb. 2, 2012) (Exhibit 4).

[30] Letter from Theodore Hester, Attorney at King & Spalding, to Senators Baucus and Grassley (Nov. 29, 2011) (Exhibit 5).

[31] *See, e.g.,* Consent Order Granting Permanent Inj. at 4, N.C. State Bd. of Dental Exam'rs v. Heartland Dental Care, Inc., 11 CVS 2343 (N.C. Gen. Court of Justice Super. Ct. Div. 2011) (rescinding the Management Services Agreements between Heartland and Drs. Cameron & Son) (Exhibit 61).

[32] *See* Appendix A. *See generally* Jim Moriarty, *Survey of State Laws Governing the Corporate Practice of Dentistry,* Moriarty Leyendecker 2012, at 10–11, *http://moriarty.com/content/documents/ML_PDFs/cpmd_4.10.12.pdf.*

[33] *See* Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 8 (Oct. 1, 2010) (Exhibit 6). ("Gross Revenues shall mean all fees and charges recorded or booked on an accrual basis each month by or on behalf of Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice or the Clinic, less a reasonable allowance for uncollectable accounts, professional courtesies and discounts.").

[34] *See id.* (emphasis added).

[35] *Id.* at 9.

According to a December 2011 letter from CSHM, "owners typically pay themselves a fixed administrative fee from the practices they own."[36] However, when Senate staff interviewed a Small Smiles "owner dentist," a different story emerged. After claiming that she owned five clinics in Maryland and Virginia, the interviewee stated that she was paid a flat fee by the company, as opposed to paying herself a fixed administrative fee.[37] Claiming that she had no input in choosing the amount of said fee, the "owner dentist" further indicated she did not know if she was entitled to additional payments based on the number of clinics she supposedly owned, but was currently receiving one flat fee as if she owned only one clinic.[38] When asked why she chose to tell state authorities that she owned additional clinics for no additional compensation, the "owner dentist" stated that CSHM told her the clinics would close if someone else could not be found to list as the owner.[39] This arrangement is in direct contradiction to the representations made by CSHM in its December 16, 2011, letter to Senators Grassley and Baucus.[40]

At Small Smiles, "owner dentists" enjoy none of the traditional benefits normally associated with ownership. The "owner dentist" has no equity in the practice in any meaningful sense of the word. According to the Buy-Sell Agreement, CSHM can replace the "owner dentists" at will, and the "owner dentist" has no right to sell the practice without consent from CSHM.[41] Furthermore, the Buy-Sell Agreement states that should an Event of Transfer occur, a Small Smiles representative is then entitled to buy *all* of the "owner dentist's" ownership interests.[42] Event of Transfer includes (but is not limited to) the following: owner's death, owner's loss of license to practice dentistry, owner's ineligibility to participate in Medicare or Medicaid, loss of owner's professional liability insurance, or owner's termination or end of employment with CSHM or Small Smiles.[43] In the event of an Event of Transfer or Involuntary Transfer,[44] the "owner dentist" is only entitled to the purchase price of $100.[45] Notably, pursuant to stock pledge agreements with CSHM, "owner dentists" are prohibited from issuing additional shares of capital stock in the dental clinic without first obtaining

---

[36] Letter from Graciela M. Rodriquez, Attorney at King & Spalding, to Senators Baucus and Grassley (Dec. 16, 2011) (Exhibit 7).

[37] *See* Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

[38] *See id.*

[39] *See id.*

[40] *See* Letter from Graciela M. Rodriquez, Attorney at King & Spalding, to Senators Baucus and Grassley (Dec. 16, 2011) (Exhibit 7).

[41] *Id; see, e.g.,* CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 1 (Oct. 1, 2010) (CSHM–00000950) (Exhibit 8).

[42] CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 1 (Oct. 1, 2010) (CSHM–00000950) (Exhibit 8).

[43] CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 2–3 (Oct. 1, 2010) (CSHM–00000950) (Exhibit 8).

[44] *See id.* at 3 ("involuntary transfer" is an event "in which Owner shall be deprived or divested of any right, title or interest in or to any Ownership Interest, including, without limitation, upon the death of Owner, transfer in connection with marital divorce or separation proceedings, levy of execution, transfer in connection with bankruptcy, reorganization, insolvency or similar proceedings. . . .").

[45] *See* Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012); *see, e.g.,* CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 2–3 (Oct. 1, 2010) (CSHM–00000950) (Exhibit 8).

CSHM's discretionary express written consent.[46] Additionally, "owner dentists" may also not amend, alter, terminate or supplement the clinic's Articles of Incorporation, corporate Bylaws, and/or other vital documents without first obtaining CSHM's express written consent.[47]

All lease agreements for the clinic buildings, property, and equipment are with CSHM, not the "owner dentist."[48] The "owner dentist" cannot determine the schedule or number of patients that they or their dentists see each day.[49] Furthermore, the "owner dentist" cannot hire or fire employees or purchase new equipment without receiving approval from CSHM.[50]

The purpose of these arrangements is made abundantly clear in a 2006 memorandum assessing CSHM's (formerly FORBA) value:

> Due to the state regulations prohibiting the corporate practice of dentistry, FORBA *does not technically* provide dental care to the patient, own any interest in its affiliated practices, or employ the dentists in the clinic. However, FORBA selects the new sites, negotiates the lease, oversees construction of the clinics, purchases the equipment, installs the IT and billing infrastructure, employs the staff, recruits the dentists and receives all of the income. Thus, it *effectively owns and manages* the clinics.[51]

Thus, by this description, it is clear that the dental management company actually maintains ownership and control over Small Smiles clinics. Moreover, the facts and circumstances surrounding the creation and implementation of the CIA illustrate that this particular ownership structure undermined the independent, professional, and clinical judgment of Small Smiles dentists. That is precisely the harm that state laws requiring that dentists own dental practices are designed to prevent.

In addition to the many other ways that CSHM limits the exercise of professional judgment by its dentists, the CIA *requires* CSHM to ensure compliance with quality of care standards,[52] perform regular audits,[53] and establish, implement, and distribute a Code of Conduct articulating consequences for non-complying dentists.[54] For example, the agreement requires CSHM's board to "ensure that each individual cared for by [CSHM] and in [CSHM] facilities receives the professionally recognized standards of care."[55] While the CIA provisions to ensure CSHM follows recognized standards of care are well-intentioned, it creates an affirmative duty for CSHM to exercise control over the professional judgment

---

[46] CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Stock Pledge Agreement with [REDACTED] at 3 (Oct. 1, 2010) (CSHM–00000959) (Exhibit 65).

[47] *See id.*

[48] *See* Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

[49] *See, e.g.,* e-mail from Dr. [REDACTED] to Dr. [REDACTED] (May 19, 2011, 4:57 pm) (Exhibit 9).

[50] *Id.; see also* Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

[51] MIC Memorandum, FORBA, LLC, Arcapita at 6 (June 2006) (FORBA_0046011) (Exhibit 10) (emphasis added). Arcapita was the private equity firm that owned FORBA, LLC.

[52] Corporate Integrity Agreement Between the Office of Inspector Gen. of the Dep't of Health & Human Serv. and Forba Holdings, LLC, at 13–14 (Jan. 14, 2010) (Exhibit 3).

[53] *Id.* at 10–11.

[54] *Id.* at 11–12.

[55] *Id.* at 8.

of dentists in states that do not allow a corporation to own dental clinics or interfere with dentists' professional judgment. Therefore, the CIA has the effect of enhancing control over dental clinic operations by CSHM which is a corporation that is not licensed to practice dentistry.

B. The Influence of Private Equity

Venture capital and private equity deals are central to economic growth and innovation. However, the interest of private equity targeting dental practices within the Medicaid system is alarming—especially considering the regular complaints of private dentists and doctors about low Medicaid reimbursement rates. If a dentist in a small family practice cannot afford to take Medicaid patients because of low reimbursement rates, why would private equity invest capital in this business model? What can firms backed by private equity investment do to make money from Medicaid patients that locally owned and operated practices cannot or will not do? The answer is "volume."

Through various meetings—both with CSHM executives and employees at the Small Smiles Oxon Hill facility—Committee staff were told that CSHM's business model was to increase patient volume as much as possible. In order to do this, CSHM executives and staff claimed that due to the population the clinics are serving, they must over-book appointments. This means, at times, two to three patients will be scheduled for a single time slot. CSHM claims that Medicaid patients tend to be unreliable, often not showing up for scheduled appointments. This is confirmed by a 2006 memorandum assessing FORBA's (CSHM's precursor) value:

> Importantly, FORBA's unique business model mitigates the 33% broken appointment challenge in that patients are not scheduled to have appointments with specific dentists. Instead, any one of four dentists at a clinic can see a patient. Therefore, since FORBA employs a minimum of three to four dentists per clinic, *FORBA can leverage its critical mass of dentists and over-schedule appointments by 25%.*[56]

CSHM has also employed the use of bonuses as a way to incentivize their employees, both dentists and non-dentists, to maximize volume and profit. Under FORBA's leadership, employees received both a salary and productivity-based bonuses based on contests amongst dental clinics. Bonuses were based on: (1) daily average productivity, (2) broken appointment rates, (3) number of patients seen per day, and (4) number of patients converted from providing simple hygiene to operative dental work (at a higher reimbursement rate).[57] Based on a clinic's productivity level, employees could receive up to $1,000.[58] FORBA would hold these contests multiple times throughout the year.

---

[56] MIC Memorandum, FORBA, LLC, Arcapita at 26–27 (June 2006) (FORBA_0046011) (Exhibit 10) (emphasis added). Arcapita was the private equity firm that owned FORBA, LLC.

[57] *See* FORBA, March Madness at 1 (FORBA 0236082/CSHM–00002086) (Exhibit 11).

[58] *See* FORBA, The Road to the Super Bowl (FORBA 0230059/CSHM–00002004) (Exhibit 45).

Under management by CSHM, compensation is based on the revenue of that dental clinic as well as the collections of each dentist.[59] This productivity-based compensation arrangement prioritizes volume, operative procedures over preventive care, and encourages unnecessary care.[60] In fact, when asked what aspects of her job were the most dissatisfying in an exit interview with CSHM, one Lead Dentist disclosed, "Only after doctors were converted to production[-]based compensation. This conversion caused distractions and realignment of priorities. Inability to concentrate only on dentistry and patient needs."[61] [sic]

If dentists in a CSHM clinic feel the schedule is unmanageable, they are not permitted to hire additional employees to handle the increased workload without approval from CSHM executives. Nor do they have the authority to reduce their own patient load. For example, in a May 2011 e-mail from a Lead Dentist to CSHM management, the Lead Dentist complained to CSHM management that staffing was not at the appropriate level to handle the patient load they were carrying.[62] CSHM replied that, "As we discussed yesterday, the patient load *will not be reduced* without collaboration from CSHM."[63] The Lead Dentist replied, "I will not be [held] responsible for errors in my center when we have asked for help numerous times."[64]

C. Federal Government Intervention

In 2010, after a lengthy investigation into the company by the United States Department of Justice, CSHM entered into a CIA with the United States Department of Health and Human Services,[65] as well as settlement agreements with the United States Department of Justice and 22 states.[66] The Department of Justice settlement cites conduct by FORBA (now CSHM) from the time period of September 2006 through June 2010.[67] Specifically, the conduct noted in the agreement includes submitting Medicaid reimbursement claims for medically unnecessary pulpotomies, crowns, extractions, fillings, sealants, x-rays, anesthesia, and behavior management; failing to meet professionally recognized standards of care; and provision of care by unlicensed persons.[68] CSHM's CIA with the Department of Health and Human Services required CSHM to institute rigorous compliance procedures and programs, as well as submit to regular audits and reviews by an Independent Monitor.[69]

To date, the Independent Monitor has audited and reviewed 60 Small Smiles clinics through an onsite review or desk audit since 2010. Consistently, the Independent Monitor reports reveal that

---

[59] *See* CSHM/Small Smiles Dental Center of Holyoke, LLC, Lead Dentist Employment Agreement with Dr. [REDACTED] at 4–6 (Aug. 30, 2010) (Exhibit 12).

[60] *Id.*

[61] CSHM Exit Interview, Medrina Gilliam at 1 (July 1, 2011) (CSHM–00006826) (Exhibit 13).

[62] *See* E-mail chain from Dr. [REDACTED] to Dr. [REDACTED] (May 19–20, 2011) (Exhibit 9).

[63] *Id.*

[64] *Id.*

[65] Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 2 (Oct. 4, 2012) (Exhibit 14).

[66] CSHM/FORBA Holdings, LLC, State Settlement Agreement with the State of N.Y. (Jan. 20, 2010) (Exhibit 15).

[67] *See* Civil Settlement Agreement, FORBA and Dep't of Justice (Jan. 15, 2010) (Exhibit 2).

[68] *See id.*

[69] *See* Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 2 (Oct. 4, 2012) (Exhibit 14).

clinic employees had little awareness of the new compliance procedures, and that CSHM was giving its dentists passing grades on chart audits which the Independent Monitor says they clearly failed.[70] In fact, of the 14 reports that graded the clinic doctors on a 100-point scale, CSHM gave their doctors grades that were on average 44% higher than the grade that the Independent Monitor awarded.[71]

D. Committee Staff Site Visit to Small Smiles of Oxon Hill, Maryland

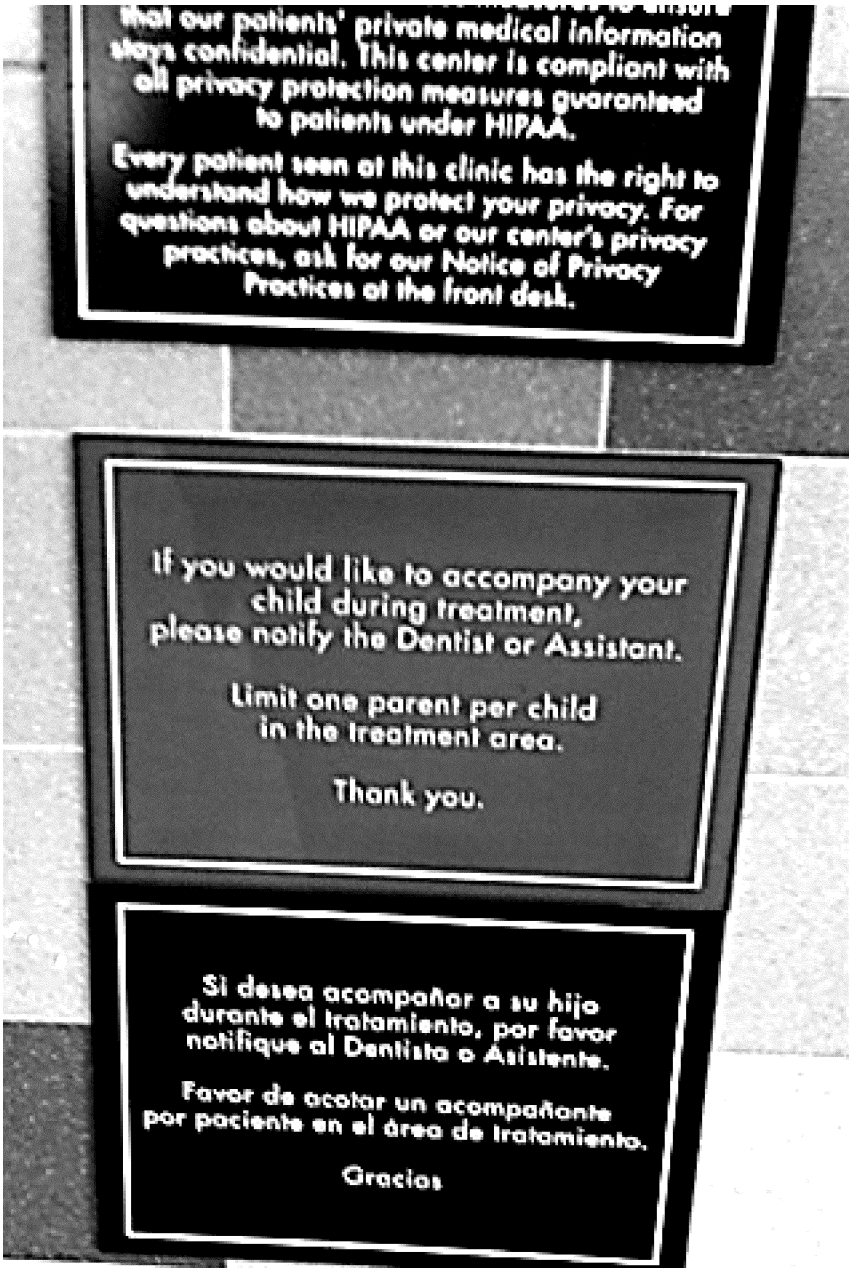
On March 7, 2012, Committee staff arranged a site visit at a Small Smiles Dental Center in Oxon Hill, Maryland, during an audit by the Independent Monitor.[72] The center was large, reasonably well kept, and clinic employees were friendly and welcoming. Signs informing parents of their right to join their children in the treatment area were prominently displayed in both English and Spanish:[73]

[70] *See* Independent Monitor Report, Oxon Hill, Md. at 11 (Apr. 20, 2012) (Exhibit 16).

[71] *See* Independent Monitor Report, Worcester, Mass. at 5 (Jan. 4, 2011) (Exhibit 46); Independent Monitor Report, Thornton, Colo. at 6 (Feb. 4, 2011) (Exhibit 47); Independent Monitor Report, Santa Fe, N.M. at 6 (Mar. 7, 2011) (Exhibit 48); Independent Monitor Report, Albuquerque, N.M. at 5 (Apr. 8 2011) (Exhibit 49); Independent Monitor Report, Myrtle Beach, S.C. at 6 (May 9, 2011) (Exhibit 50); Independent Monitor Report, Augusta, Ga. at 6 (July 1, 2011) (Exhibit 51); Independent Monitor Report, Austin, Tex. at 6 (July 29, 2011) (Exhibit 52); Independent Monitor Report, Mattapan, Mass. at 6 (Sept. 6, 2011) (Exhibit 53); Independent Monitor Report, Manassas, Va. at 8 (Sept. 22, 2011) (Exhibit 23); Independent Monitor Report, Youngstown, Ohio at 5 (Oct. 14, 2011) (Exhibit 27); Independent Monitor Report, Oklahoma City, Okla. at 6 (Nov. 4, 2011) (Exhibit 54); Independent Monitor Report, Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40); Independent Monitor Report, Brockton, Mass. at 6 (Nov. 9, 2012) (Exhibit 55); Independent Monitor Report, Denver, Colo. at 7 (Dec. 7, 2012) (Exhibit 56). The 44% figure was calculated by averaging the CSHM score and the Independent Monitor score for each doctor in the listed reports. The difference was found between each score, which resulted in 44% higher average in CSHM scores than Independent Monitor scores.

[72] *Id.* at 8.

[73] *See* Small Smiles Clinic, Oxon Hill, Md. Photograph of signs (Exhibit 37).


that our patients' private medical information
stays confidential. This center is compliant with
all privacy protection measures guaranteed
to patients under HIPAA.
Every patient seen at this clinic has the right to
understand how we protect your privacy. For
questions about HIPAA or our center's privacy
practices, ask for our Notice of Privacy
Practices at the front desk.
If you would like to accompany your
child during treatment,
please notify the Dentist or Assistant.
Limit one parent per child
in the treatment area.
Thank you.
Si desea acompañar a su hijo
durante el tratamiento, por favor
notifique al Dentista o Asistente.
Favor de acotar un acompañante
por paciente en el área de tratamiento.
Gracias

Committee staff was given the opportunity to sit in with the Independent Monitor during the interview of three employees of the clinic and ask supplemental questions.

The first employee interviewed was the clinic's Office Manager/Compliance Liaison.[74] The role of the Compliance Liaison is to keep up-to-date with CSHM compliance policies and ensure that staff is knowledgeable and well-trained in compliance policies.[75] For example, the Compliance Liaison is responsible for regularly checking the company's web portal to see if there are any new compliance trainings on topics such as X-ray safety, record management, and billing practices.[76] During questioning, it became increasingly clear that the Compliance Liaison was simply too busy running the clinic to keep up with his compliance duties. This particular clinic treats as many as 70 children each day, and makes appointments for well over 100.[77]

The Compliance Liaison also indicated that he was previously the Office Manager and Compliance Liaison at yet another troubled Small Smiles clinic in Manassas, Virginia.[78] When asked whether he thought there were any problem areas with the Manassas clinic, he responded that he did not think so.[79]

The next employee interviewed was the Clinical Coordinator. The Clinical Coordinator is typically a facilitator—making certain that the busy treatment area operates efficiently. The Clinical Coordinator maintains and orders supplies, monitors patient flow, and keeps things moving. During the interview, it was clear that the Clinical Coordinator was not knowledgeable about important safety and compliance policies. For example, when the Independent Monitor asked what should be done when a child has evidence of tooth decay, but will not sit still for X-rays, the Clinical Coordinator responded that the dental assistant or available staff should sit with the child in the X-ray area and hold the child still.[80] However, pediatric dental education literature emphasizes that given "associated risks and possible consequences of [protective stabilization], the *dentist* is encouraged to evaluate thoroughly its use on each patient and possible alternatives."[81] A dentist must consider the following factors prior to using protective stabilization: "1. alternative behavior guidance modalities; 2. dental needs of the patient; 3. the effect on the quality of dental care; 4. the patient's emotional development; [and] 5. the patient's medical and physical considerations."[82] The Clinical Coordinator was terminated.

Finally, Committee staff questioned the "owner dentist" of Oxon Hill Small Smiles, who was also the Lead Dentist. The "owner dentist" appeared nervous when speaking with the Independent Monitor and Committee staff, but appeared genuinely passionate about

---

[74] *See generally* Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

[75] *See* CSHM Office Manager's Manual, v. 06–2011, at 15 (Dec. 17, 2010) (Exhibit 17).

[76] *See* Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

[77] *See* Daily Patient Flow at 5 (Apr. 13, 2011) (Exhibit 18).

[78] Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012); see discussion at Parts E.2.

[79] *Id.*

[80] *Id.*

[81] 34 AM. ACAD. OF PEDIATRIC DENTISTRY, REFERENCE MANUAL: GUIDELINE ON BEHAVIOR GUIDANCE FOR THE PEDIATRIC DENTAL PATIENT 176 (1990) (emphasis added) (Exhibit 19).

[82] *Id.*

dental care for underprivileged children. When asked about the details of her compensation, the "owner dentist" stated that she receives a salary, and an additional flat payment for being the "owner dentist."[83] When asked how many Small Smiles Dental Centers she owned, she stated that she owned five clinics and had just recently become the owner of the Manassas, Virginia clinic.[84] She was then asked if she received an additional flat fee payment for each clinic that she owned, and she stated that she did not.[85] Following up on that question, she was asked why she chose to become the owner of the troubled Manassas[86] clinic for no additional compensation, and she stated that she was told it would have to close if she did not agree to become the owner.[87] The "owner dentist" was then asked if she could name any of the dentists under her employ at the Manassas clinic she purported to own.[88] She could not name a single dentist at that facility. When asked if she had ever been to the Small Smiles clinic in Manassas, she replied that she had not.[89] When asked whether she knew the names of any of the dentists at another Maryland clinic she purported to own, she struggled for some time before recalling one dentist's first name.[90]

The next line of questioning for the "owner dentist" was regarding her control over operations at the clinics she supposedly owns. She was adamant that all medical decisions remain under her control. However, she conceded that CSHM receives 100% of the proceeds of the business, pays all of the staff salaries at her clinic, pays her salary, dictates the number of patients to be scheduled for each day, sets the budget for supplies, rents the space the clinic uses, and has complete control over all hiring and firing decisions.[91] When pressed further regarding her ability to hire additional staff should the clinic need an additional dentist to keep up with demand and provide quality care, she did not wish to engage in the hypothetical discussion, but conceded that she had never hired or fired anyone without the permission of CSHM.[92]

Despite the language in the management services agreement regarding the payment structure and management fees paid to CSHM, it is clear that the "owner dentists" have no idea where the money from the procedures for which they bill Medicaid actually ends up. "Owner dentists" are merely paid a salary by CSHM and receive a flat fee to assert ownership to their respective state, but they exercise none of the traditional elements of ownership.

---

[83] Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).
[84] *Id.*
[85] *Id.*
[86] *See* discussion at Parts E.2.
[87] *Id.*
[88] Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *Id.*

E. CSHM Repeatedly Fails to Meet Quality and Compliance Standards

The Department of Health and Human Services Office of Inspector General and the Independent Monitor have closely monitored Small Smiles clinics and their corporate owners since 2010. Monitoring has included audits, site visits, fines, penalties, and changes to management, and yet CSHM repeatedly fails to meet basic quality and compliance standards. According to Independent Monitor reports, the company is still rushing through dental treatments, providing substandard and in some cases dangerous care, performing medically unnecessary treatments, and risking the safety of children—all of which are ultimately financed by taxpayers through the Medicaid program.[93]

Each time the company fails to meet its obligations or the Independent Monitor uncovers problems, the company promises to do better, and HHS OIG gives CSHM another chance. The following sections outline the major failures of CSHM during the monitoring period, and the seemingly endless capacity for the government to grant the company more chances.

1. Phoenix, Arizona Independent Monitor Report

The Independent Monitor visited a Small Smiles clinic in Phoenix, Arizona on December 23, 2010, relatively early on in the monitoring period. At this clinic, the Lead Dentist informed the Independent Monitor that she automatically performed pulpotomies on primary anterior teeth that received a NuSmiles crown.[94] A NuSmiles crown is a stainless steel crown (SSC) with a natural-looking, tooth-colored coating.[95] According to the Lead Dentist, "the amount of tooth structure removal necessary to prepare the teeth for the crowns endanger the pulp and necessitated pulpotomies."[96] However, a pulpotomy is only necessary when the nerve is exposed, and is typically only indicated in one-third of patients.[97] Therefore, if the patient population is typical, two-thirds of the pulpotomies that the Lead Dentist in Phoenix performed were potentially unnecessary, at a total cost of approximately $5,300 per 100 Medicaid patients.[98] Not only is this a quality of care issue, with children receiving unnecessarily prolonged treatments, but it is also a drain on the Medicaid system. When dentists perform unnecessary pulpotomies, it is the Medicaid system that initially foots the bill, and then ultimately the taxpayers. It is unclear whether outside influence or information compelled the dentist to do pulpotomies every single time, but this case illustrates that the trainings and compliance programs necessitated by the CIA were largely ineffectual.

Of the 30 records reviewed by the Independent Monitor, 15 documented children being strapped down to a papoose board during

---

[93] *See* IMR Oxon Hill, Md. at 27 (Exhibit 16).
[94] Independent Monitor Report Phoenix, Ariz. at 3 (Dec. 23, 2010) (Exhibit 20).
[95] NuSmile, Pediatric Crowns, *http://www.nusmilecrowns.com* (last visited Mar. 22, 2013).
[96] IMR Phoenix, Ariz. at 3 (Exhibit 20).
[97] Thikkurissy, Sarat, et al., *Pulpotomy to Stainless Steel Crown Ratio in Children With Early Childhood Caries: A Cross-sectional Analysis Pediatric Dentistry,* Pediatric Dentistry, vol. 33 n. 7, 496, (Nov./Dec. 2011) (Exhibit 21).
[98] Arizona Health Care Cost Containment System—Schedule of Dental Rates (Jan. 1, 2007) (Exhibit 22). Each pulpotomy costs $81. *Id.* at 2.

treatment.[99] However, none of these patients received nitrous oxide/oxygen anesthesia, which is the preferred method of calming young dental patients.[100] Furthermore, one child was documented as being on the papoose board for 1 hour and 45 minutes, without monitoring of vital signs or a bathroom break.[101] This is a clear violation of CSHM's policies and is dangerous and distressing for the child.[102]

This early Independent Monitor report demonstrates that many of the problems identified in prior news reports and flagged by DOJ in 2007 and 2008 were still common practice at Small Smiles in late 2010, including unnecessary procedures, overuse of the papoose board on distressed children, and a general lack of understanding by Small Smiles dentists regarding how children should be treated.

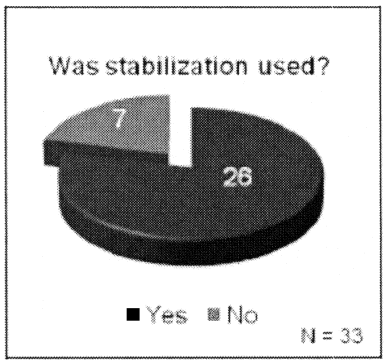
2. Manassas, Virginia Independent Monitor Report

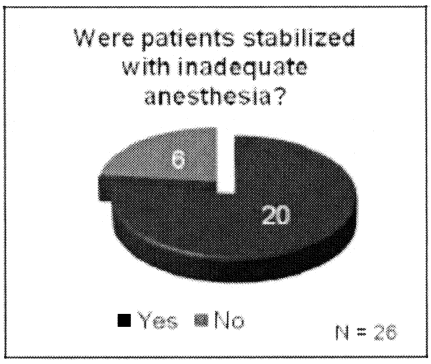
The Independent Monitor visited a Small Smiles clinic in Manassas, Virginia on September 22, 2011—nearly one year after the initiation of compliance programs, training, and monitoring by the government. The Independent Monitor found many of the same problems, and nearly an identical case involving the misuse of a papoose board. Both dentists at the clinic scored lower on the Independent Monitor's evaluation than on a previous internal audit conducted by CSHM. These dentists did not follow proper protocols for implementing and documenting dental procedures, and this ultimately resulted in one dentist receiving an automatic failure from the Independent Monitor.[103] This fact is critical. The purpose of the monitoring period is that, at the end of 5 years, CSHM should be able to use its own internal monitoring and compliance programs. In numerous Independent Monitor reports, however, CSHM's audits have given dentists passing grades, while the subsequent Independent Monitor's review found that these same dentists clearly failed.[104] Therefore, despite the passage of time and ample guidance from the government, CSHM is still unable to rely on its own internal monitoring and compliance programs.

Just like the Phoenix clinic, one dentist at the Manassas clinic utilized a papoose board on a patient for 1 hour and 45 minutes, a violation of CSHM use of restraint policy,[105] and in violation of generally recognized standards from the American Academy of Pediatric Dentists.[106]

---

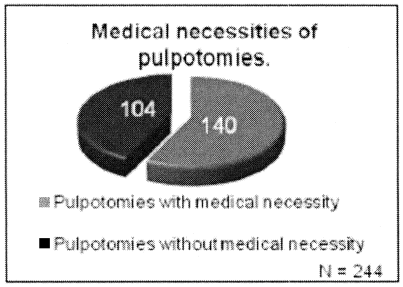
[99] IMR Phoenix, Ariz. at 17 (Exhibit 20).
[100] *Id.* at 18.
[101] *Id.* at 17.
[102] *Id.* at 17–18.
[103] Independent Monitor Report Manassas, Va. at 2 (Sept. 22, 2011) (Exhibit 23).
[104] Independent Monitor Report, Worcester, Mass. at 5 (Jan. 4, 2011) (Exhibit 46); Independent Monitor Report, Thornton, Colo. at 6 (Feb. 4, 2011) (Exhibit 47); Independent Monitor Report, Santa Fe, N.M. at 6 (Mar. 7, 2011) (Exhibit 48); Independent Monitor Report, Albuquerque, N.M. at 5 (Apr. 8 2011) (Exhibit 49); Independent Monitor Report, Myrtle Beach, S.C. at 6 (May 9, 2011) (Exhibit 50); Independent Monitor Report, Augusta, Ga. at 6 (July 1, 2011) (Exhibit 51); Independent Monitor Report, Mattapan, Mass. at 6 (Sept. 6, 2011) (Exhibit 53); Independent Monitor Report, Manassas, Va. at 8 (Sept. 22, 2011) (Exhibit 23); Independent Monitor Report, Youngstown, Ohio at 5 (Oct. 14, 2011) (Exhibit 27); Independent Monitor Report, Oklahoma City, Okla. at 6 (Nov. 4, 2011) (Exhibit 54); Independent Monitor Report, Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40); Independent Monitor Report, Denver, Colo. at 7 (Dec. 7, 2012) (Exhibit 56).
[105] CSHM Policy on Protective Stabilization at 3 (Jan. 14, 2012) (Exhibit 24).
[106] *Guideline on Behavior Guidance for the Pediatric Dental Patient,* American Academy of Pediatric Dentistry, vol. 33 no. 6, 167–68 (2011/2012) (Exhibit 25).



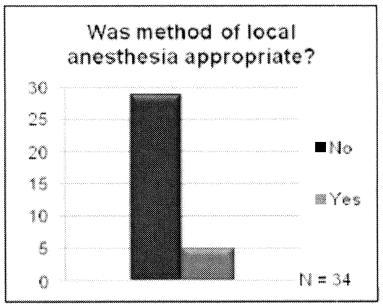


Source: IMR Manassas, Va. at 32 (Exhibit 23).

Another example includes one dentist automatically failing due to the lack of documentation for medical necessity.[107] Manassas clinic dentists billed Medicaid for reimbursement of X-rays even though the Independent Monitor's audit found no evidence that the X-rays were actually performed.[108] Five records revealed patients receiving treatment for 8 to 12 teeth during a single visit without the proper amount of anesthesia being administered. Of 244 pulpotomies performed, 104 "were not medically necessary,"[109] costing taxpayers and the Medicaid program a total of $8,391.[110] This audit also revealed that CSHM's chart audit tool failed to uncover several documentation errors and improper anesthesia use.[111]



Source: IMR Manassas, Va. at 30 (Exhibit 23).



Source: IMR Manassas, Va. at 31 (Exhibit 23).

Allegations of abuse plagued the Manassas clinic, leading to its eventual closure by CSHM. The Committee staff have received information that the Virginia Department of Health Professions will be reviewing the dentists who practiced at the Manassas clinic. Contrary to assertions that a vulnerable population would go un-

[107] *See* IMR Manassas, Va. at 2 (Exhibit 23).
[108] *Id.*
[109] *Id.* at 3.
[110] Virginia Smiles for Children—Schedule of Allowable Fees (Exhibit 66). Each pulpotomy costs $80.69.
[111] *Id.*

treated without Small Smiles, the patients of the Manassas clinic and other clinics closed by CSHM have been absorbed into other practices with little difficulty.[112]

3. Oxon Hill, Maryland Small Smiles Clinic

The report issued by the Independent Monitor after the site visit at the Oxon Hill Small Smiles confirms the findings of the Committee staff who observed the clinic with the Independent Monitor.

First, the Independent Monitor discovered numerous quality of care issues. It found that the clinic was inappropriately documenting and administering local anesthetics and nitrous oxide.[113] Notably, the Independent Monitor observed that "[t]he maximum dose of local anesthetic was not calculated for patients treated by the Lead Dentist before she administered local anesthetic."[114] Rather, local anesthetic calculations were performed and filled in after the fact.[115] Moreover, the clinic was found to be substituting the papoose board for anesthesia or nitrous oxide.[116] This means that the child was both experiencing pain while also being restrained. Out of 30 records, there were six instances in which a child *younger than 5 years old* was restrained during treatment without the use of local anesthetic, and seven instances in which primary teeth fillings on children younger than 7 years old were administered without local anesthesia or nitrous oxide.[117]

Second, the Independent Monitor found alarming practices that had threatened patient safety at Oxon Hill, Maryland clinic. One notable incident involved a child treated with a pulpotomy and a stainless steel crown who was restrained using a patient stabilization device (PSD):

> [C]hild screamed and fought the entire time. The patient kept moving her head, making it difficult to keep it secured. *She vomited approximately half way through the procedure.* The dentist immediately turned the patient on her side and suctioned her mouth and throat. This child's airway was in jeopardy because the mouth prop opened her mouth so wide it restricted her ability to swallow and protect her airway. The patient was screaming and gasping, leaving her airway open and vulnerable. Cotton pellets used during the pulpotomy were placed and removed while SSC's were fitted and removed on a moving, combative, and hysterical child with no methods employed to protect the airway.[118]

Notably, the dentist resumed treatment despite the child's vomiting.

Most shocking was the Independent Monitor's final observation regarding the clinic:

> Treatment was provided to restrained children who were fighting, crying, and basically hysterical, using large mouth props

---

[112] *See* Interview with Church Street Health Management, in Washington, D.C. (Feb. 21, 2012).
[113] *See* IMR Oxon Hill, Md. at 27 (Exhibit 16).
[114] *Id.* at 36.
[115] *Id.*
[116] *Id.*
[117] *See id.* at 27.
[118] *Id.* at 36 (emphasis added).

> that overextended their mouths, compromising their ability to swallow and protect their airways. Water spray from hand pieces, cotton pellets used for pulpotomies, and stainless steel crowns (SSCs) that are fitted and removed all presented potential risk to these children's airways.
>
> Preparedness and anticipation was lacking on the part of the dental assistants during procedures on uncooperative young children.[119]

Third, the Independent Monitor found instances in which no medical necessity was provided for treatments performed. In 9 of the 30 records reviewed by the Independent Monitor, no documentation or X-rays were provided to support the medical necessity of treatments provided to patients.[120] Therefore, in 30% of the records reviewed, the Medicaid program was billed for unjustified and potentially unnecessary treatments. Larger sampling at this and other clinics could reveal massive overpayments by the government to CSHM.

4. Oxon Hill, Maryland Small Smiles Overpayment

At the Oxon Hill Small Smiles Center, mentioned above, HHS OIG was alerted to an $852,492.74 overpayment.[121] Not only was this clinic providing substandard care, according to the Independent Monitor, it was also providing unnecessary treatments and getting excessive payments from Medicaid. Shortly after the overpayment was identified, CSHM satisfied its obligations under the CIA to refund the overpayment.[122]

5. Youngstown, Ohio Clinic

Similar problems occurred at the Youngstown, Ohio clinic, where the Independent Monitor found that the clinic provided unnecessary care and also had billing, reimbursement, and records management issues. HHS OIG even went as far as to demand that Small Smiles pay a $100,000 stipulated penalty and issued a Notice of Material Breach and Intent to Exclude to the Youngstown clinic. Such notices signal that HHS OIG intends to exclude a facility from the Medicaid program. Exclusion would prohibit a facility from treating Medicaid beneficiaries and seeking state and Federal reimbursement. HHS OIG cites the Independent Monitor report findings as the primary reason to exclude the Youngstown facility from participating in the Medicaid program.[123]

Specifically, 7 of the 15 records reviewed by the Independent Monitor revealed a lack of documentation or radiographic evidence to support medical necessity for treatments provided by Small Smiles.[124] Of those 7 records, 6 revealed pulpotomies were performed without medical necessity, while one record showed no X-

---

[119] *Id.* at 5.
[120] *Id.* at 29.
[121] *See* Letter from CSHM to HHS OIG, re: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill at 2 (May 22, 2012) (Exhibit 57).
[122] *See id.*
[123] Letter from HHS OIG to CSHM, re: Demand for Stipulated Penalties and Notice of Material Breach and Intent to Exclude (June 22, 2012) (Exhibit 26).
[124] *Id.* at 4–5.

rays or photographs were taken to support the medical necessity for treatment provided." [125]

The Independent Monitor report found "poorly performed fillings and stainless steel crowns, undiagnosed recurrent decay or faulty restorations, lack of rationale for extractions, no use of local anesthesia for placement of fillings in teeth with deep decay, use of multiple surface fillings without any substantiation as to why stainless steel crowns were not used." [126] In perhaps the most troubling violation observed by the Independent Monitor, the report describes:

> A combative 4-year-old child received a cut to the tongue while three teeth were being treated with fillings, a pulpotomy and a [stainless steel crown]. The documentation in the patient's record did not record the size of the cut and reported the patient was "very strong and vocal." Four people were required to help manage the patient. Documentation also showed that a protective stabilization device (PSD) was used and the patient was "double wrapped" in order to provide treatment. The e-mail communication related with this case did not show that X-rays were requested; therefore, **it appeared there was no evaluation to determine whether the treatment rendered was medically necessary.** [127]

On July 3, 2012, HHS OIG received confirmation that CSHM paid the $100,000 stipulated penalty.[128] On August 23, 2012, HHS OIG sent a letter to CSHM stating that it determined that CSHM "cured the breaches identified in the OIG's Notice, and will not proceed with an exclusion action against CSHM's Small Smiles Dental Centers of Youngstown at this time." [129] CSHM advised HHS OIG of its effort to cure the specific breaches through various actions, including: (1) evaluation and termination of nine staff people; (2) the temporary, 2-day closure to conduct training; and (3) the development of an ongoing oversight and monitoring plan by the Chief Compliance Officer, Chief Dental Officer, the Regional Director, and the Senior Vice President of Operations.[130]

F. Health and Human Services Office of Inspector General Notice of Intent to Exclude

On March 8, 2012, HHS OIG sent a Notice of Material Breach and Intent to Exclude to CSHM. HHS OIG states in its letter that due to CSHM's "repeated and flagrant violation of certain provisions" of the CIA, the OIG is exercising "its right under the CIA to exclude CSHM from participation in the Federal health care programs." [131] HHS OIG largely cites violations occurring at the Manassas, Virginia clinic as primary reasons for its intent to exclude. Specifically, HHS OIG points to five main areas in which CSHM

---

[125] *Id.*
[126] *Id.* at 5.
[127] Independent Monitor Report Youngstown, Ohio at 11 (May 25, 2012) (Exhibit 27) (emphasis added).
[128] *See* Letter from HHS OIG, to CSHM, re: Resolution of the Stipulated Penalties and Notice of Material Breach and Intent to Exclude Matter at 2 (Aug. 23, 2012) (Exhibit 28).
[129] *Id.* at 1.
[130] *See id.*
[131] Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 1 (Mar. 8, 2012) (Exhibit 29).

violated the terms of the CIA: (1) management certifications and accountability; (2) policies and procedures requirements; (3) change to termination policy and procedure; (4) CSHM review of pulp-to-crown ratios and provision of medically unnecessary services at other CSHM facilities; and (5) quality of care reportable event requirements.[132]

Part of complying with the CIA requires CSHM to certify that each employee knows and understands his/her responsibilities and duties under Federal law, state dental board requirements, and professionally recognized standards of care. The certification also requires the employee to "attest that his/her job responsibilities include ensuring compliance with regard to the area under his/her supervision. . . ." [133] On March 15, 2011, CSHM submitted a report to the HHS OIG, including a certification for LaTanya O'Neal, the Lead Dentist in the Manassas, Virginia clinic. On November 16, 2011, HHS OIG conducted a site visit to the Manassas Clinic to gauge if the clinic was in compliance with its obligations under the CIA. During this site visit, the OIG interviewed Ms. O'Neal to ascertain her level of compliance and discuss her oversight role as Lead Dentist. Unfortunately, Ms. O'Neal was not able to address "any compliance-related obligations that she oversaw at Manassas Center." [134] Additionally, Ms. O'Neal could not "recall signing an annual certification or any specific steps that she took to evaluate compliance at Manassas Center for purposes of signing that certification." [135] Ultimately, HHS OIG found Ms. O'Neal's certification to be false.[136] CSHM responded that it could not cure the breach of having submitted a false certification, but indicated that the Certifying Employee who signed the false certification is no longer employed by CSHM. Additionally, CSHM "implemented significant training and revamped [its] process for certifications." [137] These two actions were enough to satisfy HHS OIG.

Section III.B.2.u of the CIA requires CSHM to have written Policies and Procedures in place to terminate employees who have been found to have violated professionally recognized standards of health care.[138] In January 2012, CSHM revised its "Adverse Events, Quality of Care Reportable Events, and OMIG Patient Care Matters" policy which states the following:

> Practitioners who have violated professionally recognized standards of healthcare, including the AAPD Guidelines, the CSHM Clinical Policies and Guidelines for CSHM Associated Dental Centers, and any applicable state or local standards or guidelines, and whose violation has been deemed by the Chief Dental Officer to be a Quality of Care reportable event *will be terminated or will undergo a remediation plan developed by the Chief Dental Officer with approval of the OIG.*[139]

---

[132] *Id.* at 2–8.
[133] *Id.* at 2.
[134] *Id.* at 3.
[135] *Id.*
[136] *See* Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 3 (Mar. 8, 2012) (Exhibit 29).
[137] Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 2–3 (Mar. 13, 2012) (Exhibit 30).
[138] *Id.*
[139] *Id.* at 6 (emphasis added).

The CIA does not allow for the Chief Dental Officer to dismantle the termination process with a remediation plan. Therefore, HHS OIG found this revision to directly contradict the requirements of the CIA because it allowed the Chief Dental Officer to avoid the termination requirement with his/her own remediation plan.[140]

Part of every audit conducted under the CIA includes a desk audit report. Included in each desk audit is a review of all of the dental work associated with that clinic. The Manassas, Virginia clinic desk audit report "indicated that of 244 pulpotomies reviewed by the Monitor, 104 were medically unnecessary."[141] The desk audit also found that as a result, CSHM improperly billed the Medicaid program. CSHM issued a response to the findings on October 31, 2011, stating that it "agrees that pulpotomies were performed that were not medically necessary . . . [and that] CSHM's systems were ineffective in identifying this issue."[142]

Included in the October 2011 response, CSHM also identified 13 dentists with high pulp-to-crown ratios similar to those at the Manassas Clinic in its response to the desk audit.[143] CSHM was planning on addressing these 13 dentists by "monitor[ing] the pulp-to-crown ratio for each of these 13 individuals" and providing "indirect pulp therapy as an alternative to pulpotomies."[144] After its October 2011 response, CSHM clarified that it had identified 12 dentists, and not 13 dentists, who exhibited high pulp-to-crown ratios.[145] However, HHS OIG was not able to determine whether CSHM "had performed or planned to perform a financial review of claims it submitted on behalf of the 12 identified dentists to determine whether CSHM had any overpayment or other liability for claims that were associated with high pulp-to-crown utilization."[146] HHS OIG determined this was a breach of CSHM's duty to develop and implement a policy to promptly and appropriately investigate compliance issues.[147]

CSHM had 30 days to demonstrate to HHS OIG that its material breach had been cured. CSHM submitted a written response on March 12, 2012, and met with HHS OIG on March 13, 2012.[148] Later that day, on March 13, 2012, HHS OIG sent CSHM a letter formalizing the terms of the agreement with CSHM whereby the OIG would not proceed with an exclusion action for the CIA breaches identified in the March 8, 2012 notice.[149]

With respect to the Manassas facility, HHS OIG agreed not to pursue an exclusion action that would apply to the entire company if CSHM agreed to: (1) a voluntary exclusion of Manassas Center within 90 days of the date of March 13, 2012, letter; and (2) comply with additional program integrity-related obligations that will be

---

[140] Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 6 (Mar. 8, 2012) (Exhibit 29).
[141] *Id.*
[142] *Id.*
[143] *Id.* at 7.
[144] *Id.*
[145] *See id.*
[146] Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 7 (Mar. 8, 2012) (Exhibit 29).
[147] *Id.* at 7–8.
[148] Letter from CSHM, to HHS OIG, re: Notice of Material Breach and Intent to Exclude (Mar. 12, 2012) (Exhibit 64).
[149] Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude (Mar. 13, 2012) (Exhibit 30).

incorporated as an amendment to the CIA by the March 13, 2012 letter. On June 4, 2012, CSHM sold the Manassas Clinic to a third party buyer, satisfying the first requirement.

The additional integrity-related provisions HHS OIG placed on CSHM include the following:

> 1. *Compliance Program Onsite Reviews of CSHM Facilities.* "Within 30 days CSHM shall develop and implement a process by which the Chief Dental Officer, the Compliance Officer, and Regional Dentists shall conduct at least one onsite review each month to a CSHM facility for the purpose of evaluating and ensuring compliance with all Federal health care program requirements, state dental board requirements, and the obligations of the CIA. The OIG will require CSHM to recruit Regional Pediatric Dentists who will assist with the Onsite Reviews. . . ." [150]
>
> CSHM has completed its hiring of Regional Pediatric Dentists.[151]
>
> 2. *Quality Improvements Initiatives.* "Within 30 days, CSHM shall develop and implement a process by which CSHM identifies specific risk areas and relevant quality benchmarks, taking into account the recommendations of the Independent Monitor. . . ." [152]
>
> CSHM fulfilled this requirement within the allocated time frame set forth by the HHS OIG.[153]
>
> 3. *Referral Process.* "Within 30 days, CSHM shall develop and implement guidance for each CSHM facility regarding patient referrals from CSHM facilities to other facilities better equipped to treat a patient in specific circumstances involving concerns for patient safety, including but not limited to anesthesia requirement[s] and behavior guidance techniques." [154]
>
> CSHM fulfilled this requirement within the allocated time frame set forth by the HHS OIG.[155]
>
> 4. *Certifying Employee Certifications.* "Within 30 days, CSHM shall develop a process by which Certifying Employees shall perform a comprehensive assessment of the areas of his/her responsibility under Federal law, state dental board requirements, and the obligations under the CIA." [156]

---

[150] *Id.* at 3.

[151] E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

[152] Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 4 (Mar. 13, 2012) (Exhibit 30).

[153] E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

[154] Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 4 (Mar. 13, 2012) (Exhibit 30).

[155] E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

[156] Letter to CSHM, from HHS OIG, re: Notice of Material Breach and Intent to Exclude at 4–5 (Mar. 13, 2012) (Exhibit 30).

CSHM fulfilled this requirement within the allocated time frame set forth by the HHS OIG.[157]

5. *Pulp-to-Crown Medical Necessity Review.* "Within 120 days, CSHM shall review claims by those dentists with high 'pulp-to-crown ratios' to determine whether such documentation supports the medical necessity of the services."

The Independent Monitor will give CSHM the appropriate pulp-to-crown ratio and CSHM will compare all dentists to that standard.[158] HHS OIG has directed CSHM to conduct a new and more expansive review of the pulp-to-crown Medical Necessity Review requirement, due in part to the change in ownership in 2012.[159]

During the course of the breach, CSHM emerged from bankruptcy in June 2012 and began operating under a new owner, a new Board of Directors, and a new senior management team. The new senior management team consists of a new Chief Executive Officer, Chief Compliance Officer, Chief Dental Officer, and new General Counsel. HHS OIG has stated that "The [Independent] Monitor has further indicated to OIG that the onsite visits to CSHM's facilities under the new ownership structure have all been positive." [160]

G. Continuation of Abuses Following the Health and Human Services Office of Inspector General Notice of Intent to Exclude and New Ownership

The new owners have only been in place a relatively short time, but the issues involving quality of care and abuse of taxpayer dollars still remain. Time and time again, CSHM has demonstrated that its Small Smiles clinics do not operate in compliance with the CIA. The core of the problem appears to be structural. The new CSHM ownership acquired and has maintained their predecessors' flawed management services agreements, which remove traditional ownership authority from dentists. These agreements fundamentally limit the ability of the dentists to exercise independent clinical judgment.[161] Despite management changes and assurances that the company is improving, the same problems that were uncovered in 2008 and ultimately led to the CIA persist. It is unacceptable that this type of activity has been allowed to continue for 4 years despite aggressive oversight by the Independent Monitor and HHS OIG.

As stated above, in October 2012 HHS OIG declared that "The Monitor has further indicated to OIG that the onsite visits to CSHM's facilities under the new ownership have all been posi-

---

[157] E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

[158] Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 5 (Mar. 13, 2012) (Exhibit 30).

[159] E-mail from Hinkle of HHS OIG, to CSHM from re: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013, 11:22 a.m.) (Exhibit 58).

[160] Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 5 (Oct. 4, 2012) (Exhibit 14).

[161] *See* Letter from Theodore Hester, Attorney at King & Spalding, to Senators Baucus and Grassley, at 1–2 (Nov. 29, 2011) (Exhibit 5).

tive."[162] However, a review of Independent Monitor Reports following the establishment of new CSHM ownership in June 2012 and the subsequent Notice of Intent to Exclude, paints a very different picture—the abuses that plagued Small Smiles clinics have yet to subside. Although documenting different locations, the Independent Monitor's reviews of CSHM clinics under new ownership from late 2012 reveal findings of the same violations that plagued the Oxon Hill, Manassas, and other aforementioned clinics. Curiously, despite having previously received numerous Independent Monitor reports of misconduct at CSHM facilities, in October 2012 HHS OIG nonetheless proceeded to relay and seemingly endorse an inaccurate Monitor assertion that new CSHM ownership had begun to implement changes. Below are a few examples of the glaring errors that HHS OIG considers positive.

1. Florence, South Carolina Independent Monitor Report

In 2011, the Independent Monitor conducted a desk audit of the Florence, South Carolina Small Smiles clinic. A desk audit does not involve an onsite audit but instead involves an exchange of documents followed by a review. The desk audit report laid out a number of findings and recommendations for the staff.[163]

On July 3, 2012, the Independent Monitor followed up with an onsite visit of the Small Smiles clinic in Florence, South Carolina. This site visit occurred almost 4 months after HHS OIG issued its Notice of Material Breach and Intent to Exclude to CSHM. When the Monitor interviewed the staff and dentists, it was clear that none of them was aware of the findings or recommendations from the desk audit:

> The Compliance Liaison reported she had been in communication with several members of CSHM's management team and determined from their questions there was a report. However, when she asked about it, she was told it had been divided and distributed by department.[164]

Additionally, the Independent Monitor found that the clinic continued to perform unnecessary procedures, while failing to diagnose and treat other problems. In three recorded cases, pulpotomies were performed without removing the required amount of pulpal tissue, and two patients were fitted with oversized crowns.[165] The records also indicated that a patient's mesial decay went undiagnosed and a single surface occlusal amalgam filling was placed on the tooth leading to further decay and the need for a stainless steel crown.[166] Moreover, the Independent Monitor noted that one associate dentist administered Septocaine to a child younger than 4 years of age—a practice that has not been approved by the FDA.[167]

---

[162] Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 5 (Oct. 4, 2012) (Exhibit 14).
[163] Independent Monitor Report Florence, S.C. at 2–3 (July 3, 2012) (Exhibit 38).
[164] *Id.*
[165] *See id.* at 3.
[166] *See id.*
[167] *See id.*

2. Lynn, Massachusetts Independent Monitor Report

A month after the Florence report, the Independent Monitor found similar issues with the Lynn, Massachusetts clinic. After reviewing the post-operative X-rays, the Monitor found five poorly performed pulpotomies, where the tissue from the pulp chamber was not properly removed.[168] There was also one record that showed a failure to use a local anesthesia when it was required, and two instances where the wrong anesthetic was used.[169]

Similar to the report from Akron, the Monitor found that 10 records did not justify using surface fillings over stainless steel crowns.[170] The Monitor also found 11 records where the same teeth were treated multiple times.[171] As was reported in Akron, failing to use the proper filling can result in further decay and multiple treatments to the same tooth.

Despite the continued attention from HHS, the clinic has yet to fulfill all of the recommendations from the initial 2011 Independent Monitor review. Following its interviews, document review, and treatment observations, the Independent Monitor determined that "CSHM had successfully met and implemented 19 of the 29 recommendations" from the Independent Monitor's previous report.[172]

3. Mishawaka, Indiana Independent Monitor Report

On October 5, 2012, the Independent Monitor's findings from its review of the Mishawaka Small Smiles clinic revealed evaluation discrepancies, patient safety concerns, and questions involving medical necessity. As part of its desk audit, the Independent Monitor examined a 2012 internal CSHM chart audit by replicating the testing parameters and initiating its own assessment.[173] The CSHM chart audit ultimately issued passing scores for all three audited dentists.[174] While concurring in the finding that two dentists passed,[175] the Independent Monitor issued an automatic failure to the third dentist based on a "lack of documentation and radiographic evidence to support the medical necessity for treatment."[176] Notably, prior to the Independent Monitor's replicated audit, CSHM had given this very same dentist a score of 100%, the highest score of all three audited dentists.[177]

More disturbing than the discrepancies in the CSHM evaluations of dentists are the incorrect calculations for administering anesthesia. In 4 of 15 records reviewed, the Independent Monitor found miscalculations of the anesthesia dosage, and, while finding that the administered dosage never exceeded the prescribed maximum, the miscalculations "allowed for the possibility of patient harm."[178] Furthermore, in three of these four miscalculations, a review revealed the use of anesthesia "without the recognition of a total

---

[168] See Independent Monitor Report Lynn, Mass. at 3 (Aug. 2, 2012) (Exhibit 39).
[169] *See id.*
[170] *Id.*
[171] *Id.*
[172] *Id.* at 9–10.
[173] Independent Monitor Report Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40).
[174] *See id.*
[175] *See id.* ("The Monitor also identified instances of under-treatment and over-treatment that resulted in lower scores for the Clinic and passing dentists.")
[176] *Id.*
[177] *See id.*
[178] *Id.* at 23.

maximum allowable dose . . . regardless of patient weight or age" and "no evidence of calculation adjustments for overweight patients based on their healthy weight range." [179]

The Independent Monitor's findings also raised questions about the medical necessity of performed care. In 1 of 15 records reviewed, it was discovered that neither documentation nor X-rays were provided to justify the medical necessity for a performed pulpotomy.[180] In fact, the review found that along with a complete lack of X-rays to determine the depth of tooth decay, the patient's file lacked a "descriptive narrative" and "the digital photographs did not support the need for a pulpotomy on [said] tooth." [181] Approximately 6–7% of all pulpotomies performed by that clinic would be unnecessary if the records reviewed are a representative sample of the clinic's business. Taxpayers needlessly spend $100 in Indiana every time an unnecessary pulpotomy is performed on a Medicaid patient.[182]

4. Colorado Springs, Colorado Independent Monitor Report

As late as November 15, 2012, the Small Smiles clinic in Colorado Springs was committing violations resembling those found at numerous other Small Smiles clinics: under-utilization of X-rays, inadequate documentation of medical necessity, questionable procedure rationale, and quality of care issues. First, out of 24 records reviewed, the Independent Monitor found 5 records containing medically unnecessary X-rays and 12 records revealed evidence of under-utilization of diagnostic X-rays.[183]

Second, questions of medical necessity also emerged from the Colorado Springs Small Smiles clinic. Notably, the Independent Monitor observed a trend of treatment being provided without diagnostic X-rays and further found 5 out of 24 patient records lacked "documentation and/or radiographic evidence to support the medical necessity for treatment[s]" which included pulpotomies, a stainless steel crown, and a 4-surface filling.[184]

Third, the Independent Monitor review exposed questionable rationales for performed procedures. Along with finding a trend of under-utilizing stainless steel crowns, the review revealed 5 out of 24 records lacked documentation for choosing to perform multiple surface filings and not stainless steel crowns.[185]

Fourth, the review confirmed that, much like its fellow Small Smiles clinics around the country, quality of care issues were evident in the Colorado Springs clinic. Out of 24 records reviewed, 2 patient records lacked an explanation as to why teeth with noted decay were left untreated.[186] Lastly, and of great concern, is that 3 out of 24 records revealed that treatment was administered without the requisite informed and documented consent.[187]

These five clinic findings reflect that, despite HHS OIG's Intent to Exclude and the new ownership structure, CSHM has continued

---

[179] *Id.*
[180] *See id.*
[181] *Id.*
[182] Indiana Health Coverage Programs, IHCP Bulletin at 5 (Apr. 15, 2010) (Exhibit 62).
[183] *See* Independent Monitor Report Colorado Springs, Colo. at 16 (Nov. 15, 2012) (Exhibit 41).
[184] *Id.* at 18.
[185] *Id.* at 19.
[186] *Id.* at 20.
[187] *Id.*

to leave patients with decaying teeth untreated, while performing needless surgery on other patients. In other words, CSHM continues to treat a high volume of patients while sacrificing quality care and benefitting from the Medicaid system. The needless procedures ensure higher reimbursements, while mismanaged treatments ensure return visits that require more intensive treatments. What is most disconcerting from these reports is the timing in which these violations occurred. Although subpar dental treatment to children should never be tolerated, it is even more unforgivable when it follows admonishment from the Department of Justice and the Department of Health and Human Services Office of Inspector General.

V. Dental Demographics

When the Committee staff started investigating dental management companies, a common refrain emerged: if their businesses did not employ dentists to provide care to those in need, the Medicaid population would go untreated. As such, we began to take a closer look into the demographics of today's dentists. Although it is undeniable that certain parts of our country, particularly rural areas, have a shortage of dental providers, this same problem plagues all areas where Small Smiles Clinics are found. Ultimately, the current model is not sustainable, and dentists will not be able to meet the growing demand for treatment. Thus, maybe it is time to begin discussing the incorporation of mid-level providers in order to alleviate the treatment needs of and provide dental care to patients. Mid-level dental providers' education and skill level would place them between a dentist and dental hygienist. They would be qualified and licensed to perform relatively minor, but common procedures, such as cavity fillings and simple teeth extractions.[188]

According to Oral Health America, the adequate ratio of dentists to population is 1 to 1,500.[189] Today, that ratio is 1 to 2,000 and in some states, such as Washington, the distribution is even greater having only one dentist for 12,300 people.[190] If this uneven distribution is not corrected, the problems will worsen. The U.S. Department of Labor, Bureau of Labor Statistics expects the dental profession to grow by 21% from 2010 to 2020.[191] The potential for a large gap between the number of dentists needed and the number of dentists practicing is due to a number of variables. First, there will be a need for more complicated dental procedures for the baby boom generation.[192] In addition, each generation is more likely to keep their teeth than the last, and studies continue to link dental

---

[188] *See* Phil Cauthon, *National advocates for mid-level dental providers meet in Kan.,* KHI NEWS SERVICE (Dec. 5, 2012), *http://www.khi.org/news/2012/dec/05/national-advocates-mid-level-dental-providers-meet/*.

[189] *Combating the Silent Epidemic: The Shortage of Dentists in America,* Staff Care, at 4, *http://www.staffcare.com/pdf/Dentistry-WhitePaper2007.pdf.*

[190] U.S. Dep't of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *Dentists Job Outlook, http://www.bls.gov/ooh/Healthcare/Dentists.htm#tab-6* (last visited Mar. 22, 2013); Clair Gordon, *Extreme Dentist Shortage Leads To 'Dental Therapists' Filling Cavities,* AOL Jobs [hereinafter *Gordon*] (Apr. 16, 2012, 2:14 PM), *http://jobs.aol.com/articles/2012/04/16/extreme-dentist-shortage-leads-to-dental-therapists-filling-ca/*.

[191] U.S. Dep't of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *Dentists Job Outlook, http://www.bls.gov/ooh/Healthcare/Dentists.htm#tab-6* (last visited Mar. 22, 2013). Nationwide there are 48.7 million Americans who live in areas with a shortage of dental care.

[192] *See id.*

health with overall health.[193] Also, 5.3 million more children will qualify for dental services under the Affordable Care Act.[194] However, "without changes in state policies, expanded coverage is unlikely to translate into more dental care for every child in need." [195] Children's susceptibility to tooth decay is particularly problematic, because dental problems starting at a young age will compound into larger problems through adulthood.

The lack of care for both children and adults has resulted in 27 percent of children and 29 percent of adults having untreated cavities in 2003 and 2004.[196] The risks of untreated dental conditions are not confined to poor oral health, but can have devastating effects on overall health. Many Americans end up in the emergency room from tooth abscesses that keep them from eating or cause an infection that can travel to the brain and kill.[197] This horrifying result of tooth decay was the impetus for the ABC–7 I–Team investigative report into the Small Smiles clinics. The report identified a 12-year-old Maryland boy, Deamonte Driver, who died of a brain infection resulting from tooth decay that was not properly treated.[198]

In 2009, more than 830,000 visits to the emergency room nationwide were the result of preventable dental problems.[199] In Florida alone the bill exceeded $88 million.[200] Although many of these problems can be solved by preventive measures, the fundamental problems of lack of care and substandard care persist.[201]

As more dentists graduate from school with an average debt of $181,000, with one out of five exceeding $250,000,[202] it is less economical for dentists to open practices in rural areas. Compounding the problem is available data which suggests low dentist participation in Medicaid,[203] and the fact that some of those clinics that are providing care to Medicaid patients, such as Small Smiles, are doing so at a substandard level. The cost of correcting dental problems is much more expensive than the preventive measures, but

---

[193] *See id.*

[194] Dep't of Labor, Dentists Job Outlook; *The State of Children's Dental Health: Making Coverage Matter,* The Pew Center on the States (May 2011), 208, 209, and 210; Louis W. Sullivan, *Dental Insurance, but No Dentists,* N.Y. TIMES [hereinafter *Sullivan*], Apr. 8. 2012, *http://www.nytimes.com/2012/04/09/opinion/dental-insurance-but-no-dentists.html?_r=2&.*

[195] *The State of Children's Dental Health: Making Coverage Matter,* The Pew Center on the States (May 2011).

[196] *Gordon.* The 2003 and 2004 data is the latest available when the article was written.

[197] *Sullivan.*

[198] I–Team: Small Smiles Investigation, *http://www.youtube.com/watch?v=pIoMaw4zC9Q* (last visited Mar. 22, 2013). In a similar news story a, 24-year-old single father, Kyle Willis died of a brain infection that was the result of untreated tooth decay. Gretchen Gavett, *Tragic Results When Dental Care Is Out of Reach,* PBS (June 26, 2012, 9:50 PM), *http://www.pbs.org/wgbh/pages/frontline/health-science-technology/dollars-and-dentists/tragic-results-when-dental-care-is-out-of-reach/.*

[199] *Sullivan.*

[200] *Id.* Dental disease is the number one chronic child disease that creates more children needing medical care than asthma. *Id.* In Maine a recent report has indicated that 55 percent of MaineCare children go without dental care even though they have insurance, resulting in more money being spent on fixing dental problems that preventing them. *Report Details Dental Care Shortage in Rural Maine,* Boston Globe (Feb. 5, 2013), *http://www.boston.com/news/local/maine/2013/02/05/report-details-dental-care-shortage-rural-maine/NkYZrj1bb1OEMKGFQZ1E5O/story.html.*

[201] *Sullivan.*

[202] *Gordon.*

[203] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO–11–96, ORAL HEALTH: EFFORTS UNDER WAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS 12 (2010) (Exhibit 60).

clearly the cost of providing preventive measures is not cheap or easy in certain parts of our country.

To address dental care access problems, two states have taken novel approaches to immediately address the lack of dental care. Alaska and Minnesota have been training dental therapists who provide fewer services than a dentist and more than a dental hygienist.[204] These dental therapists are able to perform basic dental procedures that are in great demand, such as filling cavities and extracting childrens' primary teeth.[205] These training programs are shorter than dentistry school, and the therapists receive pay that is roughly half of what a dentist would receive. This program has opened up dental care in rural areas of Minnesota and Native villages in Alaska. The ADA has opposed these positions out of fear that mid-level providers will provide substandard care.[206]

VI. Recommendations

Recommendation 1: HHS OIG should exclude from participating in the Medicaid program CSHM, Small Smiles clinics, and any other corporate entity that employs a fundamentally deceptive business model resulting in a sustained pattern of substandard care.

- Despite a change in ownership and repeated professed improvements, CSHM and Small Smiles clinics continue to operate under fundamentally deceptive contracts that circumvent state laws passed to ensure licensed dentists own dental practices, and thus, that the owners are held accountable to maintain a professional standard of care. As a result, Small Smiles clinics continue failing to meet basic quality and compliance standards, providing unjustified and deficient procedures, improperly withholding and recklessly administering anesthesia, and performing dubious internal audits. All of these actions strain the Medicaid system. Excluding CSHM and companies with similarly deceptive ownership structures from the Medicaid program would deter companies from engaging in similar egregious behavior in the future.

Recommendation 2: States should enforce existing laws against the corporate practice of dentistry and, where appropriate, take enforcement action against those that violate the law.

- State authorities have either ignored or been oblivious to dental management services agreements like those used by CSHM that allow companies to operate dental clinics under the guise of providing administrative and/or financial management support.

---

[204] *Sullivan.* Kansas, New Mexico, and Vermont are also debating legislation that would create similar training programs; *Gordon.*

[205] *Gordon.*

[206] *See* AM. DENTAL ASS'N, BREAKING DOWN BARRIERS TO ORAL HEALTH FOR ALL AMERICANS: REPAIRING THE TATTERED SAFETY NET 16 (2011); *see also* AM. DENTAL ASS'N, BREAKING DOWN BARRIERS TO ORAL HEALTH FOR ALL AMERICANS: THE ROLE OF WORKFORCE 11 (2011) ("[A] critical attribute that the ADA opposes unequivocally: *Allowing non-dentists to perform surgical procedures, often with little or no direct supervision by fully trained dentists.*").

- In the 22 states and the District of Columbia that ban corporate dentistry, appropriate action should be taken to eliminate such circumvention of the law.

Recommendation 3: If states consider licensure of mid-level dental providers, such as dental therapists, the Federal Government should allow them to be reimbursed by the Medicaid program.

- According to GAO findings, the dental profession has low Medicaid participation rates and thus has failed to provide needed care and treatment to lower-income individuals in Medicaid. While struggling to encourage the providers to adequately participate and serve the Medicaid program, the dental profession has done little to curb the abuses described in this report.
- States have already begun creating mid-level dental providers, such as dental therapists, and licensing them to practice in their states in order to better meet the unmet needs of their populations.
- Some in the dental profession argue that "low Medicaid reimbursement rates" are the root cause of the types of abuses described in this report. Yet, the dental profession has also opposed allowing mid-level providers into the program who could provide much of the needed care at the current reimbursement rates.

APPENDIX

EXHIBIT 1

FILED
DONETTA DAVIDSON
COLORADO SECRETARY OF STATE

ARTICLES OF INCORPORATION 20011029658 C
$ 100.00
OF SECRETARY OF STATE
02-09-2001 11:50:12
FORBA INC.

The undersigned, a natural person over the age of eighteen years, acting as incorporator of a corporation under the Colorado Business Corporation Act, adopts the following Articles of Incorporation for such corporation.

ARTICLE I

The name and principal address of the corporation is:

FORBA INC.
415 North Grand
Pueblo, CO 81003

ARTICLE II

The said corporation shall have a perpetual term of existence unless and until dissolved according to law.

ARTICLE III

The powers and purposes for which the corporation is organized are:

1. To carry on any lawful business or businesses whatsoever permitted by corporations and to do any and all acts in furtherance of any lawful business which is calculated, directly or indirectly to promote the interests of the corporation.

2. This corporation shall have and may exercise all the rights, powers and privileges conferred by the laws of the State of Colorado or necessary or convenient to carry out its purpose.

ARTICLE IV

The aggregate number of shares which the corporation shall have the authority to issue is 1,000,000 shares of common

COMPUTER UPDATE COMPLETE
MW

stock without par value, which stock shall be fully paid at the time of issue and non-assessable. Each share of common stock shall be entitled to one vote. Cumulative voting shall not be permitted.

With respect to the issued and outstanding shares of the corporation, the shareholders shall have no preemptive right to acquire additional or treasury shares of the corporation, or securities convertible into shares carrying stock purchase warrants or privileges.

ARTICLE V

The corporation, acting through its directors, may impose restrictions on the transfer of any of its authorized shares of stock.

No director shall have any personal liability to the corporation or to its shareholders for monetary damages for breach of fiduciary duty as a director except that this provision shall not eliminate or limit the liability of a director for monetary damages for any breach of the director's duty of loyalty to the corporation; acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law; or any transaction for which the director received an improper personal benefit. No contract or other transaction between the corporation and one or more of its directors, officers, or any other corporation, partnership, association, or entity in which any director or officer of the corporation is financially or otherwise interested or is a director, member, or officer of such other corporation, partnership, association, or entity shall, in the absence of fraud, be affected or invalidated because of such

relationship or interest, provided that the existence and nature of any such interest of such director or officer shall be disclosed or shall have been known to the directors present at any meeting of the Board at which the action on any such contract or transaction shall have been taken, provided that the fact of such relationship is disclosed or known to the shareholders entitled to vote, and they authorize, approve, or ratify the contract or transaction by vote or written consent and the contract or transaction is fair and reasonable to the corporation. Any interested director may be counted in determining the existence of a quorum and may vote at any meeting of the Board of Directors for the purpose of authorizing any such contract or transaction.

ARTICLE VI

The address of the initial registered office of the corporation is: 415 North Grand, Pueblo, CO 81003. The name of its initial registered agent at such address is: DAN DeROSE.

ARTICLE VII

The business and affairs of this corporation shall be under the control and management of a Board of Directors, the number of which will be fixed by the Bylaws.

ARTICLE VIII

This corporation, by its Directors, reserves the right to amend or repeal any provisions of these Articles of Incorporation, in any manner now or hereinafter prescribed by statute, subject to limitations herein contained, and all rights conferred upon the stockholders herein granted are subject to this reservation.

ARTICLE IX

The name and address of the incorporator is: DAN DeROSE, 415 North Grand, Pueblo, CO 81003.

IN WITNESS WHEREOF, the said incorporator has hereunto set his hand and seal this 17 day of November, 2000.

Registered Agent & Incorporator
DAN DeROSE
415 North Grand
Pueblo, CO 81003
(719)546-3333

EXHIBIT 2

CIVIL SETTLEMENT AGREEMENT

I PARTIES

This Settlement Agreement ("Agreement") is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (OIG-HHS) of the Department of Health and Human Services (HHS) (collectively the "United States"); FORBA Holdings, LLC, ("FORBA"); and John Haney, Angela Crawford, and Deborah McDaniel (collectively referred to as "the Parties"), through their authorized representatives.

II PREAMBLE

As a preamble to this Agreement, the Parties agree to the following:

A. FORBA provides (or has provided) business management services to dental clinics, as set forth in Exhibit A hereto, located in Alabama, Arizona, Colorado, Connecticut, the District of Columbia, Georgia, Idaho, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Nebraska, Nevada, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, and Virginia that provide services primarily to Medicaid-eligible patients (collectively, the "Centers").

B. Deborah McDaniel ("McDaniel") is an individual resident of Maryland. On December 21, 2007, McDaniel filed a qui tam action in the United States District Court for the District of Maryland captioned United States ex rel. McDaniel v. FORBA Holdings LLC, et al., No. 07-3416 (D. Md.) (hereinafter, "the Maryland Civil Action").

C. Angela Crawford ("Crawford") is an individual resident of Virginia. On June 12, 2008, Crawford filed a qui tam action in the United States District Court for the Western District of Virginia captioned United States of America and Commonwealth of Virginia ex rel. Angela Crawford v. Small Smiles of Roanoke LLC, et al., Case No. 7:08-cv-00370 (hereinafter "the Virginia Civil Action").

D. John J. Haney ("Haney") is an individual resident of South Carolina. On July 16, 2008, Haney filed a qui tam action in the United States District Court for District of South Carolina captioned John J. Haney o/b/o the United States of America v. Children's Medicaid Dental of Columbia, LLC d/b/a "Small Smiles", Case No 3:08-CV-2562-CMC (hereinafter "the South Carolina Civil Action"). (The South Carolina Action, the Virginia Civil Action, and the Maryland Civil Action will collectively be known as "the Civil Actions.") (The individuals listed in Paragraphs B, C, and D will collectively be referred to as "the Relators.")

E FORBA has entered into or will be entering into separate settlement agreements with the states listed in Exhibit B hereto (hereinafter referred to as the "Medicaid Participating States") that will be receiving settlement funds from FORBA pursuant to Paragraph 1.c for the Covered Conduct described in Paragraph G (the "State Medicaid Settlement Agreements").

F The United States contends that FORBA caused to be submitted claims for services provided by the Centers for payment to the Medicaid Program ("Medicaid"), 42 U.S.C. §§ 1396-1396v and State Children's Health Insurance Program ("SCHIP").

G The United States contends that it and the Medicaid Participating States (hereinafter collectively referred to as the "Government") have certain civil claims against FORBA for engaging in the following conduct (hereinafter referred to as the "Covered Conduct") in connection with services and items that the Centers provided to children who were Medicaid and SCHIP beneficiaries during the period from September 2006 through the Effective Date of this Agreement: (1) causing claims to be submitted by the Centers for reimbursement for performing pulpotomies that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care; (2) causing claims to be submitted by the Centers for reimbursement for placing crowns that were not medically necessary and/or were performed in a manner that did not meet

professionally-recognized standards of care; (3) causing claims to be submitted by the Centers for reimbursement for the administration of anesthesia (including, without limitation, nitrous oxide) that was not medically necessary, that was performed in a manner that did not meet professionally-recognized standards of care, and/or was administered by an unlicensed, non-certified, or otherwise unauthorized individual; (4) causing claims to be submitted by the Centers for reimbursement for extractions that were not medically necessary and/or were performed in a manner that did not meet professionally recognized standards of care; (5) causing the Centers to fail to obtain informed consent for certain dental procedures and services; (6) causing claims to be submitted by the Centers for reimbursement for fillings that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care; (7) causing claims to be submitted by the Centers for reimbursement for sealants that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care; (8) causing claims to be submitted by the Centers for reimbursement for radiographs (i.e., x-rays) that were not medically necessary, were taken in a manner that did not meet professionally-recognized standards of care, and/or were taken by an unlicensed, non-certified, or otherwise unauthorized individual; and (9) causing claims to be submitted by the Centers for reimbursement for behavior management techniques, including without limitation those techniques involving a papoose board, that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care.

H The United States also contends that it has certain administrative claims against FORBA for engaging in the Covered Conduct

I. The United States and the Relators have reached an agreement with respect to the Relators' claims of entitlement under 31 U.S.C. § 3730(d) to a share of the proceeds of this Agreement

J. This Agreement is neither an admission of liability by FORBA nor a concession by the United States that its claims are not well founded.

K To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, the Parties reach a full and final settlement pursuant to the Terms and Conditions below.

III. TERMS AND CONDITIONS

1. FORBA shall pay to the United States and the Medicaid Participating States, collectively, the sum of twenty-four million dollars ($24,000,000), plus any interest that has accrued between June 15, 2009, and the Effective Date of this Agreement at a rate of 2.75% per annum (Settlement Amount"). On the Effective Date of this Agreement, as defined in Paragraph 35 herein ("Effective Date"), this sum shall constitute a debt due and immediately owing to the United States and the Medicaid Participating States. FORBA shall discharge its debt to the United States and the Medicaid Participating States under the following terms and conditions:

a. FORBA shall pay to the United States the principal sum of $14,285,644.75 (the "Federal Settlement Amount"). FORBA shall pay the Federal Settlement Amount, plus interest accrued thereon at the rate of 2.75% per annum, in accordance with the payment schedule attached hereto as Exhibit C ("Payment Schedule"). Within 10 days after the Effective Date of this Agreement, FORBA shall pay the United States the initial fixed payment in the amount of $595,235.22 ("Initial Payment"), plus any interest that may have accrued thereon between June 15, 2009, and the Effective Date, and thereafter make principal payments with interest according to the schedule in Exhibit C.

b. All payments set forth in this Paragraph 1.a. shall be made to the United States by electronic funds transfer pursuant to written instructions provided by the Office of the United States Attorney for the District of Maryland. The entire principal

balance of the Federal Settlement Amount or any portion thereof, plus any interest accrued on the principal as of the date of any prepayment, may be prepaid without penalty

c. FORBA shall pay to the Medicaid Participating States the sum of $9,714,355.25 ("State Settlement Amount") FORBA shall pay the Medicaid State Settlement Amount, plus interest accrued thereon at the rate of 2.75% per annum, in accordance with the Payment Schedule found at Exhibit C Within 10 days after the Effective Date of this Agreement, FORBA shall set aside $404,764.78, plus any interest that may have accrued between June 15, 2009, and the Effective Date, into an interest-bearing account of its own choosing as agreed upon between FORBA and the National Association of Medicaid Fraud Control Units Settlement Team ("NAMFCU Team") and, upon reaching agreements with, and obtaining releases from, each of the Medicaid Participating States and upon receipt of written payment instrusctions from the NAMFCU Team, shall pay the State Settlement Amount plus any additional interest earned in the Deposit Account as directed by each settling Medicaid Participating State. FORBA shall thereafter make fixed pro rata payments according to the schedule in Exhibit C and as directed by each settling Medicaid Participating State The entire principal balance of the Medicaid State Settlement Amount or any portion thereof, plus any interest accrued on the principal as of the date of any prepayment, may be prepaid without penalty

d. FORBA shall pay attorney's fees to the Relators in the aggregate amount of $182,183.52. This amount shall be paid as an electronic funds transfer to the Relators' attorneys (to be allocated in accordance with their instructions) no later than seven (7) business days after the stipulations of dismissal are filed as set forth in Paragraph 23.

e. Contingent upon the United States receiving the Federal Settlement Amount from FORBA, the United States agrees to pay the Relators the following amounts as their shares of the proceeds pursuant to 31 U.S.C. § 3730(d)(the "Relators' Shares").

McDaniel: $2,039,979

Crawford: $51,392

Haney: $314,330

The United States will pay the Relators their pro rata share of each payment, in addition to the pro rata share of the actual accrued interest, that FORBA pays the United States under the Payment Schedule set forth in Exhibit D. The United States will pay the Relators their pro rata shares within 21 days of the United States' receipt of each payment from FORBA. The Relators expressly understand and agree that the United States is only liable to the Relators for funds actually received or collected by the United States.

2. Subject to the exceptions in Paragraph 5 (concerning excluded claims), below, in consideration of the obligations of FORBA in this Agreement, and subject to Paragraph 19, below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the United States (on behalf of itself, its officers, agents, agencies, and departments) agrees to grant a temporary covenant not to sue FORBA, its parent (Small Smiles Holding Company, LLC), its current and former direct and indirect subsidiaries (EEHC, Inc., FORBA Services, Inc., Sanus Services, Inc., FORBA NY, LLC, and Sanus NY, LLC), the Centers, and the successors and assigns of any of them, and all current officers and directors of FORBA, and its parent or direct and indirect subsidiaries (collectively, the "FORBA Released Parties"), for any civil or administrative monetary claims the United States has or may have for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-33; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-12; any statutory provision creating causes of action for civil damages or penalties for which the Civil Division of the Department of Justice has actual and present authority to assert and compromise pursuant to 28 C.F.R. Part O, Subpart I, Section 0.45(d); or the common law theories of payment by

mistake, unjust enrichment, conversion, disgorgement, restitution, recoupment, constructive trust, misrepresentation, and fraud ("Temporary Covenant Not to Sue"). Conditioned upon full payment by FORBA of the Settlement Amount, the United States (on behalf of itself, its officers, agents, agencies, and departments) agrees to retract the Temporary Covenant Not to Sue and agrees to release the FORBA Released Parties for any civil or administrative monetary claim the United States has or may have for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-33; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-12; any statutory provision creating causes of action for civil damages or penalties for which the Civil Division of the Department of Justice has actual and present authority to assert and compromise pursuant to 28 C.F.R. Part O, Subpart I, Section 0.45(d); or the common law theories of payment by mistake, unjust enrichment, conversion, disgorgement, restitution, recoupment, constructive trust, misrepresentation, and fraud. Other than as expressly referred to herein, no individuals are released by this Agreement, nor are any of the entities listed in Exhibit E hereto.

3. Relators agree to the following:

a. Subject to the exceptions in Paragraph 3c (concerning Relator Crawford) and Paragraph 5 (concerning excluded claims), below, in consideration of the obligations of FORBA in this Agreement, conditioned upon FORBA's full payment of the Settlement Amount, and the amounts described in paragraph 1(d), and subject to Paragraph 19, below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), Relators, for themselves and for their respective heirs, successors, attorneys, agents, and assigns, agree to release the FORBA Released Parties and each of their current and former officers, agents and employees from all causes of action, whether known or unknown as of the date of this Agreement, that Relators have or may have as of the date of this Agreement against any of

the FORBA Released Parties or any of their current and former officers, agents or employees for any violation of any federal, state or local law, contract, duty, standard of care, right, or other source of obligation that Relators may have, or may assert, including but not limited to all causes of action related to any civil monetary claims the United States or any of the Relators have or may have for the Covered Conduct under the False Claims Act, 31 U S C §§ 3729-33, state false claims acts, common law, any other statute or doctrine creating civil causes of action for relief for the Covered Conduct, any liability to Relators arising from the filing of the Civil Actions, or any liability under 31 U S C § 3730(d) for expenses or attorney's fees and costs , other than causes of action arising under this Agreement

b Subject to Paragraphs 3(c), 19 and 20, Relators further agree that they will not pursue the Civil Actions or any related actions, pending the fulfillment by FORBA of its obligations under the Agreement

c Relator Crawford's release in 3(a) and agreement in 3(b) do not apply to the following Virginia Civil Action Defendants: Latavias Ellington, Leonisha Thomas, Clint McQueen, and Peggy Lovecchio

4 In consideration of the obligations of FORBA in this Agreement and the Corporate Integrity Agreement (CIA), entered into between OIG-HHS and FORBA, conditioned upon FORBA's full payment of the Settlement Amount, and subject to Paragraph 19, below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the OIG-HHS agrees to release and refrain from instituting, directing, or maintaining any administrative action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U S C § 1320a-7b(f)) against FORBA under 42 U S C § 1320a-7a (Civil Monetary Penalties Law), 42 U S C § 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities), or 42 U S C § 1320a-7(b)(6)(B) (permissive

exclusion for furnishing or causing to be furnished items or services to patients substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care) for the Covered Conduct, except as reserved in Paragraph 5 (concerning excluded claims), below, and as reserved in this Paragraph. The OIG-HHS expressly reserves all rights to comply with any statutory obligations to exclude FORBA from Medicare, Medicaid, and other Federal health care programs under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) based upon the Covered Conduct. Nothing in this Paragraph precludes the OIG-HHS from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 5, below. OIG-HHS expressly reserves all rights to institute, direct, or maintain any administrative action seeking exclusion against the Centers and/or FORBA's officers, directors, and employees from Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) or 42 U.S.C. §§ 1320a-7(b) or 42 U.S.C. § 1320a-7a (permissive exclusion). Notwithstanding the foregoing, in the event of Default as defined in Paragraph 19, below, OIG-HHS may exclude FORBA from participating in all Federal health care programs until FORBA pays the Settlement Amount and reasonable costs as set forth in Paragraph 1, above. OIG-HHS will provide written notice of any such exclusion to FORBA. FORBA waives any further notice of the exclusion under 42 U.S.C. § 1320a-7(b)(7), and agrees not to contest such exclusion either administratively or in any state or federal court. Reinstatement to program participation is not automatic. If at the end of the period of exclusion FORBA wishes to apply for reinstatement, FORBA must submit a written request for reinstatement to OIG-HHS in accordance with the provisions of 42 C.F.R. §§ 1001.3001-3005. FORBA will not be reinstated unless and until OIG-HHS approves such request for reinstatement.

5. Notwithstanding any term of this Agreement, specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including FORBA and Relators) are the following claims of the United States:

a. Any civil, criminal, or administrative liability arising under Title 26, U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusion from Federal health care programs;

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

e Any liability based upon such obligations as are created by this Agreement;

f. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;

g. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct;

h. Any liability for failure to deliver goods or services due; or

i. Except as expressly provided for in Paragraph 2, any liability of individuals, including employees of the Centers.

6. Relators and their respective heirs, successors, attorneys, agents, and assigns agree not to object to this Agreement and agree and confirm that this Agreement is fair, adequate, and reasonable under all the circumstances, pursuant to 31 U.S.C. § 3730(c)(2)(B), and expressly waive the opportunity for a hearing on any objection to this Agreement pursuant to 31 U.S.C. § 3730(c)(2)(B).

7. Upon receipt of their pro rata share of the Initial Payment, the Relators and their respective heirs, successors, agents, and assigns, fully and finally release, waive, and forever discharge the United States, its agencies, employees, servants, and agents from any claims arising from or relating to 31 U S C § 3730 from any claims arising from the filing of the Civil Actions, and from any other claims for a share of the Federal Settlement Amount, other than claims to enforce the provisions of this Agreement This Agreement does not resolve or in any manner affect any claims the United States has or may have against the respective Relators arising under Title 26, U S Code (Internal Revenue Code), or any claims arising under this Agreement

8 Conditioned upon the Relators' releases contained in Paragraph 3, FORBA fully and finally releases the Relators, and each of their respective attorneys, agents and employees, from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that FORBA has or may have as of the date of this Agreement against the Relators or their attorneys, agents or employees related to the Covered Conduct, the Civil Claims and the Relator's investigation and prosecution thereof

9. FORBA has provided various financial materials to the United States including certain audited financial statements ('Financial Statements') The United States has relied on the completeness and reliability of those financial materials in reaching this Agreement FORBA warrants that the Financial Statements are complete, accurate, and were prepared in accordance with Generally Accepted Accounting Principles (GAAP') If the United States learns of any asset(s) in which FORBA had an interest at the time of this Agreement that were not disclosed in the Financial Statements, or if the United States learns of any misrepresentation by FORBA on, or in connection with, the Financial Statements, and if such nondisclosure or misrepresentation changes the estimated net worth of FORBA set forth in the Financial Statements by 1 2 million dollars ($1,200,000 00) or more, the United

States may at its option: (a) rescind this Agreement and file suit based on the Covered Conduct; or (b) let the Agreement stand and collect the full Settlement Amount plus one hundred percent (100%) of the value of the net worth of FORBA previously undisclosed FORBA agrees not to contest any collection action undertaken by the United States pursuant to this provision, and immediately to pay the United States all reasonable costs incurred in such an action, including attorney's fees and expenses.

10 In the event that the United States, pursuant to Paragraph 9 (concerning disclosure of assets), above, opts to rescind this Agreement, FORBA agrees not to plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any civil or administrative claims that (a) are filed by the United States within ninety (90) calendar days of written notification to FORBA that this Agreement has been rescinded, and (b) relate to the Covered Conduct, except to the extent these defenses were available on the Effective Date of this Agreement

11 FORBA waives and shall not assert any defenses FORBA may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action Nothing in this Paragraph or any other provision of this Agreement constitutes an agreement by the United States concerning the characterization of the Settlement Amount for purposes of the Internal Revenue laws, Title 26 of the United States Code.

12. FORBA fully and finally releases the United States, its agencies, employees, servants, and agents from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that FORBA has asserted, could have asserted, or may assert

in the future against the United States, its agencies, employees, servants, and agents, related to the Covered Conduct and the United States' investigation and prosecution thereof.

13. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicaid carrier or intermediary or any state payer, related to the Covered Conduct; and FORBA agrees not to cause the Centers to resubmit to any Medicaid carrier or intermediary or any state payer any previously-denied claims related to the Covered Conduct, and agrees not to appeal any such denials of claims. Nothing in this Paragraph 13 shall restrict FORBA's or the Centers' right to contest any denials, withholdings, or claims by any private payors or insurers, including those paid by the Medicaid Participating States' Medicaid Programs on a capitated basis.

14. FORBA agrees to the following:

a. Unallowable Costs Defined: that all costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395hhh and 1396-1396v; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of FORBA, its present or former officers, directors, employees, shareholders, and agents in connection with the following shall be "Unallowable Costs" on government contracts and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP):

(1) the matters covered by this Agreement;

(2) the United States' audit(s) and civil investigation(s) of the matters covered by this Agreement;

(3) FORBA's investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil investigation(s) in connection with the matters covered by this Agreement (including attorney's fees);

(4) the negotiation and performance of this Agreement;

(5) the payment FORBA makes to the United States pursuant to this Agreement and any payments that FORBA may make to Relators, including costs and attorney's fees; and

(6) the negotiation of, and obligations undertaken pursuant to the CIA to:

(i) retain an independent review organization to perform annual reviews as described in Section III of the CIA;

(ii) retain an independent monitor to perform the monitoring functions described in Section III of the CIA; and

(iii) prepare and submit reports to the OIG-HHS

However, nothing in this Paragraph 14 a (6) that may apply to the obligations undertaken pursuant to the CIA affects the status of costs that are not allowable based on any other authority applicable to FORBA (All costs described or set forth in this Paragraph 14.a are hereafter "Unallowable Costs")

b. Future Treatment of Unallowable Costs: These Unallowable Costs shall be separately determined and accounted for by FORBA, and FORBA shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement, or payment request submitted by FORBA or any of its subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c Treatment of Unallowable Costs Previously Submitted for Payment:

FORBA further agrees that within ninety (90) days of the Effective Date of this Agreement it shall identify to applicable Medicaid fiscal intermediaries, carriers, and/or contractors, and Medicaid and fiscal agents, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. FORBA agrees that the United States, at a minimum, shall be entitled to recoup from FORBA any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by FORBA or any of its subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this Paragraph) on FORBA or any of its subsidiaries or affiliates' cost reports, cost statements, or information reports

d Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine FORBA's books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this Paragraph.

15. FORBA agrees to cooperate fully and truthfully with the United States' investigation of individuals and entities not released in this Agreement. Upon reasonable notice, FORBA shall encourage, and agrees not to impair, the cooperation of its agents, directors, officers, and employees, and shall use its best efforts to make available, and encourage the cooperation of former agents, directors, officers, and employees for interviews

and testimony, consistent with the rights and privileges of such individuals FORBA agrees to furnish to the United States, upon request, complete and unredacted copies of all non-privileged documents, reports, memoranda of interviews, and records in its possession, custody, or control concerning any investigation of the Covered Conduct that it has undertaken, or that has been performed by its counsel or other agent.

16 This Agreement is intended to be for the benefit of the Parties and the FORBA Released Parties only The Parties do not release any claims against any other person or entity, other than the FORBA Released Parties, except to the extent provided for in Paragraph 17 (waiver for beneficiaries paragraph), below

17 FORBA agrees that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct

18. FORBA warrants that it has reviewed its financial situation and that following the restructuring outlined in Exhibit F hereto (the "Restructuring"), it will be solvent within the meaning of 11 U S C §§ 547(b)(3) and 548(a)(1)(B)(ii)(I), and shall remain solvent subject to the projections provided to the United States on February 10, 2009 (the "Projections"), following payment to the United States of the Settlement Amount Further, the Parties warrant that, in evaluating whether to execute this Agreement, they (a) have intended that the mutual promises, covenants, and obligations set forth constitute a contemporaneous exchange for new value given to FORBA, within the meaning of 11 U S C § 547(c)(1); and (b) conclude that these mutual promises, covenants, and obligations do, in fact, constitute such a contemporaneous exchange. Further, the Parties warrant that the mutual promises, covenants, and obligations set forth herein are intended to and do, in fact, represent a reasonably equivalent exchange of value that is not intended to hinder, delay, or defraud any entity to

which FORBA was or became indebted to on or after the date of this transfer, within the meaning of 11 U.S.C. § 548(a)(1).

19. If within ninety-one (91) days of the Effective Date of this Agreement or of any payment made under this Agreement, FORBA commences, or a third party commences, any case, proceeding, or other action under any law relating to bankruptcy, insolvency, reorganization, or relief of debtors (1) seeking to have any order for relief of FORBA's debts, or seeking to adjudicate FORBA as bankrupt or insolvent; or (2) seeking appointment of a receiver, trustee, custodian, or other similar official for FORBA or for all or any substantial part of FORBA's assets, FORBA agrees as follows:

a. FORBA's obligations under this Agreement may not be avoided pursuant to 11 U.S.C. § 547, and FORBA shall not argue or otherwise take the position in any such case, proceeding, or action that: (i) FORBA's obligations under this Agreement may be avoided under 11 U.S.C. § 547; (ii) FORBA was insolvent at the time this Agreement was entered into, or became insolvent as a result of the payment made to the United States; or (iii) the mutual promises, covenants, and obligations set forth in this Agreement do not constitute a contemporaneous exchange for new value given to FORBA.

b. If FORBA's obligations under this Agreement are avoided for any reason, including, but not limited to, through the exercise of a trustee's avoidance powers under the Bankruptcy Code, the United States, at its sole option, may rescind the releases in this Agreement and bring any civil and/or administrative claim, action, or proceeding against FORBA for the claims that would otherwise be covered by the releases provided in Paragraphs 2-4, above. FORBA agrees that (i) any such claims, actions, or proceedings brought by the United States (including any proceedings to exclude FORBA from participation in Medicare, Medicaid, or other Federal health care programs) are not subject to an "automatic stay" pursuant to 11 U.S.C. § 362(a) as a result of the action, case, or

proceedings described in the first clause of this Paragraph, and FORBA shall not argue or otherwise contend that the United States' claims, actions, or proceedings are subject to an automatic stay; (ii) FORBA shall not plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claims, actions, or proceeding that are brought by the United States within ninety (90) calendar days of written notification to FORBA that the releases have been rescinded pursuant to this Paragraph, except to the extent such defenses were available on the Effective Date; and (iii) the United States has a valid claim against FORBA in the amount of forty-five million dollars ($45,000,000 00), plus civil penalties to be determined by the Court, and the United States may pursue its claim in the case, action, or proceeding referenced in the first clause of this Paragraph, as well as in any other case, action, or proceeding

c FORBA acknowledges that its agreements in this Paragraph are provided in exchange for valuable consideration provided in this Agreement

20. a If, for any reason, FORBA fails to pay any and all of the payments owed pursuant to this Agreement within fifteen (15) calendar days of the due date, the United States will provide written notice of the non-payment to the persons identified in Paragraph 20 b, below, and FORBA shall have an opportunity to pay the unpaid balance within fifteen (15) calendar days from the date of receipt of the written notice. If FORBA fails to pay the remaining unpaid balance of its payment obligations under this Agreement within fifteen (15) calendar days of receiving the notice of non-payment ("Default"), any dismissals as to FORBA shall, at the United States' option, be null and void, and the Settlement Amount referenced in Paragraph 1 above, less any payments already made, shall become immediately due and payable and shall bear interest at the Medicare interest rate (per 42 C.F.R. part 405 378) as of the date of Default until payment of the Settlement Amount is made in full. Furthermore:

In the event of Default as described above, the United States may at its option: (1) rescind its releases; (2) offset the remaining unpaid balance of the Settlement Amount from any amounts due and owing to FORBA by any department, agency, or agent of the United States at the time of Default; (3) institute an action or actions against FORBA in the United States District Court for the District of Maryland; and (4) FORBA agrees not to contest any draw, offset, or collection action undertaken by the United States pursuant to this Paragraph, either administratively or in any court.

In the event of a Default as described above, FORBA agrees to pay the United States all reasonable costs of collection and enforcement of this Agreement, including attorney's fees and expenses. In the event the United States opts to rescind this Agreement pursuant a Default, FORBA agrees that: (i) FORBA shall not plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claims, actions, or proceeding that are brought by the United States within ninety (90) calendar days of written notification to FORBA that the releases have been rescinded pursuant to this Paragraph, except to the extent such defenses were available on the Effective Date; and (ii) the United States has a valid claim against FORBA in the amount of forty-five million dollars ($45,000,000.00) and the United States may pursue its claim in the case, action, or proceeding referenced in the first clause of this Paragraph, as well as in any other case, action, or proceeding.

b The United States will provide notice, as required under Paragraph 20 a, above, by courier or registered mail, to Michael G. Lindley, FORBA Holdings, LLC, 618 Church Street, Suite 520, Nashville, TN 37219, and Grace M. Rodriguez, King & Spalding LLP, 1700 Pennsylvania Avenue NW, Washington, DC 20006.

21 In the event of a Default as defined in Paragraph 20, above, OIG-HHS may exclude FORBA from participating in all Federal health care programs until FORBA pays the

Settlement Amount and reasonable costs as set forth in Paragraphs 1 and 20 above Such exclusion shall have national effect and shall also apply to all other federal procurement and nonprocurement programs. Federal health care programs shall not pay anyone for items or services, including administrative and management services, furnished, ordered, or prescribed by FORBA in any capacity while FORBA is excluded. This payment prohibition applies to FORBA and all other individuals and entities (including, for example, anyone who employs or contracts with FORBA, and any hospital or other provider where FORBA provides services). The exclusion applies regardless of who submits the claim or other request for payment. FORBA shall not submit or cause to be submitted to any Federal health care program any claim or request for payment for items or services, including administrative and management services, furnished, ordered, or prescribed by FORBA during the exclusion Violation of the conditions of the exclusion may result in criminal prosecution, the imposition of civil monetary penalties and assessments, and an additional period of exclusion FORBA further agrees to hold the Federal health care programs, and all federal beneficiaries and/or sponsors, harmless from any financial responsibility for items or services furnished, ordered, or prescribed to such beneficiaries or sponsors after the Effective Date of the exclusion. FORBA waives any further notice of the exclusion under 42 U.S.C. § 1320a-7(b)(7), and agrees not to contest such exclusion either administratively or in any state or federal court. Reinstatement to program participation is not automatic If at the end of the period of exclusion FORBA wishes to apply for reinstatement, FORBA must submit a written request for reinstatement to the OIG-HHS in accordance with the provisions of 42 C.F.R. §§ 1001.3001-3005. FORBA will not be reinstated unless and until the OIG-HHS approves such request for reinstatement

22 If after the Effective Date, and before FORBA has made all payments required pursuant to Paragraph 1 of this Agreement, FORBA's actual annual revenues for any

fiscal year exceed the projected revenues for that fiscal year as reflected in the Projections by fifteen percent (15%) or more, then an additional payment of $1,000,000.00 shall be made for that applicable year (with a 40 48% pro rata share of the payment allocated to the Medicaid Participating States and the remaining 59 52% pro rata share allocated to the United States) Payments under this provision shall reduce the outstanding principal balance and shall be applied against principal payments due in the settlement payment schedule (Exhibit C) in reverse order, in order to shorten the total payment period. FORBA agrees to provide its financial statements no later than one-hundred and twenty (120) days following the end of each calendar year along with any payment required under this clause for that year. This will be measured annually.

If after the Effective Date, and before FORBA has made all payments required pursuant to Paragraph 1 of this Agreement, FORBA enters into management agreements with new clinics that are over and above the number of new clinics that were included in the Projections as of that year, then an additional payment of $500,000 00 shall be made for each year in which the total number of clinics exceed the total number of clinics in the Projections as of that year (with a 40 48% pro rata share of the additional payment allocated to the Medicaid Participating States and the remaining 59 52% pro rata share allocated to the United States). Payments under this provision shall reduce the outstanding principal balance and shall be applied against principal payments due in the Payment Schedule in reverse payment order, in order to shorten the total payment period. FORBA shall provide an annual statement with a certification from a company officer that states the total number of new clinics that FORBA entered into management agreements with in that year no later than one-hundred and twenty (120) days following the end of each calendar year along with any payment required under this clause for that year

If after the Effective Date, and before FORBA has made all payments required pursuant to Paragraph 1 of this Agreement, in the event of a "Company Change of Control," all principal and interest remaining outstanding and unpaid pursuant to this Settlement Agreement shall accelerate and become immediately due and payable, and such principal and accrued and unpaid interest shall be paid upon the consummation of such Company Change of Control. A "Company Change of Control" shall not include the Restructuring or transfers to existing equity owners in accordance with the Restructuring, and shall mean the sale of all or substantially all of the assets of FORBA, or the sale or transfer of more than fifty percent (50%) of the equity ownership of FORBA to any person not an equity owner of FORBA or otherwise an affiliate of FORBA on the date of this Settlement Agreement.

Amounts that are due under these paragraphs and not paid when due will be considered amounts in Default. Default amounts are subject to the Default provisions contained in this Settlement Agreement as specified in Paragraph 20, including the Default rate of interest at the Medicare interest rate (per 42 C.F.R. part 405 378) beginning as of the date of Default until payment of the Settlement Amount is made in full.

23. Upon receipt of their pro rata share of the Initial Payment described in Paragraph 1 above, the United States and Relators shall promptly sign and file in the Civil Actions a Notice of Intervention and Joint Stipulation of Dismissal of the Civil Actions pursuant to the terms of the Agreement.

24. Except as expressly provided to the contrary in this Agreement, each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

25. FORBA represents that this Agreement is freely and voluntarily entered into without duress or compulsion.

34. All parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

35. This Agreement is effective on the date of the last signatory to the Agreement ("Effective Date of this Agreement"). Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE UNITED STATES OF AMERICA

TONY WEST
Assistant Attorney General

DATED: 1/15/10 BY: _____
Andy J. Mao
Senior Counsel for Health Care Fraud and Elder Justice
Niall M. O'Donnell
Trial Attorney
Commercial Litigation Branch, Civil Division
United States Department of Justice

ROD J. ROSENSTEIN
United States Attorney, District of Maryland

DATED: _____ BY: _____
Thomas F. Corcoran
Assistant United States Attorney

TIMOTHY J. HEAPHY
United States Attorney, Western District of Virginia

DATED: _____ BY: _____
Rick A. Mountcastle
Assistant United States Attorney

W. WALTER WILKINS
United States Attorney, District of South Carolina

DATED: _____ BY: _____
Jennifer J. Aldrich
Assistant United States Attorney

DATED: _____ BY: _____
GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General
United States Department of
Health and Human Services

THE UNITED STATES OF AMERICA

TONY WEST
Assistant Attorney General

DATED:_____ BY: _____
Andy J. Mao
Senior Counsel for Health Care Fraud and Elder Justice
Niall M. O'Donnell
Trial Attorney
Commercial Litigation Branch, Civil Division
United States Department of Justice

ROD J. ROSENSTEIN
United States Attorney, District of Maryland

DATED: 1/15/10 BY: _____
Thomas F. Corcoran
Assistant United States Attorney

TIMOTHY J. HEAPHY
United States Attorney, Western District of Virginia

DATED: _____ BY: _____
Rick A. Mountcastle
Assistant United States Attorney

W. WALTER WILKINS
United States Attorney, District of South Carolina

DATED:_____ BY: _____
Jennifer J. Aldrich
Assistant United States Attorney

DATED:_____ BY: _____
GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General
United States Department of
Health and Human Services

THE UNITED STATES OF AMERICA

TONY WEST
Assistant Attorney General

DATED:_____ BY: _____
Andy J. Mao
Senior Counsel for Health Care Fraud and Elder Justice
Niall M. O'Donnell
Trial Attorney
Commercial Litigation Branch, Civil Division
United States Department of Justice

ROD J. ROSENSTEIN
United States Attorney, District of Maryland

DATED:_____ BY: _____
Thomas F. Corcoran
Assistant United States Attorney

TIMOTHY J. HEAPHY
United States Attorney, Western District of Virginia

DATED: 1/14/10 BY: _____
Rick A. Mountcastle
Assistant United States Attorney

W. WALTER WILKINS
United States Attorney, District of South Carolina

DATED:_____ BY: _____
Jennifer J. Aldrich
Assistant United States Attorney

DATED:_____ BY: _____
GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General
United States Department of
Health and Human Services

THE UNITED STATES OF AMERICA

TONY WEST
Assistant Attorney General

DATED:_____ BY: _____
Andy J Mao
Senior Counsel for Health Care Fraud and Elder Justice
Niall M O'Donnell
Trial Attorney
Commercial Litigation Branch, Civil Division
United States Department of Justice

ROD J ROSENSTEIN
United States Attorney, District of Maryland

DATED:_____ BY: _____
Thomas F Corcoran
Assistant United States Attorney

TIMOTHY J HEAPHY
United States Attorney, Western District of Virginia

DATED:_____ BY: _____
Rick A Mountcastle
Assistant United States Attorney

KEVIN McDONALD
W. WALTER WILKINS
Acting United States Attorney, District of South Carolina

DATED: 1/5/10 BY: _____
Jennifer J. Aldrich
Assistant United States Attorney

DATED:_____ BY: _____
GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General
United States Department of
Health and Human Services

THE UNITED STATES OF AMERICA

TONY WEST
Assistant Attorney General

DATED:_____ BY: _____
Andy J. Mao
Senior Counsel for Health Care Fraud and Elder Justice
Niall M. O'Donnell
Trial Attorney
Commercial Litigation Branch, Civil Division
United States Department of Justice

ROD J. ROSENSTEIN
United States Attorney, District of Maryland

DATED: _____ BY: _____
Thomas F. Corcoran
Assistant United States Attorney

TIMOTHY J. HEAPHY
United States Attorney, Western District of Virginia

DATED:_____ BY: _____
Rick A. Mountcastle
Assistant United States Attorney

W. WALTER WILKINS
United States Attorney, District of South Carolina

DATED:_____ BY: _____
Jennifer J. Aldrich
Assistant United States Attorney

DATED: 1/15/10 BY: _____
GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General
United States Department of
Health and Human Services

FORBA - DEFENDANT

DATED: _____ BY: _____
MICHAEL G. LINDLEY
Chief Executive Officer of FORBA

DATED: 1/14/10 BY: _____
GRACE M. RODRIGUEZ
Counsel for FORBA

JOHN J. HANEY - Relator

DATED: 1-15-2010 BY: John J. Haney
JOHN J. HANEY

DATED: 1-15-2010 BY: Thomas A Rath
Counsel for John J Haney

ANGELA CRAWFORD -Relator

DATED: 01-15-10 BY: Angela Crawford
ANGELA CRAWFORD

DATED: Jan. 15, 2010 BY: David P. Rusk
Counsel for Angela Crawford

DEBORAH MCDANIEL - Relator

DATED: 1/15/10 BY: _____
DEBORAH MCDANIEL

DATED: 1-15-10 BY: _____
Counsel for Deborah McDaniel

EXHIBIT 3

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
FORBA HOLDINGS, LLC

I. PREAMBLE

FORBA Holdings, LLC hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, FORBA Holdings, LLC is entering into a Settlement Agreement with the United States. FORBA Holdings, LLC also will enter into settlement agreements with various States (Related State Settlement Agreements) and FORBA Holdings, LLC's agreement to this CIA is a condition precedent to those agreements.

For the purposes of this CIA, "FORBA" shall mean the following: (1) FORBA Holdings, LLC and its wholly-owned subsidiaries and affiliates; and (2) any other corporation, limited liability corporation, partnership, joint venture, or any other legal entity or organization in which FORBA owns a direct or indirect equity interest of 5% or more, or in which FORBA has a control interest, at any time during the term of the CIA.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by FORBA under this CIA shall be five years from the effective date of this CIA, unless otherwise specified. The effective date shall be the date on which the final signatory of this CIA executes this CIA (Effective Date). Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. Sections VII, IX, X, and XI shall expire no later than 120 days after OIG's receipt of: (1) FORBA's final annual report; or (2) any additional materials submitted by FORBA pursuant to OIG's request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions:

1. "FORBA facility" includes any dental practice or other legal entity that FORBA operates or with whom FORBA has a contract or arrangement to provide management, administrative, or staffing services at any time during the term of the CIA.

2. "Covered Persons" includes:

a. all owners, officers, directors, and employees of FORBA;

b. all owners, officers, directors, and employees of FORBA facilities; and

c. all contractors, subcontractors, agents, and other persons who on behalf of FORBA or FORBA facilities: (1) perform patient care duties; (2) make assessments of patients that affect treatment decisions or reimbursement; (3) perform billing, coding, audit, or review functions; (4) make decisions or perform managerial or administrative functions in connection with staffing, compensation, benefits, performance standards, patient care, reimbursement, policies and procedures, or this CIA; or (5) perform any function that relates to or is covered by this CIA, including individuals who are responsible for quality assurance, setting policies or procedures, or making staffing decisions.

Notwithstanding the above, the term "Covered Person" does not include:

a. part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year, except that any such individuals shall become "Covered Persons" at the point when they work more than 160 hours during the calendar year; and

b. vendors whose sole connection with FORBA or any affiliated company is selling supplies, materials or equipment.

3. "Billing and Reimbursement Covered Persons" includes all Covered Persons involved, directly or in a supervisory role, in the preparation,

coding, billing, auditing or submission of claims for reimbursement by any Federal health care program.

4. "Clinical Quality Covered Persons" includes all Covered Persons involved in the delivery of patient care items or services at FORBA and/or FORBA facilities or involved in the monitoring of clinical quality at FORBA and/or FORBA facilities.

5. "Relevant Covered Persons" means all Billing and Reimbursement Covered Persons and Clinical Covered Persons.

III. CORPORATE INTEGRITY OBLIGATIONS

FORBA shall establish and maintain a Compliance Program that includes the following elements:

A. Compliance Responsibilities of Corporate Officers, Compliance Committee, Board of Directors, and Management.

1. *Compliance Officer.* Prior to the Effective Date, FORBA appointed a Compliance Officer, and FORBA shall maintain a Compliance Officer during the term of the CIA. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Compliance Officer shall be a member of senior management of FORBA, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Directors of FORBA, and shall be authorized to report on such matters to the Board of Directors at any time. The Compliance Officer shall not be, or be subordinate to, the General Counsel or Chief Financial Officer. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by FORBA and FORBA facilities as well as for any reporting obligations created under this CIA. The Compliance Officer shall also ensure that FORBA is appropriately identifying and correcting quality of care problems. The Compliance Officer shall supervise the Compliance Department, including the responsibilities of the Patient Advocate. The Compliance Officer shall also serve as the Chair of the Compliance Liaisons Committee. Any noncompliance job responsibilities shall be limited and shall not interfere with the Compliance Officer's ability to perform the duties outlined in this CIA.

FORBA shall report to OIG, in writing, any changes in the identity or position description of the Compliance Officer, or any actions or changes that would affect the

Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

2. *Chief Dental Officer.* Prior to the Effective Date, FORBA appointed a Chief Dental Officer, and FORBA shall maintain a Chief Dental Officer during the term of the CIA. The Chief Dental Officer shall be a pediatric dentist who is a graduate of an advanced education program approved by the United States Commission on Dental Accreditation. Further, the Chief Dental Officer shall be a member of the American Academy of Pediatric Dentistry and a diplomate of the American Board of Pediatric Dentistry. The Chief Dental Officer shall be responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by FORBA and FORBA facilities meet the professionally recognized standards of health care. The Chief Dental Officer shall review patient care matters at FORBA and FORBA facilities, including but not limited to quality protocols, quality assessments, patient safety issues, utilization review, performance improvement, and dental staff training. The Chief Dental Officer shall also conduct routine (at least monthly) audits of dental records. The Chief Dental Officer shall be a member of senior management and the Board of Directors of FORBA, shall make periodic (at least quarterly) written reports regarding quality of care matters directly to the Board of Directors of FORBA with a copy to the qualified monitoring team (the "Monitor") as set forth in section III.E, and shall be authorized to report on such matters directly to the Board of Directors or the Monitor at any time. The Chief Dental Officer shall not be, or be subordinate to, the General Counsel or Chief Financial Officer.

FORBA shall report to OIG, in writing, any changes in the identity or position description of the Chief Dental Officer, or any actions or changes that would affect the Chief Dental Officer's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

3. *Compliance Liaisons.* Within 90 days after the Effective Date, FORBA shall appoint a Compliance Liaison from each FORBA facility, and FORBA shall maintain a Compliance Liaison at each facility for the term of the CIA. The Compliance Liaison shall be either the Lead Dentist or the Office Manager of the FORBA facility. The Compliance Liaison shall be responsible for: (a) assisting the Compliance Officer to implement the policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA, Federal health care program requirements, state dental board requirements, and professionally recognized standards of health care; (b) assisting the Compliance Officer to monitor the day-to-day compliance activities of the applicable FORBA facility; and (c) serving as the contact person for the Compliance Officer for compliance activities at the applicable FORBA facility. The Compliance Liaisons shall

make periodic (at least quarterly) written reports regarding compliance matters directly to the Compliance Officer, and shall be authorized to report on such matters directly to the Compliance Committee, the Board of Directors, and the Monitor at any time. The Compliance Liaisons shall meet as a group, at minimum, every month. Each Compliance Liasion is required to attend, at minimum, one Compliance Liaisons Group meeting per month. For each scheduled Compliance Liaisons Group meeting, individual Compliance Liaisons shall be chosen, on a rotating basis, to report to the Compliance Liaisons Group on the adequacy of care being provided at their facilities. Attendance at such committee meetings by Compliance Liaisons may be via conference phone or video conferencing equipment, although in person attendance is the desired and intended form of attendance.

FORBA shall report to OIG, in writing, any changes in the identity or position description of the Compliance Liaison, or any actions or changes that would affect the Compliance Liaisons' ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

4. *Patient Advocate.* Within 90 days after the Effective Date, FORBA shall appoint a Patient Advocate, and FORBA shall maintain a Patient Advocate for the term of the CIA. The Patient Advocate shall report to the Compliance Officer. The Patient Advocate shall be responsible for recording, remedying, and responding to comments, concerns, and complaints by patients of FORBA facilities. The Patient Advocate shall also be responsible for ensuring that materials disseminated to patients contain information related to FORBA's commitment to ensuring that all dental services and items provided meet professionally recognized standards of health care, including Federal health care program and state dental board requirements. The Patient Advocate shall ensure that materials disseminated to all patients are available in both English and Spanish and also include contact information for filing or registering a complaint with the Parent Compliance Hotline, the local state dental board, and the Office of Inspector General. Such publications shall be made in locations reasonably designed to reach members of the Medicaid population, existing and potential patients, such as FORBA's website, FORBA facilities, and any newsletters. The Patient Advocate shall make periodic (at least quarterly) written reports to the Compliance Committee and the Board Committee regarding patient care matters.

FORBA shall report to OIG, in writing, any changes in the identity or position description of the Patient Advocate, or any actions or changes that would affect the Patient Advocate's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

5. *Compliance Committee.* Within 90 days after the Effective Date, FORBA shall appoint a Compliance Committee. The purpose of this committee shall be to address issues concerning quality of care and to assist the Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of the organization's risk areas and shall oversee monitoring of internal and external audits and investigations). The Compliance Committee shall, at a minimum, include the Compliance Officer, Chief Executive Officer, Chief Dental Officer, Patient Advocate, Director of Clinical Coordinators, other members of senior corporate management necessary to thoroughly implement the requirements of this CIA (e.g., senior managers of relevant departments such as billing, clinical, human resources, audit, compliance, marketing, licensing, and operations), and Regional Managers. At least seven Compliance Liaisons shall be selected on a rotating basis to participate in each Compliance Committee meeting. The Compliance Officer shall chair the Compliance Committee. The Compliance Committee shall meet, at a minimum, every month. Attendance at such committee meetings may be via conference phone or video conferencing equipment, although in person attendance is the desired and intended form of attendance. For each scheduled Compliance Committee meeting:

a. senior management of FORBA shall report to the Compliance Committee on the adequacy of care being provided by FORBA facilities; and

b. the Compliance Committee shall monitor the quality of care being provided by FORBA and FORBA facilities through the use of a "Quality of Care Dashboard" (Dashboard) which will function as a performance scorecard for the organization. Through the creation and monitoring of the Dashboard, the Compliance Committee shall oversee FORBA's progress towards its quality improvement and compliance goals.

1. Within 120 days after the Effective Date, the Compliance Committee shall identify and establish the overall quality of care improvement goals for FORBA and FORBA facilities. The goals shall be patient-centric and shall be designed to promote the delivery of dental care items and services that meet or exceed professionally recognized standards of health care and are necessary, reasonable, and appropriate to the needs of patients. The Compliance Committee shall provide a copy of the quality improvement goals to the Board of Directors (Board) and the Monitor.

2. Within 120 days after the Effective Date, the Compliance Committee shall identify and establish the quality indicators that FORBA will monitor through the Dashboard. These indicators shall measure the quality of dental care items and services furnished by FORBA and FORBA facilities. The indicators shall include, but are not limited to:

a. underutilization/overutilization of dental services;
b. patient adverse events and medical errors;
c. patient record documentation; and
d. patient and staff satisfaction.

The Compliance Committee shall also establish performance metrics for each quality indicator. The Compliance Committee shall provide a copy of the quality indicators and performance metrics to the Board and the Monitor.

The Compliance Committee shall review the quality indicators (at least semi-annually) to determine if revisions are appropriate and shall make any necessary revisions based on such review. The Compliance Committee shall report to the Board and the Monitor, in writing, any changes in the quality indicators, within 15 days after such a change.

3. The Compliance Committee shall measure, analyze, and track performance metrics for the quality indicators on a monthly basis. Quality indicator data shall be collected and reported on a Dashboard. The Committee shall provide a copy of the Dashboard and a written report to the Board and the Monitor. As part of the report, the Committee shall: (a) identify high risk, high-volume, or problem-prone areas; (b) consider the incidence, prevalence, and severity of problems in those areas; (c) identify indicators that consistently fail to meet performance goals; and (d) recommend corrective actions for problem areas and indicators that fail to meet performance goals.

The Compliance Committee shall implement any corrective actions within 30 days of receiving Board approval.

4. A copy of the Dashboard shall be readily available to any Covered Person and shall be provided to Compliance Liaisons.

5. For each Reporting Period, FORBA shall provide to the Board a copy of the Dashboard that tracks FORBA's performance over the full 12-month period.

FORBA shall report to OIG, in writing, any changes in the composition of the Compliance Committee, or any actions or changes that would affect the Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

6. *Board of Directors*. The Board or a Committee of the Board, if applicable, shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements, state dental board requirements, professionally recognized standards of health care, and the obligations of this CIA. The individuals who serve on the Board shall be readily available to the Compliance Officer and the Monitor required under this CIA to respond to any issues or questions that might arise. The Board, or a Committee of the Board, shall, at a minimum, be responsible for the following:

a. meeting (at least quarterly) to review and oversee FORBA's Compliance Program, including but not limited to the performance of the Compliance Officer and Compliance Department and review of the Quality of Care Dashboard;

b. providing oversight on quality of care issues, including but not limited to: (1) reviewing the adequacy of FORBA and FORBA facilities' system of internal controls, quality assurance monitoring, and patient care; (2) ensuring that FORBA's response to state, federal, internal, and external reports of quality of care issues is complete, thorough, and resolves the issue(s) identified; (3) ensuring that FORBA adopts and implements policies and procedures that are designed to ensure that each individual cared for by FORBA and FORBA facilities receives the professionally recognized standards of health care; and (4) reviewing and responding to the Dashboard. As part of its review of the Dashboard, the Board shall ensure that FORBA implements effective responses when clinical quality problems are discovered or when quality indicators are not meeting established goals. For each Reporting Period, the Board shall present a written report that summarizes its oversight of the Dashboard, the status of quality of care at FORBA and FORBA facilities, and identifies any corrective action that took place in response to the Dashboard; and

c. for each Reporting Period of the CIA, adopting a resolution (consistent with the bylaws for adopting resolutions) summarizing its review and oversight of FORBA's compliance with Federal health care program requirements, state dental board requirements, and the obligations of this CIA. Each individual member of the Board or, if applicable, each member of the Committee of the Board having responsibility for compliance, shall sign a statement indicating that he or she agrees with the resolution.

At minimum, the resolution shall include the following language:

"The Board of Directors [or a Committee of the Board] has made a reasonable inquiry into the operations of FORBA's Compliance Program, including the performance of the Compliance Officer and the Compliance Department. The Board has also provided oversight on quality of care issues. Based on its inquiry and review, the Board [or Committee] has concluded that, to the best of its knowledge, FORBA has implemented an effective Compliance Program and FORBA is in compliance with the Federal health care program requirements, state dental board requirements, professionally recognized standards of health care, and the obligations of the CIA."

If the Board (or the Board Committee) is unable to provide such a conclusion in the resolution, the Board (or Committee) shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to ensure the implementation of an effective Compliance Program at FORBA.

FORBA shall report to OIG, in writing, any changes in the composition of the Board, or any actions or changes that would affect the Board's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

7. *Management Accountability and Certifications.* In addition to the responsibilities set forth in this CIA for all Covered Persons, certain Covered Persons ("Certifying Employees") are specifically expected to monitor and oversee activities within their areas of authority and shall annually certify in writing or electronically that the applicable area of authority is compliant with the obligations of this CIA, Federal health care program requirements, state dental board requirements, and professionally recognized standards of care. The Certifying Employees include, at a minimum, the following: Chairman and Chief Executive Officer, Executive Vice President and Chief Financial Officer, President and Chief Operating Officer, Chief Dental Officer, all Senior Vice Presidents, Regional Managers, Director of Clinical Coordinators, Marketing Coordinator, Assistant Vice President of Dentist Recruitment, Manager for Licensing and

Credentialing, Office Managers of FORBA facilities, and Lead Dentists of FORBA facilities.

For each Reporting Period, each Certifying Employee shall certify in writing or electronically that:

"I have been trained on and understand the compliance requirements and responsibilities as they relate to [department or functional area], an area under my supervision. My job responsibilities include ensuring compliance with regard to the _____ [insert name of the department, functional area, or FORBA facility.] To the best of my knowledge, except as otherwise described herein, the _____ [insert name of department or functional area] of FORBA (or "(insert name of FORBA facility), a FORBA facility,") is in compliance with all applicable Federal health care program requirements, state dental board requirements, and the obligations of the CIA."

8. *Internal Audit Program.* Within 90 days after the Effective Date, FORBA shall create a program for performing internal quality audits and reviews (hereinafter "Internal Audit Program"). The Internal Audit Program shall:

a. make findings of whether the patients at FORBA facilities are receiving the quality of care consistent with professionally recognized standards of health care, including, but not limited to, any applicable federal and state statutes, state dental board requirements, regulations, and directives, and American Academy of Pediatric Dentistry Reference Manual and guidelines (AAPD guidelines);

b. make findings of whether the Policies and Procedures mandated by Section III.B (Written Standards) of this CIA are created, implemented, and enforced;

c. make findings of whether training is performed in accordance with Section III.C (Training and Education) of this CIA;

d. make findings of whether Disclosure Program (as described in Section III.F of this CIA) complaints are appropriately investigated;

e. make findings of whether the reporting obligations are complied with in accordance with Section III.I (Reporting) of this CIA; and

f. make findings of whether corrective action plans are timely created, implemented, and enforced.

The Compliance Officer shall report a summary of the internal audit reports to the Board as part of his or her written report.

B. Written Standards.

1. *Code of Conduct.* Within 90 days after the Effective Date, FORBA shall develop, implement, and distribute a written Code of Conduct to all Covered Persons. FORBA shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. The Code of Conduct shall, at a minimum, set forth:

a. FORBA's commitment to full compliance with all Federal health care program requirements, state dental board requirements, and professionally recognized standards of health care, including its commitment to prepare and submit accurate claims, and provide dental services and items consistent with such requirements;

b. FORBA's requirement that all Covered Persons shall be expected to comply with all Federal health care program requirements, state dental board requirements, professionally recognized standards of health care and with FORBA's own Policies and Procedures as implemented pursuant to Section III.B (including the requirements of this CIA);

c. the requirement that all Covered Persons shall be expected to report, within 30 days, to the Compliance Officer, or other appropriate individual designated by FORBA, suspected violations of any Federal health care program requirements, state dental board requirements, professional standards of health care, or of FORBA's own Policies and Procedures; if there are credible allegations of patient harm, such report shall be made immediately and shall be complete, full, and honest;

d. the possible consequences to both FORBA and Covered Persons of failure to comply with Federal health care program requirements, state dental board requirements, professionally recognized standards

of health care, and with FORBA's own Policies and Procedures and the failure to report such noncompliance; and

e. the right of all individuals to use the Disclosure Program described in Section III.F, and FORBA's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

Within 90 days after the Effective Date, each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by FORBA's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later.

FORBA shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. Any revised Code of Conduct shall be distributed within 30 days after any revisions are finalized. Each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by the revised Code of Conduct within 30 days after the distribution of the revised Code of Conduct.

2. *Policies and Procedures.* Within 90 days after the Effective Date, FORBA shall implement written Policies and Procedures regarding the operation of FORBA's compliance program and its compliance with Federal health care program requirements. At a minimum, the Policies and Procedures shall address:

a. the subjects relating to the Code of Conduct identified in Section III.B.1;

b. measures designed to ensure that FORBA fully complies with Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395hhh and 1396-1396v, and all regulations, directives, and guidelines promulgated pursuant to these statutes, including, but not limited to, 42 C.F.R. Part 440 and any other state or local statutes, regulations, directives, or guidelines, and any that address quality of care in dental practices, such as state dental board requirements and the AAPD guidelines;

c. FORBA's commitment to ensuring that FORBA facilities provide services and items to their patients that meet professionally

recognized standards of health care, including but not limited to Federal health care program requirements, state dental board requirements, and the AAPD guidelines.

d. Measures designed to promote the delivery of patient items or services at FORBA and FORBA facilities that meet professionally recognized standards of health care, including but not limited to the following areas:

1. patient safety;

2. appropriate patient assessment and treatment planning;

3. appropriate documentation of dental records, including radiographs or digital photos consistent with professionally recognized standards of health care;

4. appropriate anesthesia guidelines for pediatric dental patients;

5. appropriate behavior guidance approaches for the pediatric dental patient, including dental team behavior, dentist behavior, communications, patient assessment, barriers, and deferred treatment;

6. advanced behavior guidance techniques for the pediatric dental patient, including protective stabilization, sedation, general anesthesia, and contraindications for each technique;

7. appropriate management of dental patients with special health care needs;

8. time management;

9. appropriate amount of treatment in an individual visit;

10. parental accompaniment;

11. informed consent;

12. periodic audit of clinical quality;

13. the ethical responsibility to treat or refer patients;

14. infection control; and

15. appropriate use of medications, including antibiotic therapy for pediatric dental patients.

e. Measures designed to promote adherence to the compliance and quality of care standards set forth in the applicable statutes, regulations, Federal health care program and state dental board requirements, AAPD guidelines, and the CIA, by including such adherence as a significant factor in determining the compensation to Covered Persons. These Policies and Procedures shall be designed to ensure that financial incentives do not motivate such individuals to engage in improper conduct, or provide excessive or substandard services or items. These Policies and Procedures shall include a requirement that compliance be a component of each employee's performance objectives and evaluation, and that compensation and incentive awards, such as bonuses, be directly linked to performance on clinical quality measures (if applicable) and compliance program effectiveness.

f. Measures designed to ensure cooperation by FORBA and its Covered Persons with the Monitor in the performance of his or her duties as set forth in Section III.E of this CIA;

g. Measures designed to ensure that compliance issues are identified internally (e.g., through reports to supervisors, complaints received through the Disclosure Program, internal audits, patient satisfaction surveys, quality indicators, facility-specific key indicators, clinical quality audits, or exit interviews) and that issues, whether identified internally or externally (e.g., through federal or state agency reports, consultants, or the Monitor's Reports) are promptly and appropriately investigated and, that if the investigation substantiates compliance issues, FORBA implements effective and timely corrective action plans and monitors compliance with such plans;

h. Measures designed to effectively collect and analyze staffing data, including but not limited to staff turnover, reasons for staff

departures, and staff bonuses and compensation. The measures should ensure that exit interviews of employees of FORBA and FORBA facilities include the individual's impressions of patient care or harm;

i. Measures designed to ensure that contractors, subcontractors, and agents that fall within the ambit of Covered Persons are appropriately supervised to ensure that they are acting within the parameters of the CIA, FORBA's Policies and Procedures, Federal health care program and state dental board requirements, and professionally recognized standards of health care;

j. Measures designed to ensure that appropriate and qualified individuals perform the internal quality audits and reviews under the Internal Audit Program required by Section III.A.8;

k. Nonretaliation policies and methods for Covered Persons to make disclosures or otherwise report on compliance issues through the Disclosure Program required by Section III.F of this CIA;

l. Disciplinary guidelines to reflect the Code of Conduct requirements as specified in Section III.B.1 of this CIA;

m. Measures designed to ensure that FORBA has a system to require and centrally collect reports relating to patient care incidents, injuries, abuse, and neglect. The reports required under this system shall be of a nature to allow the Compliance Committee meaningful information to be able to determine: (1) whether a quality of care problem exists; and (2) the scope and severity of the problem. The measures should ensure that patients, parents, and guardians are provided with FORBA's Parent Compliance Hotline number, state dental board complaint numbers, and the OIG Hotline number. The measures should also develop a mechanism for informing all current patients, parents, and guardians who received care from a FORBA facility when a substantiated incident of patient harm occurs at that facility;

n. Measures designed to ensure that FORBA and FORBA facilities comply with Federal health care program requirements on billing and reimbursement, including, but not limited to the following:

1. ensuring the proper and accurate preparation and submission of claims to Federal health care programs;

2. ensuring the proper and accurate documentation of dental records;

3. conducting periodic billing and coding reviews and audits of FORBA facilities; and

4. reporting and repaying all identified Overpayments to Federal health care programs and other payors.

o. Measures that define the responsibilities and role of the Chief Dental Officer required by Section III.A;

p. Measures that define the responsibilities and role of the Patient Advocate required by Section III.A;

q. Measures that define the responsibilities and role of the Compliance Liaisons required by Section III.A;

r. Measures that relate to the creation and use of the Quality Of Care Dashboard required by Section III.A, including, but not limited to:

1. the responsibilities of the Compliance Committee and the Board regarding the Dashboard;

2. the requirement to identify quality indicators and establish performance goals for each indicator;

3. the means by which quality indicator data is collected, analyzed, and monitored; and

4. the requirement to use the information from the Dashboard to monitor the quality of care at FORBA and FORBA facilities, including, but not limited to, identifying opportunities for improvement, and implementing and monitoring performance improvement activities;

s. disciplinary policies and procedures for violations of FORBA's Policies and Procedures, including policies relating to professionally

recognized standards of health care, Federal health care program requirements, and state dental board requirements.

t. measures to collect, verify, and assess current licensure, education, and training of all Relevant Covered Persons; and

u. the requirement that FORBA terminate its relationship with any Covered Person that is found to have violated professionally recognized standards of health care.

Within 90 days after the Effective Date, the relevant portions of the Policies and Procedures shall be distributed to all individuals whose job functions relate to those Policies and Procedures. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures. The Policies and Procedures shall be available to OIG upon request.

At least annually (and more frequently, if appropriate), FORBA shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, the relevant portions of any such revised Policies and Procedures shall be distributed to all individuals whose job functions relate to those Policies and Procedures.

C. Training and Education.

All training required in this section shall be competency-based. Specifically, the training must be developed and provided in such as way as to focus on Covered Persons achieving learning outcomes to a specified competency and to place emphasis on what a Covered Person has learned as a result of the training.

1. *General Training.* Within 90 days after the Effective Date, FORBA shall provide at least two hours of General Training to each Covered Person. This training, at a minimum, shall explain FORBA's:

a. CIA requirements; and

b. FORBA's Compliance Program (including the Code of Conduct and the Policies and Procedures as they pertain to general compliance issues).

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least two hours of General Training in each subsequent Reporting Period.

2. *Specific Training.* Within 90 days after the Effective Date, FORBA shall initiate the provision of Specific Training to each Relevant Covered Person under the following training modules in addition to the General Training required above in a manner relevant to the individual's job training responsibilities as follows:

a. Billing and Reimbursement Training. Each Billing and Reimbursement Covered Persons shall receive at least three hours of Specific Training pertinent to their responsibilities in addition to the General Training required above. This Specific Training shall include a discussion of:

(1) Federal health care program and state requirements regarding the accurate preparation and submission of claims;

(2) Policies, procedures, and other requirements applicable to the documentation of dental records;

(3) the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

(4) applicable reimbursement statutes, regulations, and program requirements and directives;

(5) the legal sanctions for violations of Federal health care program requirements;

(6) examples of proper and improper claims submission practices; and

(7) policies and procedures for the reporting and repayment of Overpayments to Federal health care programs and other payors.

b. Clinical Quality Training. Each Clinical Quality Covered Person shall receive at least three hours of Clinical Quality Training that covers the following topics:

(1) FORBA's policies, procedures, and other requirements relating to clinical quality, including, but not limited to the policies set forth in Section III.B.2.d;

(2) the proper documentation of patient charts and dental records;

(3) the personal obligation of each individual involved in the delivery of items or services at FORBA and FORBA facilities, or involved in the monitoring of clinical quality at FORBA facilities, to know the applicable legal requirements, FORBA's policies and procedures, and professionally recognized standards of health care;

(4) legal sanctions for violating Federal health care program requirements; and

(5) examples of proper and improper patient care at FORBA facilities.

New Relevant Covered Persons shall begin receiving this training within 10 days after the start of their employment or contract or within 90 days after the Effective Date, whichever is later. A FORBA employee who has completed the Specific Training shall review a new Relevant Covered Person's work, to the extent that the work relates to the delivery of patient care, until such time as the new Relevant Covered Person completes his or her Specific Training.

After receiving the initial Specific Training described in this Section, each Relevant Covered Person shall receive at least two hours of Specific Training in each subsequent Reporting Period.

3. *Periodic Training.* In addition to the Specific Training described above, FORBA shall provide Periodic Training to all Covered Persons at FORBA facilities who are responsible for patient care on the quality of care issues identified by the Compliance Committee. This periodic training shall be provided on an "as needed" basis, but shall be provided at least semi-annually. In determining what training should be performed, the Compliance Committee shall review the complaints received, satisfaction surveys, staff turnover data, the Dashboard, any state or federal audits or reports, any internal audits, and the findings, reports, and recommendations of the Monitor. Such training shall be for a minimum of two hours annually.

4. *Certification.* Each Covered Person who is required to attend training shall certify, in writing, or in electronic form, if applicable, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Officer (or designee) shall retain the certifications, along with all course materials and documentation evidencing that the individual attained competency in the required training areas. These shall be made available to OIG, upon request.

5. *Qualifications of Trainer.* Persons providing the training shall be knowledgeable about the subject area.

6. *Update of Training.* FORBA shall review the training annually, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or by the Independent Monitor, and any other relevant information.

7. *Computer-based Training.* FORBA may provide the training required under this CIA through appropriate computer-based training approaches. If FORBA chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers to answer questions or provide additional information to the individuals receiving such training.

D. Review Procedures.

1. *General Description.*

a. *Engagement of Independent Review Organization.* Within 90 days after the Effective Date, FORBA shall engage an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform reviews to assist FORBA in assessing and evaluating its billing, coding, and quality of care practices and certain other obligations pursuant to this CIA and the Settlement Agreement. The applicable requirements relating to the IRO are outlined in Appendix A to this CIA, which is incorporated by reference.

Each IRO engaged by FORBA shall have expertise in applicable Federal health care program and other requirements as may be appropriate to the Review for which the IRO is retained. Each IRO shall assess, along with FORBA, whether it can perform the

engagement in a professionally independent and objective fashion, as appropriate to the nature of the review, taking into account any other business relationships or other engagements that may exist.

The IRO(s) shall conduct reviews that assess FORBA's coding, billing, and claims submission to the Federal health care programs, the reimbursement received, and the quality of items and services provided to patients.

b. *Frequency and Brief Description of Reviews.* As set forth more fully in Appendix B, the Reviews shall consist of at least two components - a Claims Review and an Additional Items Review. An Unallowable Cost Review may also be included, if applicable.

(1) Claims Review. The Claims Review shall be performed annually and shall cover each of the Reporting Periods. The IRO(s) shall perform all components of each annual Claims Review. The Claims Review shall include three Discovery Samples, each of 50 Paid Claims (as described further in Appendix B) and, if the Error Rate for any Discovery Sample is 5% or greater, a Full Sample and Systems Review. The applicable definitions, procedures, and reporting requirements are outlined in Appendix B to this CIA, which is incorporated by reference.

The IRO shall prepare a report based upon the Claims Review performed (Claims Review Report). Information to be included in the Claims Review Report is described in Appendix B. In accordance with Section III.I, FORBA shall repay within 30 days any Overpayment(s) identified in the Discovery Samples or the Full Sample(s) (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. FORBA shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor.

(2) Additional Items Review. In addition, beginning with the second Reporting Period, each Review shall also include a review of up to three additional areas or practices of FORBA identified by the OIG in its discretion (hereafter "Additional Items").

For purposes of identifying the Additional Items to be included in the Reviews for a particular Reporting Period, the OIG may consult with FORBA and may consider internal audit work conducted or planned by FORBA, the nature and scope of FORBA's practices, and other information known to it. As set forth more fully in Appendix B, FORBA may propose to the OIG that its internal audit(s) be partially substituted for one or more of the Additional Items that would otherwise be reviewed by the IRO. The OIG retains sole discretion over whether, and in what manner, to allow FORBA's internal audit work to be substituted for a portion of the Additional Items review conducted by the IRO.

The OIG shall notify FORBA of the nature and scope of the IRO review for each of the Additional Items no later than 90 days prior to the end of the second through fifth Reporting Periods. Prior to undertaking the review of the Additional Items, the IRO and/or FORBA shall submit an audit work plan to the OIG for approval and the IRO shall conduct the review of the Additional Items based on a work plan approved by the OIG.

(3) Unallowable Cost Review. If applicable, the IRO shall perform the Unallowable Cost Review for the first Reporting Period. The IRO shall conduct a review of FORBA's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether FORBA has complied with its obligations not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from the United States, or any state Medicaid program. This unallowable cost analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by FORBA or any affiliates. To the extent that such cost reports, cost statements, information reports, or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

If applicable, the IRO shall prepare a report based upon the Unallowable Cost Review performed. The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Costs Review and whether FORBA has complied with its obligation not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from such payor.

c. *Retention of Records.* The IRO and FORBA shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and FORBA) related to the reviews.

2. *Validation Review.* In the event OIG has reason to believe that: (a) FORBA's Claims Review, Additional Items Review, or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings, Claims Review results, Additional Items Review results, or Unallowable Cost Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review, Additional Items Review, or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Claims Review results, Additional Items Review results, or Unallowable Cost Review results are inaccurate (Validation Review). FORBA shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of Reports submitted as part of FORBA's final Annual Report shall be initiated no later than one year after FORBA's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify FORBA of its intent to do so and provide a written explanation regarding the necessity of such review. To resolve any concerns raised by OIG, FORBA may request a meeting with OIG to: (a) discuss the results of any Claims Review, Additional Items Review, or Unallowable Cost Review submissions or findings; (b) present any additional information to clarify the results of the Claims Review, Additional Items Review, or Unallowable Cost Review or to correct the inaccuracy of the Claims Review, Additional Items Review, or Unallowable Cost Review; and/or (c) propose alternatives to the proposed Validation Review. FORBA agrees to provide any additional information as may be requested by OIG under this Section III.D.2 in an expedited manner. OIG will attempt in good faith to

resolve any Claims Review, Additional Items Review, or Unallowable Cost Review issues with FORBA prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

3. *Independence and Objectivity Certification.* The IRO shall include in its report(s) to FORBA a certification or sworn affidavit that it has evaluated its professional independence and objectivity, as appropriate to the nature of the engagement, with regard to the Claims Review, Additional Items Review, or Unallowable Cost Review and that it has concluded that it is, in fact, independent and objective.

E. Independent Monitor

Within 60 days after the Effective Date, FORBA shall retain an appropriately qualified monitoring team (the "Monitor"), appointed by OIG after consultation with FORBA. The Monitor may retain additional personnel, including, but not limited to, independent consultants, if needed to help meet the Monitor's obligations under this CIA. FORBA shall be responsible for all reasonable costs incurred by the Monitor, including, but not limited to, travel costs, consultants, administrative personnel, office space and equipment, or additional personnel. The Monitor shall charge a reasonable amount for his or her fees and expenses. Failure to pay the Monitor within 30 calendar days of submission of its invoices for services previously rendered shall constitute a breach of the CIA and shall subject FORBA to one or more of the remedies set forth in Section X; provided, however, nothing in this section shall prevent or prohibit FORBA from bringing disputed bills to OIG's attention. The Monitor may be removed solely at the discretion of OIG. If the Monitor resigns or is removed for any reason prior to the termination of the CIA, FORBA shall retain another Monitor appointed by OIG after consultation with FORBA, with the same functions and authorities. The Monitor may confer and correspond with FORBA and OIG on an ex parte basis. The Monitor and FORBA shall not negotiate or enter into a financial relationship, other than the monitoring engagement required by this section, until after the date of OIG's CIA closure letter to FORBA.

1. The Monitor shall be responsible for assessing the effectiveness, reliability, and thoroughness of the following:

a. FORBA's internal quality control systems, including, but not limited to:

i. whether the systems in place to promote quality of care and to respond to quality of care issues are operating in a timely and effective manner;

ii. whether the communication system is effective, allowing for accurate information, decisions, and results of decisions to be transmitted to the proper individuals in a timely fashion; and

iii. whether the training programs are effective and thorough.

b. FORBA's response to quality of care issues, which shall include an assessment of:

i. FORBA's ability to identify the problem;

ii. FORBA's ability to determine the scope of the problem, including, but not limited to, whether the problem is isolated or systemic;

iii. FORBA's ability to create a corrective action plan to respond to the problem;

iv. FORBA's ability to execute the corrective action plan; and

v. FORBA's ability to evaluate whether the assessment, corrective action plan, and execution of that plan was effective, reliable, and thorough.

c. FORBA's development and implementation of corrective action plans and the timeliness of such actions;

d. FORBA's proactive steps to ensure that each patient receives care in accordance with:

i. professionally recognized standards of health care, including but not limited to the AAPD guidelines;

ii. State and local statutes, regulations, and other directives or guidelines; and

iii. the Policies and Procedures adopted by FORBA and set forth in Section III.B of this CIA.

2. The Monitor shall have:

a. immediate access to FORBA, at any time and without prior notice, to assess compliance with this CIA, to assess the effectiveness of the internal quality assurance mechanisms, and to ensure that the data being generated is accurate;

b. immediate access to (1) internal or external audits, surveys, or reports; (2) Disclosure Program complaints; (3) patient satisfaction surveys; (4) reports of abuse, neglect, or any incident that required emergency or other responsive treatment; (5) reports of any incident involving a patient that prompts a full internal investigation; (6) patient records; (7) documents in the possession or control of any quality assurance committee, peer review committee, dental review committee, or other such committee; (8) exit interviews; (9) Eaglesoft Program and data; (10) Board minutes; (11) Navigant tracking tools and data; (12) Dashboard; (13) training materials; and (14) any other data in the format the Monitor determines relevant to fulfilling the duties required under this CIA;

c. immediate access to patients, parents and/or guardians, and Covered Persons for interviews outside the presence of FORBA supervisory staff or counsel, provided such interviews are conducted in accordance with all applicable laws and the rights of such individuals. The Monitor shall give full consideration to a patient's clinical condition before interviewing a patient; and

d. immediate access to all FORBA facilities and the Board.

3. FORBA's Obligations. FORBA shall:

a. provide the Monitor a report monthly, or sooner if requested by the Monitor, regarding each of the following occurrences:

i. Deaths or injuries related to use of restraints;

ii. Deaths or injuries related to use of sedation, local anesthesia, nitrous oxide/oxygen analgesia/anxiolysis, pain medication, or any other medication prescribed at a FORBA facility;

iii. Deaths or injuries related to abuse or neglect;

iv. Any other incident that involves or causes actual harm to a patient when such incident is required to be reported to any local, state, or federal government agency.

Each such report shall contain the full name, social security number, and date of birth of the patient(s) involved, the date of death or incident, and a brief description of the events surrounding the death or incident.

b. address any written recommendation made by the Monitor within 15 business days, either by substantially implementing the Monitor's recommendations or by explaining in writing why FORBA has elected not to do so and thereafter timely addressing the Monitor's concern(s) to the OIG's satisfaction;

c. provide to its Compliance Committee and its Board Compliance Committee copies of all documents and reports provided to the Monitor;

d. pay the Monitor's bills within 30 days of receipt. While FORBA must pay all the Monitor's bills within 30 days, FORBA may bring any disputed Monitor's Costs or bills to OIG's attention;

e. ensure the Monitor's immediate access to FORBA facilities, FORBA corporate offices, patients, Covered Persons, and documents, and assist in obtaining full cooperation by its current employees, contractors, and agents;

f. provide access to current patients and provide contact information for their families and guardians consistent with the rights of such individuals under state or federal law, and not impede their cooperation with the Monitor;

g. assist in locating past employees, contractors, agents, patients and their families, and, if requested, attempt to obtain their cooperation with the Monitor;

h. provide the last known contact information for former patients, their families, or guardians consistent with the rights of such individuals under state or federal law, and not impede their cooperation; and

i. not sue or otherwise bring any action against the Monitor related to any findings made by the Monitor or related to any exclusion or other sanction of FORBA under this CIA; provided, however, that this clause shall not apply to any suit or other action based solely on the dishonest or illegal acts of the Monitor, whether acting alone or in collusion with others.

4. The Monitor's Obligations. The Monitor shall:

a. abide by all state and federal laws and regulations concerning the privacy, dignity, and employee rights of all Covered Persons and patients;

b. abide by the legal requirements of FORBA to maintain the confidentiality of each patient's personal and clinical records. Nothing in this subsection, however, shall limit or affect the Monitor's obligation to provide information, including information from patient clinical records, to OIG, and, when legally or professionally required, reporting to other agencies;

c. at all times act reasonably in connection with its duties under this CIA, including when requesting information from FORBA;

d. simultaneously provide quarterly reports to FORBA and OIG concerning the findings made to date;

e. if the Monitor has concerns about corrective action plans that are not being enforced or systemic problems that could affect FORBA and the FORBA facilities' ability to render quality care to its patients, then the Monitor shall: (a) report such concerns in writing to OIG and (b) simultaneously provide notice and a copy of the report to FORBA's Compliance Committee and Board Compliance Committee referred to in Sections III.A.5 and III.A.6 of this CIA;

f. where independently required to do so by applicable law or professional licensing standards, report any finding to an appropriate regulatory or law enforcement authority, and simultaneously submit copies of such reports to OIG and to FORBA;

g. submit bills to FORBA on a consolidated basis, but no more than once per month;

h. submit a report for each Reporting Period representing an accounting of its costs throughout the year to FORBA and to OIG by the submission deadline of FORBA's Annual Report;

i. not be bound by any other private or governmental agency's findings or conclusions, including, but not limited to, JCAHO, CMS, or the state Medicaid agencies. Likewise, such private and governmental agencies shall not be bound by the Monitor's findings or conclusions. The Monitor's reports shall not be the sole basis for determining deficiencies by the state Medicaid agencies. The parties agree that CMS and its contractors shall not introduce any material generated by the Monitor, or any opinions, testimony, or conclusions from the Monitor as evidence into any proceeding involving a Medicaid survey, certification, or other enforcement action against FORBA, and FORBA shall similarly be restricted from using material generated by the Monitor, or any opinions, testimony, or conclusions from the Monitor as evidence in any of these proceedings. Nothing in the previous sentence, however, shall preclude OIG or FORBA from using any material generated by the Monitor, or any opinions, testimony, or conclusions from the Monitor in any action under this CIA or pursuant to any other OIG authorities or in any other situations not explicitly excluded in this subsection;

j. abide by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to the extent required by law including, without limitation, entering into a business associate agreement with FORBA;

k. except to the extent required by law, maintain the confidentiality of any proprietary financial and operational information, processes, procedures, and forms obtained in connection with its duties under this CIA and not comment publicly concerning its findings except to the extent authorized by OIG;

l. visit FORBA as often as the Monitor reasonably believes it necessary to perform its functions; and

m. shall not negotiate or enter into a financial relationship with FORBA until after the date of OIG's CIA closure letter to FORBA.

F. Disclosure Program.

Within 90 days after the Effective Date, FORBA shall establish a Disclosure Program that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with FORBA's policies, conduct, practices, or procedures with respect to quality of care or a Federal health care program, believed by the individual to be a potential violation of criminal, civil, or administrative law, including but not limited to violations of professionally recognized standards of health care and/or patient harm. FORBA shall appropriately publicize the existence of the disclosure mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas). This publication shall include contact information for the applicable state licensing board.

The Disclosure Program shall emphasize a nonretribution, nonretaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Compliance Officer (or designee) and, if the allegations involve patient care or documentation of patient care, the Chief Dental Officer, shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, FORBA shall conduct an internal review of the allegations set forth in the disclosure and ensure that proper follow-up is conducted. If the inappropriate or improper practice(s) places patients at risk of harm, then FORBA will ensure that that practice ceases immediately and that appropriate action is taken.

FORBA shall disclose any finding of violation(s) of professionally recognized standards of health care resulting in patient death to all current patients of the involved FORBA facility by way of written notice that conforms with all State and federal privacy laws and regulations. The notice shall include the contact information for the applicable state licensing board and note that the patient may want to explore his/her legal rights.

The Compliance Officer (or designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews. The disclosure log shall be sent to the Monitor not less than monthly. The Compliance Officer shall review the disclosure log with the Board Compliance Committee not less than quarterly.

G. Ineligible Persons.

1. *Definitions.* For purposes of this CIA:

a. an "Ineligible Person" shall include an individual or entity who:

i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or

ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

b. "Exclusion Lists" include:

i. the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov); and

ii. the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://www.epls.gov).

2. *Screening Requirements.* FORBA shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements.

a. FORBA shall screen all prospective and current Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall

require such Covered Persons to disclose whether they are Ineligible Persons.

b. FORBA shall screen all Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on an annual basis thereafter.

c. FORBA shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in this Section affects the responsibility of (or liability for) FORBA to refrain from billing Federal health care programs for items or services furnished, ordered, or prescribed by an Ineligible Person. FORBA understands that items or services furnished by excluded persons are not payable by Federal health care programs and that FORBA may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether FORBA meets the requirements of Section III.G.

3. *Removal Requirement.* If FORBA has actual notice that a Covered Person has become an Ineligible Person, FORBA shall remove or cause the removal of such Covered Person from responsibility for, or involvement with, the operations of FORBA and FORBA facilities related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with federal funds at least until such time as the Covered Person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions.* If FORBA has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the Covered Person's employment or contract term, FORBA shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or any claims submitted to any Federal health care program.

H. Notification of Government Investigation or Legal Proceedings.

Within 30 days after discovery, FORBA shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to FORBA conducted or brought by a governmental entity or its agents involving an allegation that FORBA and/or any Covered Person has committed a crime, engaged in fraudulent activities, or violated professionally recognized standards of health care. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. Within 30 days after the resolution of the government investigation or legal proceeding, FORBA shall provide written notice and a description of the findings and/or results of the investigation or proceedings, if any to OIG and any applicable state licensing board.

In addition, within 15 days after notification, FORBA shall notify OIG, in writing, of any adverse final determination made by a federal, state, or local government agency or licensing, accrediting or certifying agency (e.g. State licensing board) relating to quality of care issues.

I. Reporting.

1. *Overpayments.*

a. *Definition of Overpayments.* For purposes of this CIA, an "Overpayment" shall mean the amount of money FORBA has received in excess of the amount due and payable under any Federal health care program requirements.

b. *Reporting of Overpayments.* If, at any time, FORBA identifies or learns of any Overpayment, FORBA shall notify the payor (e.g., Medicaid fiscal agent or contractor) within 30 days after identification of the Overpayment and take remedial steps within 60 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. Also, within 30 days after identification of the Overpayment, FORBA shall repay the Overpayment to the appropriate payor to the extent such Overpayment has been quantified. If not yet quantified, within 30 days after identification, FORBA shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be

completed. Notification and repayment to the payor shall be done in accordance with the payor's policies, and, for Medicaid fiscal agents or contractors, shall include the information contained on the Overpayment Refund Form, provided as Appendix C to this CIA. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

2. *Reportable Events.*

a. *Definition of Reportable Event.* For purposes of this CIA, a "Reportable Event" means anything that involves:

i. a substantial Overpayment;

ii. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized; or

iii. a matter that a reasonable person would consider likely to render FORBA insolvent.

A Reportable Event may be the result of an isolated event or a series of occurrences.

b. *Reporting of Reportable Events.* If FORBA determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, FORBA shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists. The report to OIG shall include the following information:

i. If the Reportable Event results in an Overpayment, the report to OIG shall be made at the same time as the notification to the payor required in Section III.I.1, and shall include all of the information on the Overpayment Refund Form, as well as:

(A) the payor's name, address, and contact person to whom the Overpayment was sent; and

(B) the date of the check and identification number (or electronic transaction number) by which the Overpayment was repaid/refunded;

ii. a complete description of the Reportable Event, including the relevant facts, persons involved, legal and Federal health care program authorities implicated, and potential impact, if any, on Federal health care program beneficiaries;

iii. a description of FORBA's actions taken to correct the Reportable Event;

iv. any further steps FORBA plans to take to address the Reportable Event and prevent it from recurring; and

v. if the Reportable Event involves the filing of a bankruptcy petition, the report to OIG shall include documentation of the filing and a description of any Federal health care program authorities implicated.

c. *Definition of Quality of Care Reportable Event.* For purposes of this CIA, a "Quality Reportable Event" means anything that involves a violation of the obligation to provide items or services of a quality that meets professionally recognized standards of health care.

d. *Reporting of Quality of Care Reportable Events.* If FORBA receives a report that involves a potential violation of the obligation to provide items or services of a quality that meets professionally recognized standards of health care, FORBA shall initiate an investigation of the report within 5 days after receiving the report. Within 30 days after receiving the report, and, on finding a violation, FORBA shall provide written notice of FORBA's investigation and the actions taken to correct the violation to OIG, the Monitor, and the applicable state licensing board.

IV. CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Change or Closure of FORBA facility, Practice, Unit or Location. In the event that, after the Effective Date, FORBA changes locations or closes a business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, or terminates a contractual relationship with a practice owner or dental practice, FORBA shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change, closure of the location, or termination.

B. Purchase or Establishment of New FORBA facility, Practice, Unit or Location. In the event that, after the Effective Date, FORBA purchases or establishes a new business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, or enters into a contractual relationship with a practice owner or dental practice, FORBA shall notify OIG at least 30 days prior to such transaction. For each new business unit, location or contractual relationship with a practice owner or dental practice, this notification shall include the address of the new practice owner or dental practice, business unit or location, phone number, fax number, Medicaid provider number(s), and the name and address of the contractor that issued each number. Each new business unit or location, practice owner or dental practice and all Covered Persons at each new business unit, location, or dental practice shall be subject to the applicable requirements of this CIA.

C. Sale or Transfer of FORBA facility, Asset, Unit or Location. In the event that, after the Effective Date, FORBA proposes to transfer or sell any or all of its assets, business units or locations related to the furnishing of items or services that may be reimbursed by Federal health care programs, FORBA shall notify OIG of the proposed transfer or sale at least 30 days prior to the transfer or sale of such asset, business unit or location. This notification shall include a description of the asset, business unit or location to be transferred or sold, a brief description of the terms of the transfer or sale, and the name and contact information of the prospective investor/purchaser. This CIA shall be binding on the investor/purchaser of such asset, business unit or location, unless otherwise determined and agreed to in writing by OIG.

D. Expansion of Services. In the event that, after the Effective Date, FORBA and/or a FORBA facility expands the scope of services provided at any FORBA facility related to the furnishing of items or services that may be reimbursed by Federal health care programs, FORBA shall notify OIG at least 30 days prior to such expansion of services. For each expansion of services, this notification shall include a description of the expanded scope of services, the

address of the involved FORBA facilit(ies), the governing regulations, any required applications, and the name and address of every entity that issued a license, certificate, or provider number. Each new service related to the furnishing of items or services that may be reimbursed by Federal health care programs shall be subject to the scope of this CIA.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 120 days after the Effective Date, FORBA shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. the name, address, phone number, and position description of the Compliance Officer required by Section III.A, and a summary of other noncompliance job responsibilities the Compliance Officer may have;

2. the name, address, phone number, and position description of the Chief Dental Officer required by Section III.A, and a summary of other noncompliance job responsibilities the Chief Dental Officer may have;

3. the names and positions of the Compliance Liasions required by Section III.A;

4. the name, address, phone number, and position description of the Patient Advocate required by Section III.A, and a summary of other noncompliance job responsibilities the Patient Advocate may have;

5. the names and positions of the members of the Compliance Committee required by Section III.A;

6. the names and positions of the members of the Board Compliance Committee and a copy of the committee's charter required by Section III.A;

7. a description of the Internal Audit Program required by Section III.A;

8. a copy of FORBA's Code of Conduct required by Section III.B.1;

9. a copy of all Policies and Procedures required by Section III.B.2;

10. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be available to OIG, upon request);

11. the following information regarding each type of training required by Section III.C:

a. a description of such training, including the targeted audience, a summary of the topics covered, the length of sessions, and a schedule of training sessions; and

b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions.

A copy of all training materials and the documentation supporting this information shall be available to OIG, upon request.

12. a description of the Disclosure Program required by Section III.F;

13. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; and (c) a summary and description of any and all current and prior engagements and agreements between FORBA and the IRO(s);

14. a certification from the IRO regarding its professional independence and objectivity with respect to FORBA;

15. a description of the process by which FORBA fulfills the requirements of Section III.G regarding Ineligible Persons;

16. the name, title, and responsibilities of any person who is determined to be an Ineligible Person under Section III.G; the actions taken in response to the screening and removal obligations set forth in Section III.G; and the actions taken to identify, quantify, and repay any overpayments to Federal health care programs relating to items or services furnished, ordered or prescribed by an Ineligible Person;

17. a list of all of FORBA's locations, including but not limited to all FORBA facililites (including locations and mailing addresses); the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicaid provider number and/or supplier number(s); and the name and address of each Medicaid contractor to which FORBA and/or each FORBA facility currently submits claims;

18. a description of FORBA's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business;

19. a certification by the Compliance Officer that:

a. the Policies and Procedures required by Section III.B have been developed, are being implemented, and have been distributed to all pertinent Covered Persons;

b. all Covered Persons have completed the Code of Conduct certification required by Section III.B.1; and

c. all Covered Persons have completed the General Training and executed the certification required by Section III.C.

20. the certifications required by Section V.C.

B. Annual Reports. FORBA shall submit to OIG annually a report with respect to the status of, and findings regarding, FORBA's compliance activities for each of the five Reporting Periods (Annual Report).

Each Annual Report shall include, at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Compliance Officer and Chief Dental Officer, any change in the membership of the Compliance Committee or Board Compliance Committee; and any change to the Board Compliance Committee's charter described in Section III.A;

2. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B and the reasons for such changes (e.g., change in contractor policy);

3. a summary of findings under FORBA's Internal Audit Program and a summary of any corrective action taken under that program;

4. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be available to OIG, upon request);

5. the following information regarding each type of training required by Section III.C:

a. a description of such training, including the targeted audience, a summary of the topics covered, the length of sessions, and a schedule of training sessions; and

b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions.

A copy of all training materials and the documentation supporting this information shall be available to OIG, upon request.

6. FORBA's response and corrective action plan(s) related to any issues raised by the Monitor pursuant to Section III.E;

7. a copy of the disclosure log required under Section III.F (excluding any communications that relate solely to human resources issues unless those communications relate to production);

8. a copy of any patient death disclosure required under Section III.F;

9. a summary of Reportable Events (as defined in Section III.I) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Reportable Events;

10. a copy of all exit interviews that reference production, quality of care issues, or patient harm concerns;

11. any changes to the process by which FORBA fulfills the requirements of Section III.G regarding Ineligible Persons;

12. the name, title, and responsibilities of individuals any person who is determined to be an Ineligible Person under Section III.G; the actions taken by FORBA in response to the screening and removal obligations set forth in Section III.G; and the actions taken to identify, quantify, and repay any overpayments to Federal health care programs relating to items or services furnished, ordered or prescribed by an Ineligible Person;

13. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.H. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

14. a description of all changes to the most recently provided list of FORBA facilities (including addresses) as required by Section V.A.17; the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicaid provider number(s) and/or supplier number(s); and the name and address of each Medicaid fiscal agent or contractor to which FORBA and/or each FORBA facility currently submits claims;

15. a complete copy of all reports prepared pursuant to Section III.D, along with a copy of the IRO's engagement letter (if applicable);

16. FORBA's response and corrective action plan(s) related to any issues raised by the reports prepared pursuant to Section III.D;

17. a summary and description of any and all current and prior engagements and agreements between FORBA and the IRO, if different from what was submitted as part of the Implementation Report;

18. a certification from the IRO regarding its professional independence and objectivity with respect to FORBA;

19. a certification by the Compliance Officer that:

a. all Covered Persons have completed the annual Code of Conduct certification required by Section III.B.1;

b. all Covered Persons have completed the training and executed the certification required by Section III.C;

c. FORBA has effectively implemented all plans of correction related to problems identified under this CIA, FORBA's Compliance Program, internal and external audits, and/or the Monitor; and

d. For all problems identified under the CIA, FORBA's Compliance Program, internal and external audits, and/or the Monitor, for which FORBA has not yet implemented a plan of correction, FORBA will provide the date the issue was identified, the status of the efforts to implement the Plan of Correction, and reasons for any delay.

20. the certifications required by Section V.C.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

Within 180 days of the submission of each Annual Report, FORBA shall schedule and hold an in-person meeting with a representative of OIG to review FORBA's performance under the CIA. OIG, in its discretion, may waive this meeting requirement.

C. Certifications.

The following certifications shall be included in the Implementation Report and Annual Reports:

1. Certifying Employees: In the Annual Reports, FORBA shall include the certifications of Certifying Employees as required by Section III.A.

2. Compliance Officer: In the Implementation Report and Annual Reports, FORBA shall include the following individual certification by the Compliance Officer, that:

a. to the best of his or her knowledge, except as otherwise described in the applicable report, FORBA is in compliance with all of the requirements of this CIA; and

b. he or she has reviewed the Report and has made reasonable inquiry regarding its content and believes that the information in the Report is accurate and truthful.

3. Board of Directors: In the Annual Reports, FORBA shall include the Board resolution as required by Section III.6.c, certifying that they have reviewed the Report and agree with the statements made therein.

D. Designation of Information. FORBA shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. FORBA shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Administrative and Civil Remedies
Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Facsimile: 202.205.0604

FORBA:

Chief Compliance Officer
FORBA Holdings, LLC
618 Church Street, Suite 520
Nashville, TN 37219-2457
Telephone: 615.750.0338
Facsimile: 615-750-0304

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt. Upon request by OIG, FORBA may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (pdf), either instead of, or in addition to, a paper copy.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of FORBA's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of FORBA facility for the purpose of verifying and evaluating: (a) FORBA's compliance with the terms of this CIA; and (b) FORBA's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by FORBA to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of FORBA's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. FORBA shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. FORBA's employees may elect to be interviewed with or without a representative of FORBA present.

VIII. DOCUMENT AND RECORD RETENTION

FORBA shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify FORBA prior to any release by OIG of information submitted by FORBA pursuant to its obligations under this CIA and identified upon submission by FORBA as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules.

With respect to such releases, FORBA shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

FORBA is expected to fully and timely comply with all of its CIA obligations.

A. Specific Performance of CIA Provisions. If OIG determines that FORBA is failing to comply with a provision or provisions of this CIA and decides to seek specific performance of any of these provisions, OIG shall provide FORBA with prompt written notification of such determination (hereinafter referred to as "Noncompliance Notice"). FORBA shall have 30 days from receipt of the Noncompliance Notice within which to either: (1) cure the alleged failure to comply and provide OIG a written description of FORBA's corrective action; or (2) reply in writing that FORBA disagrees with the determination of noncompliance and request a hearing before an HHS Administrative Law Judge (ALJ), pursuant to the provisions set for in Section X.F of this CIA. The purpose of the hearing is to determine whether FORBA has failed to comply with the CIA and whether FORBA shall be required to implement the particular provisions at issue.

B. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, FORBA and OIG hereby agree that failure to comply with certain obligations as set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day FORBA fails to establish and implement any of the following obligations as described in Section III:

a. a Compliance Officer;

b. a Chief Dental Officer;

c. Compliance Liaisons;

d. a Compliance Committee;

e. a Board Compliance Committee;

f. an Internal Audit Program;

g. a Patient Advocate;

h. a written Code of Conduct;

i. written Policies and Procedures;

j. the training of Covered Persons in the manner required by Section III.C;

k. retention of a Monitor;

l. a Disclosure Program;

m. Ineligible Persons screening and removal requirements; and

n. notification of Government investigations or legal proceedings.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day FORBA fails to submit the Implementation Report or any Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

3. A Stipulated Penalty of $1,500 for each day FORBA fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date FORBA fails to grant access.)

4. A Stipulated Penalty of $50,000 for each false certification submitted by or on behalf of FORBA as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by OIG), or otherwise required by this CIA.

5. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day FORBA fails to pay the Monitor, pursuant to Section III.E.

6. A Stipulated Penalty of $1,000 for each day FORBA fails to comply fully and adequately with any of its obligations with respect to the

Monitor, as set forth in Section III.E. OIG shall provide notice to FORBA stating the specific grounds for its determination that FORBA has failed to comply fully and adequately with the CIA obligation(s) at issue and steps FORBA shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after FORBA receives this notice from OIG of the failure to comply.)

7. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day FORBA fails to engage an IRO, as required in Section III.D and Appendix B.

8. A Stipulated Penalty of $1,000 for each day FORBA fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to FORBA stating the specific grounds for its determination that FORBA has failed to comply fully and adequately with the CIA obligation(s) at issue and steps FORBA shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after FORBA receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1-7 of this Section.

C. Timely Written Requests for Extensions. FORBA may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after FORBA fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after FORBA receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

D. Payment of Stipulated Penalties.

1. *Demand Letter.* Upon a finding that FORBA has failed to comply with any of the obligations described in Section X.B and after determining that Stipulated Penalties are appropriate, OIG shall notify FORBA of: (a) FORBA's failure to comply; and (b) OIG's exercise of its contractual right to

demand payment of the Stipulated Penalties (this notification is referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, FORBA shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.F. In the event FORBA elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until FORBA cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.E.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.E.1.d, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that FORBA has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.E, below.

E. Exclusion for Material Breach of this CIA.

1. *Definition of Material Breach.* A material breach of this CIA means:

a. a failure by FORBA to report a Reportable Event, take corrective action to OIG's satisfaction, and make the appropriate refunds, as required in Section III.I;

b. a failure by FORBA to report a Quality of Care Reportable Event, take corrective action to OIG's satisfaction, and make the appropriate notifications, as required in Section III.I.2.c-d;

c. a repeated or flagrant violation of any obligation under this CIA, including, but not limited to, the obligations addressed in Section X.B;

d. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.D;

e. a failure to respond to a Noncompliance Notice concerning specific performance in accordance with Section X.A;

f. a failure to retain, pay, utilize, or respond to OIG's satisfaction to the recommendations of the Monitor in accordance with Section III.E;

g. a false certification submitted by or on behalf of FORBA as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by OIG), or otherwise required by this CIA;

or

h. a failure to meet an obligation under the CIA that has a material impact on the quality of care rendered to any patients of FORBA facilities

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by FORBA constitutes an independent basis for FORBA's exclusion from participation in the Federal health care programs. Upon a determination by OIG that FORBA has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify FORBA of: (a) FORBA's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude"). The exclusion may be directed at FORBA, its subsidiary, agent, or affiliate, or any FORBA facility or Covered Person, depending upon the facts of the breach.

3. *Opportunity to Cure.* FORBA shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

a. FORBA is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30-day period, but that: (i) FORBA has begun to take action to cure the material breach; (ii) FORBA is pursuing such action with due diligence; and (iii) FORBA has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30-day period, FORBA fails to satisfy the requirements of Section X.E.3, OIG may exclude FORBA from participation in the Federal health care programs. OIG shall notify FORBA in writing of its determination to exclude FORBA (this letter shall be referred to hereinafter as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in Section X.F, below, the exclusion shall go into effect 30 days after the date of FORBA's receipt of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and nonprocurement programs. Reinstatement to program participation is not automatic. After the end of the period of exclusion, FORBA may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

F. Dispute Resolution

1. *Review Rights.* Upon OIG's delivery to FORBA of its Noncompliance Notice, Demand Letter, or Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, FORBA shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties, or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving specific performance or Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Specific Performance Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for specific performance of CIA provisions shall be:

(a) whether, at the time specified in the Noncompliance Notice,

FORBA was in full and timely compliance with the obligations of this CIA for which OIG seeks specific performance; and

(b) whether FORBA failed to cure to OIG's satisfaction.

FORBA shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to specific performance. If the ALJ agrees with OIG, FORBA shall take the actions OIG deems necessary to cure within 20 days after the ALJ issues such a decision unless FORBA requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, FORBA shall take the actions OIG deems necessary to cure within 20 days after the DAB issues its decision

3. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether FORBA was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. FORBA shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders FORBA to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless FORBA requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

4. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether FORBA was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) FORBA had

begun to take action to cure the material breach within that period; (ii) FORBA has pursued and is pursuing such action with due diligence; and (iii) FORBA provided to OIG within that period a reasonable timetable for curing the material breach to OIG's satisfaction and FORBA has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for FORBA, only after a DAB decision in favor of OIG. FORBA's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude FORBA upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that FORBA may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. FORBA shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of FORBA, FORBA shall be reinstated effective on the date of the original exclusion.

5. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

FORBA and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of FORBA.

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA.

C. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

D. OIG may agree to a suspension of FORBA's obligations under the CIA in the event of FORBA's cessation of participation in Federal health care

programs. If FORBA ceases participating in Federal health care programs and is relieved of its CIA obligations by OIG, FORBA shall notify OIG at least 30 days in advance of FORBA's intent to resume participating as a provider or supplier with any Federal health care program. Upon receipt of such notification, OIG shall evaluate whether the CIA should be reactivated or modified.

E. The undersigned FORBA signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

F. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF FORBA HOLDINGS, LLC

/Michael G. Lindley/

MICHAEL G. LINDLEY
Chairman and CEO
FORBA Holdings, LLC

DATE

/Grace M. Rodriguez/

GRACE M. RODRIGUEZ
Counsel to FORBA Holdings, LLC
King & Spalding LLP

1/14/10

DATE

**ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

/Gregory E. Demske/

GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

1/15/10

DATE

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.D of the CIA.

A. IRO Engagement.

FORBA shall engage an IRO that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph D. Within 30 days after OIG receives written notice of the identity of the selected IRO, OIG will notify FORBA if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, FORBA may continue to engage the IRO.

If FORBA engages a new IRO during the term of the CIA, this IRO shall also meet the requirements of this Appendix. If a new IRO is engaged, FORBA shall submit the information identified in Section V.A.13 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives written notice of the identity of the selected IRO, OIG will notify FORBA if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, FORBA may continue to engage the IRO.

B. IRO Qualifications.

The IRO shall:

1. assign individuals to conduct the Claims Review, Additional Items Review, and Unallowable Cost Review engagement who have expertise in the billing, coding, reporting, and other requirements of dental claims, professionally recognized standards of dental care, and in the general requirements of the State and Federal health care program(s) from which FORBA seeks reimbursement;

2. assign individuals to design and select the Claims Review sample, and if applicable, the Additional Items Review sample, who are knowledgeable about the appropriate statistical sampling techniques;

3. assign individuals to conduct the coding review portions of the Claims Review and, if applicable, the Additional Items Review, who have a nationally recognized coding certification (e.g., CCA, CCS, CCS-P, CPC, RRA, etc.) and who have maintained this certification (e.g., completed applicable continuing education requirements); and

4. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities.

The IRO shall:

1. perform each Claim Review and Additional Items Review in accordance with the specific requirements of the CIA;

2. follow all applicable Federal health care program rules and reimbursement guidelines, state dental board requirements, and professionally recognized standards of health care in making assessments in the Claims Review and Additional Items Review;

3. if in doubt of the application of a particular Federal health care program or state dental board policy or regulation, request clarification from the appropriate authority;

4. respond to all OIG inquires in a prompt, objective, and factual manner; and

5. prepare timely, clear, well-written reports that include all the information required by Appendix B to the CIA.

D. IRO Independence and Objectivity.

The IRO must perform the Claims Review and the Additional Items Review in a professionally independent and objective fashion, as appropriate to the nature of the engagement, taking into account any other business relationships or engagements that may exist between the IRO and FORBA.

E. IRO Removal/Termination.

1. *Provider.* If FORBA terminates its IRO during the course of the engagement, FORBA must submit a notice explaining its reasons to OIG no later than 30 days after termination. FORBA must engage a new IRO in accordance with Paragraph A of this Appendix.

2. *OIG Removal of IRO.* In the event OIG has reason to believe that the IRO does not possess the qualifications described in Paragraph B, is not independent and/or objective as set forth in Paragraph D, or has failed to carry out its responsibilities as described in Paragraph C, OIG may, at its sole discretion, require FORBA to engage a new IRO in accordance with Paragraph A of this Appendix.

Prior to requiring FORBA to engage a new IRO, OIG shall notify FORBA of its intent to do so and provide a written explanation regarding the necessity of such a step. To resolve any concerns raised by OIG, FORBA may request a meeting with OIG to discuss any aspect of the IRO's qualifications, independence or performance of its responsibilities and to present additional information regarding these matters. FORBA shall provide any additional information as may be requested by OIG under this Paragraph in an expedited manner. OIG will attempt in good faith to resolve any differences regarding the IRO with FORBA prior to requiring FORBA to terminate the IRO. However, the final determination as to whether or not to require FORBA to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B
CLAIMS REVIEW AND ADDITIONAL ITEMS REVIEW

A. Claims Review.

1. *Definitions.* For the purposes of the Claims Review, the following definitions shall be used:

a. Overpayment: The amount of money FORBA has received in excess of the amount due and payable under any State or Federal health care program requirements.

b. Item: Any discrete unit that can be sampled (e.g., code, line item, beneficiary, patient encounter, etc.).

c. Paid Claim: A code or line item submitted by FORBA and for which FORBA has received reimbursement from any State or Federal health care program, including but not limited to Medicaid.

d. Population: For the first Reporting Period, the Population shall be defined as all Items for which a code or line item has been submitted by or on behalf of FORBA and for which FORBA has received reimbursement from any State or Federal health care program, including but not limited to Medicaid (i.e., Paid Claim) during the 12-month period covered by the first Claims Review.

For the remaining Reporting Periods, the Population shall be defined as all Items for which FORBA has received reimbursement from any State or Federal health care program, including but not limited to Medicaid (i.e., Paid Claim) during the 12-month period covered by the Claims Review.

To be included in the Population, an Item must have resulted in at least one Paid Claim.

e. Error Rate: The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of the Discovery Sample shall be included as part of the net Overpayment calculation.)

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Items in the sample.

2. *Discovery Sample.* Within 15 days after the end of the Reporting Period, FORBA will provide OIG with a list of the FORBA facilities, including the volume and type of services provided at each facility as well as any Federal health care reimbursement for each facility. OIG shall select three facilities from the list. The IRO will review a sample of 50 Paid Claims submitted by or on behalf of FORBA at each of the three facilities selected by OIG (Discovery Sample). The Paid Claims shall be reviewed based on the supporting documentation and other information available at FORBA's offices, the offices at FORBA facilities, or under FORBA's control and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed.

If the Error Rate (as defined above) for all three Discovery Samples is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The guidelines listed above do not imply that this is an acceptable error rate. Accordingly, FORBA should, as appropriate, further analyze any errors identified in the Discovery Samples. FORBA recognizes that OIG or other HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority, may also analyze or review Paid Claims included, or errors identified, in the Discovery Samples or any other segment of the universe.)

3. *Full Sample.* If any of the three Discovery Samples indicate that the Error Rate is 5% or greater, the IRO shall select an additional sample of Paid Claims only from the facility or facilities with an Error Rate which is 5% or greater (Full Sample) using commonly accepted sampling methods. The Full Sample(s) shall be designed to: (1) estimate the actual Overpayment in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate; and (2) conform with the Centers for Medicare and Medicaid Services' statistical sampling for overpayment estimation guidelines. The Paid Claims selected for the Full Sample(s) shall be reviewed based on supporting documentation and other information available at FORBA, FORBA facilities, or under FORBA's control and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed. For purposes of calculating the size of the Full Sample(s), the Discovery Sample(s) may serve as the probe sample, if statistically appropriate. Additionally, FORBA may use the Items sampled as part of each of the three Discovery Samples, and the corresponding findings for those Items, as part of its Full Sample(s), if: (1) statistically appropriate and (2) FORBA selects the Full Sample Items using the seed number generated by the Discovery Sample(s). OIG, in its sole discretion, may refer the findings of the Full Sample(s) (and any related workpapers) received from FORBA to the appropriate State

or Federal health care program payor, including the contractor (e.g., fiscal agents), for appropriate follow-up by that payor.

4. *Systems Review.* If any of FORBA's Discovery Samples identifies an Error Rate of 5% or greater, FORBA's IRO shall also conduct a Systems Review. Specifically, for each claim in the Discovery Sample(s) and Full Sample(s) that resulted in an Overpayment, the IRO shall perform a "walk through" of the system(s) and process(es), that generated the claim to identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the claim.

5. *Other Requirements.*

a. Paid Claims without Supporting Documentation. For the purpose of appraising Items included in the Claims Review, any Paid Claim for which FORBA cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by FORBA for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

b. Replacement Sampling. Considering the Population shall consist only of Paid Claims and that Items with missing documentation cannot be replaced, there is no need to utilize alternate or replacement sampling units.

c. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims associated with the Items selected in each first sample (or first sample for each strata, if applicable) shall be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample).

B. Claims Review Report. The following information shall be included in the Claims Review Report for each Discovery Sample and Full Sample (if applicable).

1. *Claims Review Methodology.*

a. Sampling Unit. A description of the Item as that term is utilized for the Claims Review.

b. Claims Review Population. A description of the Population subject to the Claims Review.

c. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.

d. Sampling Frame. A description of the sampling frame, which is the totality of Items from which the Discovery Sample and, if any, Full Sample has been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.

e. Source of Data. A description of the specific documentation relied upon by the IRO when performing the Claims Review (e.g., dental records, dentist orders, requisition forms, local dental review policies (including title and policy number), CMS program memoranda (including title and issuance number), Federal health care program carrier or intermediary manual or bulletins (including issue and date), other policies, regulations, or directives).

f. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.

2. *Statistical Sampling Documentation.*

a. The number of Items appraised in each Discovery Sample and, if applicable, in the Full Sample(s).

b. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

c. A copy of the statistical software printout(s) estimating how many Items are to be included in each Full Sample, if applicable.

d. A description or identification of the statistical sampling software package used to select the sample and determine the Full Sample size, if applicable.

3. *Claims Review Findings.*

a. Narrative Results.

i. A description of FORBA's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.

ii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of each Discovery Sample, and the results of each Full Sample (if any).

b. Quantitative Results.

i. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by FORBA (Claim Submitted) differed from what should have been the correct claim (Correct Claim), regardless of the effect on the payment.

ii. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to FORBA.

iii. Total dollar amount of all Overpayments in each sample.

iv. Total dollar amount of paid Items included in each sample and the net Overpayment associated with each sample.

v. Error Rate in each sample.

vi. Spreadsheets of the Claims Review results for each sample that includes the following information for each Paid Claim appraised: State or Federal health care program billed, beneficiary health insurance claim number, date of service, procedure code submitted, procedure code reimbursed, allowed amount reimbursed by payor, correct procedure code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount. (See Attachment 1 to this Appendix.)

4. *Systems Review.* Observations, findings, and recommendations on possible improvements to the system(s) and process(es) that generated the Overpayment(s).

5. *Credentials.* The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (2) performed the Claims Review.

B. Additional Items Review

As set forth in Section III.D of the CIA and beginning with the second Reporting Period, the OIG at its discretion may identify up to three additional items for the IRO to review (hereafter "Additional Items".) No later than 90 days prior to the end of the second through fifth Reporting Periods, the OIG shall notify FORBA of the nature and scope of the IRO review to be conducted for each of the Additional Items. Prior to undertaking the review of the Additional Items, the IRO and/or FORBA shall submit an audit work plan to the OIG for approval and the IRO shall conduct the review of the Additional Items based on a work plan approved by the OIG. The IRO shall include information about its review of each Additional Item in the Additional Items Review Report (including a description of the review conducted for each Additional Item; the IRO's findings based on its review for each Additional Item; and the IRO's recommendations for any changes in FORBA's systems, processes, policies, and procedures based on its review of each Additional Item.)

FORBA may propose to the OIG that its internal audit(s) be partially substituted for one or more of the Additional Items that would otherwise be reviewed by the IRO for the applicable Reporting Period. The OIG retains sole discretion over whether, and in what manner, to allow FORBA's internal audit work to be substituted for a portion of the Additional Items review conducted by the IRO.

In making its decision, the OIG agrees to consider, among other factors, the nature and scope of FORBA's planned internal audit work, the results of the Review(s) during prior Reporting Period(s), and FORBA's demonstrated audit capabilities to perform the proposed audit work internally. If the OIG denies FORBA's request to permit its internal audit work to be substituted for a portion of the IRO's review of Additional Items in a given Reporting Period, FORBA shall engage the IRO to perform the Review as outlined in this Section III.

If the OIG agrees to permit certain of FORBA's internal audit work for a given Reporting Period to be substituted for a portion of Additional Items review, such internal work would be subject to verification by the IRO (Verification Review). In such an instance, the OIG would provide additional details about the scope of the Verification Review to be conducted by the IRO. However, for purposes of any Verification Review,

the IRO shall review at least 20% of the sampling units reviewed by FORBA in its internal audits.

1. *Additional Items Review Report.* For each Reporting Period beginning with the Second Reporting Period, the IRO shall prepare a report based on its Additional Items Review. The report shall include the following:

a) Review Objectives: A clear statement of the objectives intended to be achieved by each Additional Items review;

b) Review Protocol: A detailed narrative description of the procedures performed and a description of the sampling unit and universe utilized in performing the procedures for each sample reviewed; and

c) Sources of Data: A full description of documentation and other information, if applicable, relied upon by the IRO in performing the Additional Items Review.

d) Results of the Review: The following results shall be included in each Additional Items Review Report:

i. for each Additional Item reviewed, a description of the review conducted;

ii. for each Additional Item reviewed, the IRO's findings based on its review;

iii. for each Additional Item reviewed, the findings and supporting rationale regarding any weaknesses in FORBA's systems, processes, policies, procedures, and practices relating to the Additional Item, if any; and

iv. for each Additional Item reviewed, recommendations, if any, for changes in FORBA's systems, processes, policies, and procedures that would correct or address any weaknesses or deficiencies uncovered during the review.

Attachment 1

Claim Review Results

Federal Health Care Program Billed	Bene HIC #	Date of Service	Procedure Code Submitted	Procedure Code Reimbursed	Allowed Amount Reimbursed	Correct Procedure Code (IRO determined)	Correct Allowed Amt Reimbursed (IRO determined)	Dollar Difference between Amt Reimbursed and Correct Allowed Amt

Attachment 1 to Appendix B
FORBA Holdings, LLC

APPENDIX C

OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICAID CONTRACTOR

Date:_____
Contractor Deposit Control #_____ Date of Deposit: _____
Contractor Contact Name:_____ Phone #_____
Contractor Address:_____
Contractor Fax:

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Please complete and forward to Medicaid Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIERNAME_____
ADDRESS_____
PROVIDER/PHYSICIAN/SUPPLIER #_____ CHECK NUMBER#_____
CONTACT PERSON:_____ PHONE #_____ AMOUNT OF CHECK $_____ CHECK DATE_____

REFUND INFORMATION

For each Claim, provide the following:
Patient Name_____ Beneficiary ID #_____
Medicaid Claim Number_____ Claim Amount Refunded $_____
Reason Code for Claim Adjustment:_____ (Select reason code from list below. Use one reason per claim)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

*Note: If Specific Patient/Beneficiary ID/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment:*_____

For Institutional Facilities Only:
Cost Report Year(s) _____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)
For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? Yes No

Reason Codes:

Billing/Clerical Error	MSP/Other Payer Involvement	Miscellaneous
01 - Corrected Date of Service	08 - MSP Group Health Plan Insurance	13 - Insufficient Documentation
02 - Duplicate	09 - MSP No Fault Insurance	14 - Patient Enrolled in an HMO
03 - Corrected CDT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers Comp.(Including Black Lung	16 - Medical Necessity
05 - Modifier Added/Removed	12 - Veterans Administration	17 - Other (Please Specify)
06 - Billed in Error		_____
07 - Corrected CDT Code		

EXHIBIT 4

B1 (Official Form 1) (12/11)

United States Bankruptcy Court Middle District of Tennessee	Voluntary Petition

Name of Debtor (if individual, enter Last, First, Middle): **Church Street Health Management, LLC**	Name of Joint Debtor (Spouse) (Last, First, Middle):
All Other Names used by the Debtor in the last 8 years (include married, maiden, and trade names): **FDBA Sanus Holdings, LLC; FDBA FORBA Holdings, LLC**	All Other Names used by the Joint Debtor in the last 8 years (include married, maiden, and trade names):
Last four digits of Soc. Sec. or Individual-Taxpayer I.D. (ITIN)/Complete EIN (if more than one, state all): [redacted]	Last four digits of Soc. Sec. or Individual-Taxpayer I.D. (ITIN)/Complete EIN (if more than one, state all):
Street Address of Debtor (No. & Street, City, and State): [redacted] ZIP CODE [redacted]	Street Address of Joint Debtor (No. & Street, City, and State): ZIP CODE
County of Residence or of the Principal Place of Business: **Davidson**	County of Residence or of the Principal Place of Business:
Mailing Address of Debtor (if different from street address): ZIP CODE	Mailing Address of Joint Debtor (if different from street address): ZIP CODE
Location of Principal Assets of Business Debtor (if different from street address above):	

Type of Debtor (Form of Organization) (Check one box.)	**Nature of Business** (Check one box.)	**Chapter of Bankruptcy Code Under Which the Petition is Filed** (Check one box)
☐ Individual (includes Joint Debtors) *See Exhibit D on page 2 of this form.* ☒ Corporation (includes LLC and LLP) ☐ Partnership ☐ Other (If debtor is not one of the above entities, check this box and state type of entity below.)	☐ Health Care Business ☐ Single Asset Real Estate as defined in 11 U.S.C. § 101(51B) ☐ Railroad ☐ Stockbroker ☐ Commodity Broker ☐ Clearing Bank ☒ Other	☐ Chapter 7 ☐ Chapter 9 ☒ Chapter 11 ☐ Chapter 12 ☐ Chapter 13 ☐ Chapter 15 Petition for Recognition of a Foreign Main Proceeding ☐ Chapter 15 Petition for Recognition of a Foreign Nonmain Proceeding

Chapter 15 Debtors	**Tax-Exempt Entity** (Check box, if applicable.)	**Nature of Debts** (Check one box)
Country of debtor's center of main interests: Each country in which a foreign proceeding by, regarding, or against debtor is pending:	☐ Debtor is a tax-exempt organization under Title 26 of the United States Code (the Internal Revenue Code).	☐ Debts are primarily consumer debts, defined in 11 U.S.C. § 101(8) as "incurred by an individual primarily for a personal, family, or household purpose." ☒ Debts are primarily business debts.

Filing Fee (Check one box.)	**Chapter 11 Debtors**
☒ Full Filing Fee attached ☐ Filing Fee to be paid in installments (applicable to individuals only). Must attach signed application for the court's consideration certifying that the debtor is unable to pay fee except in installments. Rule 1006(b). See Official Form 3A. ☐ Filing Fee waiver requested (applicable to chapter 7 individuals only). Must attach signed application for the court's consideration. See Official Form 3B.	Check one box: ☐ Debtor is a small business debtor as defined in 11 U.S.C. § 101(51D). ☒ Debtor is not a small business debtor as defined in 11 U.S.C. § 101(51D). Check if: ☐ Debtor's aggregate noncontingent liquidated debts (excluding debts owed to insiders or affiliates) are less than $2,343,300 *(amount subject to adjustment on 4/01/13 and every three years thereafter).* Check all applicable boxes: ☐ A plan is being filed with this petition. ☐ Acceptances of the plan were solicited prepetition from one or more classes of creditors, in accordance with 11 U.S.C. § 1126(b).

Statistical/Administrative Information — THIS SPACE IS FOR COURT USE ONLY

☒ Debtor estimates that funds will be available for distribution to unsecured creditors.

☐ Debtor estimates that, after any exempt property is excluded and administrative expenses paid, there will be no funds available for distribution to unsecured creditors.

Estimated Number of Creditors									
☐ 1-49	☐ 50-99	☒ 100-199	☐ 200-999	☐ 1,000-5,000	☐ 5001-10,000	☐ 10,001-25,000	☐ 25,001-50,000	☐ 50,001-100,000	☐ OVER 100,000

Estimated Assets									
☐ $0 to $50,000	☐ $50,001 to $100,000	☐ $100,001 to $500,000	☐ $500,001 to $1 million	☐ $1,000,001 to $10 million	☐ $10,000,001 to $50 million	☐ $50,000,001 to $100 million	☒ $100,000,001 to $500 million	☐ $500,000,001 to $1 billion	☐ More than $1 billion

Estimated Liabilities									
☐ $0 to $50,000	☐ $50,001 to $100,000	☐ $100,001 to $500,000	☐ $500,001 to $1 million	☐ $1,000,001 to $10 million	☐ $10,000,001 to $50 million	☐ $50,000,001 to $100 million	☒ $100,000,001 to $500 million	☐ $500,000,001 to $1 billion	☐ More than $1 billion

Voluntary Petition *(This page must be completed and filed in every case)*	Name of Debtor(s): Church Street Health Management, LLC	
All Prior Bankruptcy Cases Filed Within Last 8 Years (If more than two, attach additional sheet.)		
Location Where Filed: - None -	Case Number:	Date Filed:
Location Where Filed:	Case Number:	Date Filed:
Pending Bankruptcy Case Filed by any Spouse, Partner, or Affiliate of this Debtor (If more than one, attach additional sheet.)		
Name of Debtor: - None -	Case Number:	Date Filed:
District:	Relationship:	Judge:

Exhibit A

(To be completed if debtor is required to file periodic reports (e.g., forms 10K and 10Q) with the Securities and Exchange Commission pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 and is requesting relief under chapter 11.)

☐ Exhibit A is attached and made a part of this petition.

Exhibit B

(To be completed if debtor is an individual whose debts are primarily consumer debts.)

I, the attorney for the petitioner named in the foregoing petition, declare that I have informed the petitioner that [he or she] may proceed under chapter 7, 11, 12, or 13 of title 11, United States Code, and have explained the relief available under each such chapter. I further certify that I delivered to the debtor the notice required by 11 U.S.C. § 342(b).

X _____
Signature of Attorney for Debtor(s) (Date)

Exhibit C

Does the debtor own or have possession of any property that poses or is alleged to pose a threat of imminent and identifiable harm to public health or safety?

☐ Yes, and Exhibit C is attached and made a part of this petition.

☒ No

Exhibit D

(To be completed by every individual debtor. If a joint petition is filed, each spouse must complete and attach a separate Exhibit D.)

☐ Exhibit D completed and signed by the debtor is attached and made a part of this petition.

If this is a joint petition:

☐ Exhibit D also completed and signed by the joint debtor is attached and made a part of this petition.

Information Regarding the Debtor - Venue

(Check any applicable box.)

☒ Debtor has been domiciled or has had a residence, principal place of business, or principal assets in this District for 180 days immediately preceding the date of this petition or for a longer part of such 180 days than in any other District.

☐ There is a bankruptcy case concerning debtor's affiliate, general partner, or partnership pending in this District.

☐ Debtor is a debtor in a foreign proceeding and has its principal place of business or principal assets in the United States in this District, or has no principal place of business or assets in the United States but is a defendant in an action or proceeding [in a federal or state court] in this District, or the interests of the parties will be served in regard to the relief sought in this District.

Certification by a Debtor Who Resides as a Tenant of Residential Property

(Check all applicable boxes.)

☐ Landlord has a judgment against the debtor for possession of debtor's residence. (If box checked, complete the following.)

_____
(Name of landlord that obtained judgment)

_____
(Address of landlord)

☐ Debtor claims that under applicable nonbankruptcy law, there are circumstances under which the debtor would be permitted to cure the entire monetary default that gave rise to the judgment for possession, after the judgment for possession was entered, and

☐ Debtor has included in this petition the deposit with the court of any rent that would become due during the 30-day period after the filing of the petition.

☐ Debtor certifies that he/she has served the Landlord with this certification. (11 U.S.C. § 362(l)).

B1 (Official Form 1) (12/11) Page 3

Voluntary Petition *(This page must be completed and filed in every case)*	Name of Debtor(s): **Church Street Health Management, LLC**

Signatures

Signature(s) of Debtor(s) (Individual/Joint)

I declare under penalty of perjury that the information provided in this petition is true and correct.
[If petitioner is an individual whose debts are primarily consumer debts and has chosen to file under chapter 7] I am aware that I may proceed under chapter 7, 11, 12 or 13 of title 11, United States Code, understand the relief available under each such chapter, and choose to proceed under chapter 7.

[If no attorney represents me and no bankruptcy petition preparer signs the petition] I have obtained and read the notice required by 11 U.S.C. § 342(b).

I request relief in accordance with the chapter of title 11, United States Code, specified in this petition.

X _____
Signature of Debtor

X _____
Signature of Joint Debtor

_____
Telephone Number (If not represented by attorney)

_____
Date

Signature of a Foreign Representative

I declare under penalty of perjury that the information provided in this petition is true and correct, that I am the foreign representative of a debtor in a foreign proceeding, and that I am authorized to file this petition.

(Check only **one** box.)

☐ I request relief in accordance with chapter 15 of title 11, United States Code. Certified copies of the documents required by 11 U.S.C. § 1515 are attached.

☐ Pursuant to 11 U.S.C. § 1511, I request relief in accordance with the chapter of title 11 specified in this petition. A certified copy of the order granting recognition of the foreign main proceeding is attached.

X _____
(Signature of Foreign Representative)

_____
(Printed Name of Foreign Representative)

_____
Date

Signature of Attorney*

X /s/ [redacted]
Signature of Attorney for Debtor(s)

[redacted]
Printed Name of Attorney for Debtor(s)

[redacted], LLP
Firm Name

[redacted]
Address

[redacted]
Telephone Number

Date: **February 20, 2012**

*In a case in which § 707(b)(4)(D) applies, this signature also constitutes a certification that the attorney has no knowledge after an inquiry that the information in the schedules is incorrect.

Signature of Non-Attorney Bankruptcy Petition Preparer

I declare under penalty of perjury that: (1) I am a bankruptcy petition preparer as defined in 11 U.S.C. § 110; (2) I prepared this document for compensation and have provided the debtor with a copy of this document and the notices and information required under 11 U.S.C. §§ 110(b), 110(h), and 342(b); and, (3) if rules or guidelines have been promulgated pursuant to 11 U.S.C. § 110(h) setting a maximum fee for services chargeable by bankruptcy petition preparers, I have given the debtor notice of the maximum amount before preparing any document for filing for a debtor or accepting any fee from the debtor, as required in that section. Official form 19 is attached.

_____
Printed Name and title, if any, of Bankruptcy Petition Preparer

_____
Social-Security number (If the bankruptcy petition preparer is not an individual, state the Social-Security number of the officer, principal, responsible person or partner of the bankruptcy petition preparer.)(Required by 11 U.S.C. § 110.)

_____
Address

X _____

_____
Date

Signature of bankruptcy petition preparer or officer, principal, responsible person, or partner whose social security number is provided above.

Names and Social-Security numbers of all other individuals who prepared or assisted in preparing this document unless the bankruptcy petition preparer is not an individual

If more than one person prepared this document, attach additional sheets conforming to the appropriate official form for each person.

A bankruptcy petition preparer's failure to comply with the provisions of title 11 and the Federal Rules of Bankruptcy Procedure may result in fines or imprisonment or both. 11 U.S.C. § 110; 18 U.S.C. § 156.

Signature of Debtor (Corporation/Partnership)

I declare under penalty of perjury that the information provided in this petition is true and correct, and that I have been authorized to file this petition on behalf of the debtor.
The debtor requests relief in accordance with the chapter of title 11, United States Code, specified in this petition.

X [redacted]

[redacted]
Printed Name of Authorized Individual

Chief Executive Officer
Title of Authorized Individual

_____
Date: **February 20, 2012**

NOTICE ANNEX 1

Pursuant to 11 U.S.C. § 342, the following sets forth the name, addresses and last four digits of the tax identification number for each of the referenced Debtors:

DEBTORS AND ADDRESSES	CASE NO.	TAX I.D. NO.
Church Street Health Management, LLC [redacted]	Case No. 12-_____	2335
Small Smiles Holding Company, LLC [redacted]	Case No. 12-_____	4993
Forba NY, LLC [redacted]	Case No. 12-_____	8013
EEHC, Inc. [redacted]	Case No. 12-_____	6506
Forba Services, LLC [redacted]	Case No. 12-_____	4973

8557373.5

CHURCH STREET HEALTH MANAGEMENT, LLC

ACTIONS TAKEN BY UNANIMOUS WRITTEN CONSENT OF THE BOARD OF MANAGERS

February 20, 2012

The undersigned, constituting all of the members of the Board of Managers (the "Board") of Church Street Health Management, LLC, a limited liability company organized under the laws of the state of Delaware (the "Company"), acting pursuant to the Delaware Limited Liability Company Act, do hereby consent to and adopt, by this unanimous written consent, the following resolutions and take the following actions with the same force and effect as if they had been adopted at a duly convened meeting of the Board and direct that this written consent be filed with the minutes of the proceedings of the Board, as of the date set forth above:

Bankruptcy Filing

WHEREAS, the Board has considered the financial and operational condition of the Company's business;

WHEREAS, the Board has considered the liabilities and liquidity situation of the Company, the strategic alternatives available to it and the impact of the foregoing on the Company's business;

WHEREAS, the Board has had the opportunity to consult with the financial and legal advisors of the Company, and fully consider each of the strategic alternatives available to the Company; and

WHEREAS, in the business judgment of the Board, after consideration of the alternatives presented to it and the advice of the Company's legal advisors, the Board deems it in the best interests of the Company, its creditors and other interested parties, that a voluntary petition (the "Petition") be filed by and on behalf of the Company under the provisions of Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code");

NOW, THEREFORE, BE IT RESOLVED, that the filing of the Petition is hereby adopted, approved and ratified by, on behalf of and for the Company; and

FURTHER RESOLVED, that the proper and appropriate officers of the Company (the "Authorized Officers") are hereby authorized and directed, in the name and on behalf of the Company, to prepare, execute, deliver and file the Petition and negotiate, prepare, draft, execute, deliver and file, as applicable, any and all other consents, certificates, schedules, lists, certificates, documents and instruments relating thereto or contemplated thereby, and to take any and all action which such officer or officers may deem necessary, advisable or appropriate to effectuate the foregoing resolution or to implement the intent and purposes thereof;

Engagement of Professionals

FURTHER RESOLVED, that the Board authorizes and approves the engagement of the law firm of Waller Lansden Dortch & Davis, LLP ("Waller Lansden") as bankruptcy counsel to advise and represent the Company in connection with the proposed restructuring and bankruptcy filing, and in carrying out its duties under the Bankruptcy Code, and to take any and all actions to advance the Company's rights and obligations as the Authorized Officers or any of them deem necessary, advisable or appropriate; and, in connection therewith, the Authorized Officers are and each is hereby authorized and directed, in the name and on behalf of the Company, to execute an appropriate retention agreement or engagement letter with Waller Lansden, pay an appropriate retainer thereto prior to or immediately upon

the filing of the Petition and cause to be filed an appropriate application with the appropriate bankruptcy court for authority to retain the services of Waller Lansden; and

FURTHER RESOLVED, that the Board authorizes and approves the engagement of [redacted] as financial and restructuring advisors, and of [redacted], a Managing Director of [redacted], as Chief Restructuring Officer of the Company, to advise and represent the Company in connection with the proposed restructuring and bankruptcy filing, and in carrying out its duties under the Bankruptcy Code, and to take any and all actions to advance the Company's rights and obligations as the Authorized Officers or any of them deem necessary, advisable or appropriate; and, in connection therewith, the Authorized Officers are and each is hereby authorized and directed, in the name and on behalf of the Company, to execute an appropriate retention agreement or engagement letter with [redacted], pay an appropriate retainer thereto prior to or immediately upon the filing of the Petition and cause to be filed an appropriate application with the appropriate bankruptcy court for authority to retain the services of A&M and Mr. [redacted]; and

FURTHER RESOLVED, that the Board authorizes and approves the engagement and employment of any such other professionals necessary to advise and represent the Company in connection with the proposed restructuring and bankruptcy filing, and in carrying out its duties under the Bankruptcy Code, and to take any and all actions to advance the Company's rights and obligations as the Authorized Officers or any of them deem necessary, advisable or appropriate; and, in connection therewith, the Authorized Officers are and each is hereby authorized and directed, in the name and on behalf of the Company, to execute an appropriate retention agreement or engagement letter with any such professionals, pay an appropriate retainer thereto prior to or immediately upon the filing of the Petition and cause to be filed an appropriate application with the appropriate bankruptcy court for authority to retain the services of any such professionals;

Credit Documents

WHEREAS, in connection with the filing of the Petition, the Company desires to enter into a Debtor-In-Possession Credit Agreement (the "Credit Agreement") by and among [redacted] (the "Borrower"), the Company, the subsidiary guarantors party thereto (together with the Company, the "Guarantors"), the lenders party thereto (the "Lenders") and [redacted], as the administrative agent (the "Administrative Agent") and the collateral agent, pursuant to which the Lenders will provide the Borrower with up to an aggregate principal amount of [redacted] in a revolving credit facility, and the Borrower's obligations thereunder will be guaranteed by the Company and the other Guarantors;

WHEREAS, in connection with the execution and delivery of the Credit Agreement, the Administrative Agent and the Lenders have requested that the Company enter into the Security Agreement (the "Security Agreement"), by and among the Borrower, the Company, the other Guarantors and the Administrative Agent for the benefit of the Lenders and the other secured parties under the Credit Documents (as hereinafter defined), pursuant to which, inter alia, the Company will grant a security interest in substantially all of the Company's personal and intangible property to the Administrative Agent, for the benefit of the Lenders and the other secured parties under the Credit Documents, to secure the payment and performance of the obligations under the Credit Agreement and the other agreements, promissory notes, collateral documents, filings, intellectual property agreements and other documents contemplated thereby and by the Credit Agreement (these documents, together with the Security Agreement, collectively referred to herein as the "Credit Documents"); and

WHEREAS, the Board deems it in the best interests of the Company, its creditors and other interested parties for the Company to enter into the transactions contemplated by the Credit Agreement

and the other Credit Documents, including without limitation, the guaranty by the Company of all of the Borrower's obligations thereunder pursuant to the terms thereof and the grant of security by the Company under the Security Agreement to secure such guaranty;

NOW, THEREFORE, BE IT RESOLVED, that the execution and delivery of the Credit Agreement and each of the Credit Documents is hereby adopted, approved and ratified by, on behalf of and for the Company; and

FURTHER RESOLVED, that the Authorized Officers are and each is hereby authorized and directed, in the name and on behalf of the Company, to negotiate, execute and deliver the Credit Agreement and each of the Credit Documents and to take any and all action which such officer or officers may deem necessary, advisable or appropriate to effectuate the foregoing resolution or to implement the intent and purposes thereof, and to negotiate, execute and deliver and any other necessary agreements, certificates, documents and instruments relating thereto or contemplated thereby, including, without limitation, (i) any and all amendments and supplements to the Credit Agreement and the Credit Documents; (ii) such notes, security agreements, assignments, certificates and other instruments and documents as may from time to time be required by the Administrative Agent in connection with the Credit Agreement and the Credit Documents; and (iii) any and all amendments and supplements to such notes, security agreements, assignments, certificates, and other instruments and documents, all of the foregoing on the terms and conditions substantially as now presented to the Board and hereby approved or on such additional, modified or revised terms as may be acceptable to any of the Authorized Officers in such officer's sole discretion, upon advice of counsel, as evidenced by such officer's execution thereof, and to perform all such additional acts and deeds as are necessary or desirable, as conclusively evidenced by the performance thereof, to carry out consummation of the transactions contemplated by the Credit Agreement and the Credit Documents; and

FURTHER RESOLVED, that the Authorized Officers are and each is hereby authorized and directed, in the name and on behalf of the Company, to convey, grant, assign, transfer, pledge, mortgage, grant a security interest in, or otherwise hypothecate and deliver by such instruments in writing or otherwise as may be required by the Administrative Agent any of the property of the Company to secure the obligations arising under the Credit Agreement and the Credit Documents and any other obligations of the Company whether arising pursuant to this resolution or otherwise;

General Resolutions

FURTHER RESOLVED, that the Authorized Officers are hereby authorized and directed, in the name of and on behalf of the Company, to take or cause to be taken any and all such other and further action, to execute, deliver and file any and all such documents and instruments, and to pay all fees and expenses as any such officer or officers, in his, her or their discretion, may deem necessary or advisable in order to carry out the purpose and intent of the foregoing resolutions; and

FURTHER RESOLVED, that all acts previously performed by the Authorized Officers prior to the date of this written consent that are within the authority conferred hereby are hereby ratified, confirmed, approved and adopted in all respects; and

FURTHER RESOLVED, that any specific resolutions that may be required to have been adopted by the Board in connection with the transactions contemplated by the foregoing resolutions be, and the same hereby are, adopted, and the Secretary of the Company or other appropriate Authorized Officer is hereby authorized to certify as to the adoption of any and all such resolutions; and

FURTHER RESOLVED, that this written consent may be executed in one or more counterparts, each of which shall constitute an original, but all of which together shall constitute one and the same instrument.

[Signature Page Follows]

IN WITNESS WHEREOF, the undersigned, being all of the members of the Board, have executed this written consent as of the date above first written.

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

IN WITNESS WHEREOF, the undersigned, being all of the members of the Board, have executed this written consent as of the date above first written.

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

IN WITNESS WHEREOF, the undersigned, being all of the members of the Board, have executed this written consent as of the date above first written.

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

IN WITNESS WHEREOF, the undersigned, being all of the members of the Board, have executed this written consent as of the date above first written.

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

IN WITNESS WHEREOF, the undersigned, being all of the members of the Board, have executed this written consent as of the date above first written.

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

IN WITNESS WHEREOF, the undersigned, being all of the members of the Board, have executed this written consent as of the date above first written.

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted] Manager

[redacted], Manager

[redacted], Manager

IN WITNESS WHEREOF, the undersigned, being all of the members of the Board, have executed this written consent as of the date above first written.

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted], Manager

[redacted]

[redacted], Manager

EXHIBIT 5

KING & SPALDING

King & Spalding LLP
1700 Pennsylvania Ave, NW
Suite 200
Washington, D.C. 20006-4707
Tel: +1 202 737 0500
Fax: +1 202 626 3737
www.kslaw.com

Theodore M. Hester
Direct Dial: +1 202 626 2901

November 29, 2011

Erika Smith
Policy Advisor
U.S. Senate, Committee on Judiciary
327 Hart Senate Office Building
Washington, D.C. 20510-6200

Christopher Law
Investigator
U.S. Senate, Committee on Finance
Dirksen Senate Office Building, SD-219
Washington, DC 20510-6200

Re: Church Street Health Management

Dear Erika and Chris:

We represent Church Street Health Management, Inc. ("CSHM") in connection with the letter dated November 18, 2011 from Senators Baucus and Grassley, received by CSHM late yesterday afternoon.[1] My partner, Grace Rodriguez, and I look forward to meeting with you tomorrow at noon. To facilitate our discussion, a binder is enclosed containing certain background documents. Additionally, I am providing the following information by way of general background and to illustrate certain misperceptions in the letter.

CSHM (formerly known as FORBA Holdings, Inc.) does not own any dental centers. It provides management services to dental centers across the country pursuant to Management Services Agreements ("MSAs"). These management services include assistance with billing, accounts receivable, payroll and human resources, purchasing, lease negotiations, legal, compliance, orientation programs, marketing, and taxes. The dental centers are owned by dentists. The management services provided by CSHM allow the dentists working in the centers

[1] The letter was addressed to [redacted] as CSHM's Chairman and Chief Executive Officer. [redacted] was separated from CSHM effective November 14, 2011.

to focus on practicing dentistry, and help to alleviate for them the administrative burdens of treating a largely Medicaid population. CSHM acquired the MSAs through an asset purchase transaction in September, 2006. There have been no changes of ownership in CSHM since September, 2006, and the owners of CSHM have not received any dividends from CSHM since their initial investment.

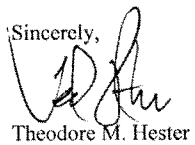
In November, 2007, CSHM learned from media reports that certain government agencies had launched an investigation concerning its operations. CSHM immediately contacted the agencies identified in the media reports, and began to cooperate fully with the investigation. CSHM provided documents and information to the Department of Justice ("DOJ"), the three relators who had filed actions against CSHM, the Office of the Inspector General for the Department of Health and Human Services ("HHS-OIG"), and state attorneys general. In January 2010, CSHM executed settlement agreements with the DOJ, the HHS-OIG, 22 state attorneys general, and the District of Columbia that provided for a settlement payment of $24 million over five years and releases for itself, its management and directors, and those dental centers with MSAs for Covered Conduct from September 2006 through January 15, 2010. CSHM also executed Corporate Integrity Agreements with the HHS-OIG and the New York Office of the Medicaid Inspector General. For your convenience, we have included each of those agreements in the enclosed binder. Pursuant to the Corporate Integrity Agreements, CSHM has been paying for an Independent Monitor chosen by HHS-OIG, headed by a former HHS-OIG lawyer, who is responsible for assessing the effectiveness, reliability and thoroughness of CSHM's internal quality control systems, its response to quality of care issues, its development and timely implementation of corrective action plans, and its proactive steps to ensure that each patient at a dental center with a MSA receives care in accordance with professionally recognized standards of health care and all applicable statutes, regulations and guidelines. The Independent Monitor has unfettered and immediate access to all personnel, facilities, patients and records relating to billing or the care of patients at the dental centers with MSAs. The Corporate Integrity Agreements also provide for an Independent Review Organization, which also evaluates the accuracy of claims submitted by the centers as well as the quality of care provided, on an annual basis. By the end of 2011, CSHM estimates that it will have spent approximately $1,300,000 just for the services of the Independent Monitor and the IRO alone. This number does not take into account the additional investment that CSHM has made in its compliance program.

Your letter refers to class action lawsuits in Colorado and Texas involving claims of patient abuse. No class actions have been filed in Colorado or Texas, and no class actions have been settled. Two class actions have been filed -- one in federal court in Ohio, and one in state court in Oklahoma. The Ohio federal class action was dismissed by the plaintiff; the Oklahoma state class action was dismissed by the court. Other litigation brought on behalf of individual patients remains pending in Ohio, Oklahoma, and New York. CSHM prevailed in a jury trial this past summer in a patient case in New Mexico. We are happy to provide you with further information regarding CSHM's litigation.

The investigations and litigation have taken a toll on CSHM and the dental centers with MSAs. CSHM currently is in negotiations with its lenders and equity holders to restructure the company and obtain a necessary cash infusion. In the meantime, CSHM is working hard to ensure that the dental centers with MSAs are providing the highest quality care to their patients, consistent with CSHM's obligations under the law and under its agreements with the government.

We look forward to our meeting tomorrow. Thank you for your time and consideration.

Sincerely,



Theodore M. Hester

EXHIBIT 6

AMENDED AND RESTATED
MANAGEMENT SERVICES AGREEMENT
Albuquerque, New Mexico

THIS AMENDED AND RESTATED MANAGEMENT SERVICES AGREEMENT ("Agreement") is made effective as of September 12 2006, by and between SMALL SMILES DENTISTRY FOR CHILDREN, ALBUQUERQUE, P.C. ("Practice"), a New Mexico professional corporation, and SANUS HOLDINGS, LLC, a Delaware limited liability company ("SANUS"), and amends and restates that certain Management Services Agreement, dated as of January 1, 2003 (the "Original Agreement"), between the Practice and FORBA, LLC, a Colorado limited liability company ("FORBA").

RECITALS:

A. Practice is the owner, operator, conductor and proprietor of a dental clinic located at 111 Coors Blvd NW #E-6, Albuquerque, New Mexico (the "Clinic").

B. SANUS and FORBA are parties to that certain Asset Purchase Agreement, dated as of June 14, 2006, as amended, pursuant to which SANUS acquired substantially all of the assets of FORBA, including all of FORBA's rights under the Original Agreement.

C. Pursuant to an Assignment and Assumption Agreement, dated as of the date hereof, SANUS assumed all of FORBA's rights under the Original Agreement.

D. Practice desires to engage SANUS to provide, or arrange for the provision of, certain administrative and business services in connection with the business operations of the Clinic, and SANUS desires and is willing to accept such engagement, upon the terms and conditions set forth herein.

NOW THEREFORE, in consideration of the premises and the mutual covenants herein contained, and in consideration of other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Practice and SANUS agree as follows:

ARTICLE I
ENGAGEMENT

Section 1.01. General. Subject to the terms of this Agreement and upon the terms and conditions hereinafter set forth, Practice hereby engages SANUS and grants SANUS the authority, on an exclusive basis, to provide or arrange for the provision of the Services described in Article II hereof to and for the Clinic and Practice's dental practice (the "Business"), during the Term (as defined in Section 8.01 below), but subject at all times to the ultimate authority, control and direction of Practice and to the limitations set forth in Section 1.04. SANUS accepts such engagement for and in consideration of the compensation hereinafter set forth, and agrees to provide, or arrange for the provision of, the Services pursuant to the terms of this Agreement. Nothing contained herein shall restrict SANUS from providing any services to third parties; provided however, that such provision of services do not materially interfere with the Services provided to Practice hereunder.

Section 1.02. Independent Parties. The legal relationship of SANUS and Practice is that of provider and purchaser, respectively, of services. None of the provisions of this Agreement are intended to, nor shall be deemed or construed to, create any relationship between the parties to this Agreement other than that of independent contractors for purpose of implementing the provisions of this Agreement, Practice and SANUS each agree that it will not represent to any third party that the relationship between Practice and SANUS is anything other than that of independent contractors.

Section 1.03. Authority. Practice and SANUS each represent and warrant to the other party that it has the requisite power and authority to execute, deliver and perform this Agreement and that the same have been authorized by all necessary action on their respective parts.

Section 1.04. Limitations. By entering into this Agreement, Practice does not delegate to SANUS (and Practice specifically retains) the power, duties and ultimate responsibilities and control vested in Practice as licensee of the Business, and, during the Term of this Agreement, Practice is and will remain the responsible licensee of the Business and, as such, shall be fully liable and legally accountable at all times to all patients, governmental agencies and others for patient care, and for all other aspects of the operation and maintenance of the Business. Therefore, it is expressly acknowledged that SANUS shall not have the authority to manage, direct, perform, supervise or oversee any matters constituting the practice of dentistry under the laws of the State of New Mexico. SANUS shall not manage, supervise, direct or interfere with the independent judgment of members of the Clinic's dental staff in the performance of their professional duties on behalf of Practice. Nothing in this Agreement or in the actual operation of the Clinic shall be construed as limiting a dental professional's independent judgment exercised for or on behalf of a patient of the Clinic.

ARTICLE II
MANAGEMENT SERVICES

Subject to applicable law, the terms of this Agreement, the ultimate authority, control and direction of Practice and the limitations set forth in Section 1.04, and without limiting the generality of Article I, SANUS shall provide, or arrange for the provision of, the following services in connection with the business and operations of the Clinic (the "Services"):

Section 2.01. Personnel.

(a) In consultation with Practice and subject to Practice's determination of the Clinic's needs, SANUS will assist Practice in the recruitment of dentists, dental hygienists, dental assistants and other dental auxiliaries and other personnel involved in the provision of clinical services at the Clinic (collectively, together with any other Clinic staff who may not be employed or engaged by SANUS under applicable state law, the "Clinical Staff"), as well as in the determination by Practice of the Clinical Staff's compensation, benefits, schedules, policies and performance standards. The Clinical Staff shall be employed, leased, engaged or contracted by Practice.

(b) In consultation with Practice and subject to Practice's determination of the Clinic's needs, SANUS will be responsible for the recruitment, hiring, leasing or contracting, training, promotion, direction, supervision and termination of the Clinic's administrator, clerical staff, receptionists and other non-clinical, business staff (collectively, the "Non-Clinical Staff"). The Non-Clinical Staff may be employed, engaged, leased or contracted by Practice, and/or SANUS may employ, engage, lease or contract with such Non-Clinical Staff on behalf of Practice, as the parties mutually agree. SANUS will assist Practice in its determination of the compensation, benefits, policies and performance standards for Non-Clinical Staff who are employed, engaged, leased or contracted by Practice.

(c) In consultation with Practice and subject to Practice's ultimate authority, control and direction, SANUS will determine staffing schedules for the Non-Clinical Staff. Certain of the Non-Clinical Staff of the Clinic shall attend continuing education and other programs offered by SANUS or its Affiliates (as defined in Section 9.07 below), and all costs and expenses related thereto, including but not limited to, travel, room and board and tuition, shall be included as an operating cost of the Clinic.

(d) All salaries, wages, bonuses, benefits, taxes and all other compensation and direct costs attributable to the Non-Clinical Staff and Clinical Staff at or for the Clinic shall be the responsibility of and for the account of Practice, whether employed, engaged, leased or contracted by

SANUS, an Affiliate thereof or Practice. Without limiting the generality of the foregoing, the direct costs attributable to the Non-Clinical Staff shall include but not be limited to the employer's contribution of FICA, unemployment compensation and other employment taxes, retirement and profit sharing plan contributions, group life, accident and health insurance premiums, disability, and other employee benefits and the costs of obtaining appropriate malpractice and/or errors and omissions insurance.

(e) SANUS shall not employ, engage, lease, hire, contract with or supervise, nor have any responsibility or liability with respect to the actions or omissions of, any Clinical Staff or other personnel who attend, practice, provide clinical, dental or professional services or have privileges at or in the Clinic; it being understood that all of such Clinical Staff shall be employed, engaged, leased or contracted by Practice and shall be under the supervision of the medical director for the Clinic (the "Medical Director"). The Medical Director for the Clinic shall be an individual selected and engaged by Practice, who shall at all times be duly licensed to practice dentistry, without restriction, in the State of New Mexico.

Section 2.02. Assets for the Business; Computer and Information Technology Systems. SANUS will assist Practice in selecting and purchasing, leasing, licensing or otherwise acquiring or arranging, in the name of Practice, SANUS or an Affiliate of SANUS, for the use of assets necessary or appropriate to operate the Business (including, without limitation, real property, medical, computer and other equipment, motor vehicles, software, supplies, drugs, inventory, utilities and other materials and items), all as determined by Practice in its reasonable judgment and in consultation with SANUS. Practice shall have and maintain complete custody, care and control of assets used in the Business during the term of this Agreement. SANUS will also assist Practice in arranging for improvements to be made to the Clinic and for the replacement of obsolete or run-down equipment, on Practice's behalf, if Practice, in its reasonable judgment and in consultation with SANUS, determines such improvements or replacements to be reasonably necessary for the operation of the Clinic. All of the costs and expenses related or incident to such assets and the obligations under this Section shall be the responsibility of and shall be for the account of Practice, regardless of whether SANUS procures such assets on Practice's behalf or whether they are procured in the name of SANUS, its affiliates or Practice. If SANUS purchases (whether in its own name, in the name of any of its Affiliates, or in the name of Practice) pharmaceuticals, supplies or other assets on behalf of Practice, Practice shall be responsible for the payment (either directly to the vendor, or to SANUS or its Affiliates if purchased by any of them on behalf of Practice) of the invoice price for such assets without mark-up or additional costs imposed by SANUS or its Affiliates, but Practice's entitlement to any company-wide discounts or rebates received by SANUS in connection with such purchases shall be based solely upon a volume based allocation methodology on a product by product basis adopted by SANUS in good faith to determine the appropriate amount to be allocated to Practice. SANUS makes no representation or warranty, express or implied, as to the condition of any assets purchased or otherwise acquired by it on behalf of Practice from any person or entity that is not an Affiliate of SANUS, and SANUS shall not be liable for any defects in any of such items.

Section 2.03. Repairs; Capital Improvements. Subject to the terms of any applicable real property, equipment or other leases, SANUS shall make or install, or cause or arrange to be made or installed, at Practice's expense and in the name of Practice, repairs, replacements, additions and improvements in and to the Clinic and its furnishings and equipment as Practice, in its reasonable judgment and in consultation with SANUS, shall deem necessary in order to keep and maintain the same in good repair, working order and condition, and outfitted and equipped for the proper operation thereof in accordance with industry standards and comparable to those prevailing in other similar facilities, and all applicable state or local rules, regulations or ordinances.

Section 2.04. Bookkeeping, Accounting and Taxes.

(a) SANUS shall perform or arrange for bookkeeping and accounting procedures for the Business, and shall maintain financial records for the Business in accordance with reasonable industry standards. SANUS shall prepare and provide to Practice with respect to the Business reasonably detailed operating statements (including balance sheets, cash flow analyses and number of treatments) on a monthly basis as soon as reasonably practicable, but in no event greater than forty-five (45) days from the last day of each calendar month and on an annual basis within ninety (90) days from the last day of each calendar year. Financial data set forth in the operating statements shall be reported on an accrual basis. SANUS shall not be responsible for preparing financials relating to any operations other than the Business. SANUS may, in its discretion, maintain any or all of the books and records relating to the Business at the Clinic or at any other location, provided that Practice shall have access to such books and records as set forth below in Article III.

(b) SANUS shall, on Practice's behalf and at Practice's expense, prepare for signature by Practice and file (or arrange for the foregoing) all necessary local, state and federal income tax returns and all necessary business tax returns, including but not limited to sales, use and personal property tax returns relating to the Business (but excluding personal tax returns of the owners and employees of Practice). All amounts payable with respect to any of such taxes shall be the responsibility of and shall be for the account of Practice. Practice shall assist SANUS at SANUS's request with the preparation of said returns.

(c) SANUS shall, directly or through an Affiliate, provide or arrange for the data processing required to maintain the financial payroll, and accounting records of the Business.

Section 2.05. Billing, Collection, and Cost Report Matters. SANUS shall perform billing and collection functions on behalf of Practice with respect to the operation of the Business, including with respect to private pay patients and reimbursement from third party payors. All out-of-pocket costs and expenses relating to the billing and collection services, including without limitation, any fees or expenses payable to collection agencies, shall be for the account of Practice, SANUS shall provide assistance to Practice in the preparation (for Practice's signature) and filing of all costs reports, exception requests and other reports and data necessary for obtaining appropriate reimbursement for the items and services provided by the Business under the Medicare and applicable Medicaid programs and any other third party payor programs in which the Clinic participates. Practice shall direct all third party payors to provide SANUS with copies of all remittance advices in electronic format or in such other format as shall be mutually agreeable to SANUS and Practice. SANUS shall, on behalf of and in consultation with Practice, negotiate contracts with third party payors, including the fee and payment schedules and discounts. SANUS will use reasonable efforts to include the Clinic as a participating provider in third party payor contracts to which SANUS or its Affiliates are parties to the extent that such contracts cover the region in which the Clinic is located and permit inclusion of the Clinic. SANUS shall also provide assistance to Practice and its advisors in connection with any Medicare, Medicaid or other reimbursement-related audits of the Business.

Section 2.06. Insurance. SANUS shall assist Practice in procuring, on behalf of Practice and at Practice's expense, insurance in such amounts and coverage, on such terms and conditions and from such carriers as reasonably required for appropriate coverage in accordance with general industry standards; provided, however, that all such insurance carriers and coverage limits shall be subject to the prior approval of Practice, which approval shall not be unreasonably withheld or delayed. All premiums, deductibles, retentions and co-insurance shall be the responsibility of and for the account of Practice.

Section 2.07. Contracts. Subject to Sections 1.01 and 1.04 hereof and the other limitations on SANUS's authority under this Agreement, including, without limitation, the limitations provided

in Sections 2.01 through 2.06 hereof, SANUS may enter into, or modify, supplement, amend or terminate, or grant waivers or releases of obligations under, such contracts, leases, licenses, instruments and other agreements ("Contracts"), in the name of and at the expense of Practice, as Practice, in its reasonable judgment and in consultation with SANUS, deems necessary or advisable for the furnishing of professional, consulting and staffing services, concessions, drugs, supplies, utilities, insurance, equipment or other property maintenance, and other products, goods and services may be necessary or appropriate from time to time for the maintenance and operation of the Business, or as may otherwise be necessary or appropriate to carry out SANUS's obligations under this Agreement, provided, however, that any Contract with a term in excess of three (3) years or involving an expenditure in excess of One Hundred Thousand Dollars ($100,000) shall be subject to the prior approval of Practice, which approval shall not be unreasonably withheld or delayed. SANUS is hereby expressly authorized, as Practice's agent, to execute and deliver any of such Contracts in the name of and on behalf of Practice, and presentation of a copy of this Agreement shall constitute conclusive evidence of such agency and authority. SANUS is expressly authorized to contract, in the name and on behalf of Practice, for the provision by SANUS or its Affiliates of any services to be provided to the Business. Notwithstanding the foregoing, without the prior written approval of Practice, SANUS may not, in the name or on behalf of Practice, enter into any leases of real property, any loan agreements, or any material Contract that does not relate to the operation or maintenance of the Business; provided, however, SANUS may, in the name and on behalf of Practice, modify, supplement, amend or terminate, or grant waivers or releases of obligations under, any of such Contracts if the same will not materially affect Practice or the Business.

Section 2.08. Licenses, Permits and Provider Numbers. SANUS shall assist Practice in applying for, and shall use its reasonable efforts to assist Practice in obtaining and maintaining, in the name and at the expense of Practice all licenses, permits and Medicare and applicable Medicaid provider numbers required or appropriate in connection with the operation of the Clinic. Practice shall cooperate with SANUS in applying for, obtaining, and maintaining such licenses, permits and provider numbers. Without limiting the generality of the foregoing, Practice shall promptly execute and deliver any certificates, applications, and other documents necessary, appropriate or otherwise reasonably required in connection with the foregoing. It is expressly understood that SANUS shall have no liability to Practice if any such license, permit or provider number is not obtained or is not obtained as promptly as desired.

Section 2.9. Governmental Regulation.

(a) SANUS will assist Practice in taking such actions as shall be reasonably necessary to ensure that the operation of the Clinic by Practice and the provision of Services hereunder by SANUS complies with applicable federal, state and local laws, regulations and ordinances.

(b) SANUS will assist Practice, at the expense of Practice, in appealing or contesting any action taken by any governmental agency or authority against the Clinic or the Business, including, without limitation any overpayment claims, or contest by legal proceedings the validity of any statute, ordinance, law, regulation or order adverse to the Clinic or the Business; provided, however, that Practice shall adequately secure and protect SANUS from all loss, cost, damage or expense related thereto by bond or other means satisfactory to SANUS unless such action taken by any government agency or authority against the Clinic or the Business could result in a loss, cost, damage, or expense as to which SANUS must indemnify Practice under this Agreement, as determined by SANUS. Upon obtaining knowledge thereof, SANUS shall promptly notify Practice (and its members, partners or shareholders, as applicable) of any material legal action filed against Practice by any governmental agency or authority in connection with the Business, and SANUS shall have the right to directly participate in any such legal action if SANUS so desires.

Section 2.10. Legal Actions. SANUS will assist Practice in instituting, defending, appealing, mediating or arbitrating, at the expense of Practice, any and all legal actions or

proceedings with individuals, entities or governmental agencies or authorities relating to the operation of the Business, including, without limitation, to collect charges, or other sums due to Practice in connection with the Business, or lawfully cancel, modify, or terminate any Contract for the breach thereof or default thereunder by the other party or parties thereto. Upon obtaining knowledge thereof, SANUS shall promptly notify Practice (and its members, shareholders or partners, as applicable) of all material legal actions filed by or against Practice in connection with the Business, and SANUS shall have the right to directly participate in any such legal action if SANUS so desires.

Section 2.11. Annual Budgets. No later than thirty (30) days prior to the end of each calendar year, SANUS will prepare and deliver to Practice a proposed operating and capital budget for the next calendar year which will set forth in reasonable detail the cost of all goods, services and capital items by line item expected to be incurred in connection with the operation of the Clinic. As soon as practicable after any proposed budget is delivered to Practice, but no later than thirty (30) days after receipt by Practice, Practice will provide SANUS with its comments regarding the proposed budget. No later than thirty (30) days after receipt of Practice's comments regarding the budget, SANUS will respond to such comments. SANUS and Practice will use their reasonable best efforts to resolve any questions with respect to revisions to the proposed budget and to agree upon a budget for the year in question prior to the beginning of the year to which such budget relates. If the budget is not approved by Practice, then SANUS will continue to provide business services for the Clinic in a manner consistent with the prior year's budget, plus a consumer price index adjustment, and plus any adjustments to cover material changes in market labor rates. If any material change of circumstance occurs during any year that either SANUS or Practice (with notice thereof to SANUS) reasonably believes makes it necessary to increase in any material respect any line items in the budget for such year, then SANUS will prepare a proposed amended budget and will deliver it to Practice, at which time the procedures applicable to the approval of a budget described above will apply (as if such proposed amended budget were for the entire year). Practice hereby acknowledges that each budget sets forth the proposed operating targets and capital needs based on assumptions both parties deem reasonable.

Section 2.12. Other Acts and Expenditures. If and to the extent the parties determine and agree that it may be applicable to and beneficial to the Business, SANUS shall endeavor to provide the Business with or arrange for substantially the same services and techniques that SANUS employs in providing or arranging for services to other dental clinics affiliated with SANUS, all at Practice's expense.

ARTICLE III
RIGHT AND RESPONSIBILITIES OF PRACTICE

Without limiting the generality of Article I and the rights, duties, responsibilities and authority of Practice described in Article II, Practice shall have the following duties, responsibilities and authority:

Section 3.01. Practice of Dentistry. Practice is the owner, operator and proprietor of the dental practice located at the Clinic and shall be responsible for and have authority over the practice of dentistry at the Clinic. Practice shall be solely responsible for the employment and supervision of the Clinic's Clinical Staff, the delivery of professional services to the Clinic's patients, all decisions concerning the course of care and types of dental services to be provided to each Clinic patient, and all decisions concerning the drugs, equipment and supplies to be used in treating each Clinic patient. Practice shall also have authority over all non-clinical decisions pertaining to the management of the Business that represent the practice of dentistry, including, without limitation, the scheduling of the Clinic's patients and staff, decisions concerning the purchase of equipment, drugs and supplies for the Clinic as discussed in Section 2.02, and decisions concerning repairs and capital improvements.

Section 3.02. Operational Policies; Quality Control. Practice shall establish all operational policies and procedures reasonably necessary for establishing the appropriate standards of patient care at the Clinic. Practice shall maintain and update, as reasonably required, quality control programs for the Clinic, including written procedures for handling patient complaints. Said procedures shall meet the legal requirements of state and federal statutes and regulations applicable to the Clinic. SANUS will assist Practice in the foregoing, as requested.

Section 3.03. Right of Inspection. Practice shall have the right to examine, inspect and make copies, at its expense, of the books and records prepared with respect to the Business, but the same shall be done with as little disruption to the Business as possible. To ensure preservation of such books and records, Practice agrees that it will not remove any such books and records maintained at the Clinic without the express written consent of SANUS. Practice acknowledges that some books and records may be maintained at SANUS's principal place of business or elsewhere, and SANUS acknowledges that Practice shall have the right, at its expense, upon reasonable advance notice to SANUS and without disruption, to examine, inspect and make copies of such books and records during reasonable business hours.

Section 3.04. Designated Liaison Person. Practice shall direct all inquiries regarding operations, procedures, policies, employee relations and all matters concerning the Business (other than patient care) to such person as SANUS may from time to time designate.

Section 3.05. Cooperation with SANUS. Practice will fully cooperate with SANUS in connection with the operation and supervision of the Business, and the provision of Services hereunder by or on behalf of SANUS.

Section 3.06. Access to Required Capital. Practice shall provide SANUS with access to such amount of capital as may be required from time to time for the operation of the Business on a sound financial basis, including, without limitation, amounts required to pay for capital improvements in accordance with Section 2.03 above, and to pay the Management Fee (as the term is defined in Section 3.09 below), any other amounts due to SANUS under this Agreement, and all other amounts payable by Practice in accordance with this Agreement. If additional capital is required, SANUS shall notify Practice thereof in writing, and Practice shall provide SANUS with such capital within thirty (30) days thereafter. If Practice fails to provide such additional capital, SANUS may, in its sole and absolute discretion, but is not obligated to, provide the same as an advance to Practice in accordance with Section 3.08 below.

Section 3.07. Sweep Account and Operating Account.

(a) Practice shall open and maintain a bank account (the "Sweep Account") at a bank or other suitable financial institution (the "Depository") to be mutually agreed to by the parties. The sole signatories on the Sweep Account shall be one or more designated officers or employees of SANUS, as agents for Practice. Practice and SANUS shall cause all amounts received by or on behalf of Practice in connection with the operation, maintenance, or ownership of the Business (the "Collections") to be deposited in the Sweep Account; provided, however, if and to the extent permitted by applicable law, at the request of SANUS, the Collections, or any part thereof, shall be deposited into a separate account established and exclusively controlled by SANUS at the Depository (the "Operating Account"). Practice shall provide disposition instructions to the Depository to transfer, at the end of each business day during the Term of this Agreement, all amounts in the Sweep Account into the Operating Account. Except for the transfers to the Operating Account, Practice shall not remove, disburse, transfer, use, pledge, hypothecate, grant a lien on or security interest in, or otherwise encumber any funds in the Sweep Account during the Term of this Agreement. Practice shall execute such documents as the Depository or SANUS may reasonably require, including without limitation, a limited power of attorney, to permit the Depository to receive the Collections, endorse any checks, drafts, notes, money orders, cash, insurance payments, and other instruments relating to such Collections, deposit the Collections into the Sweep Account, and

to transfer the Collections each day from the Sweep Account into the Operating Account. Practice shall be responsible for all fees, costs and expenses incurred in connection with establishing and maintaining the Sweep Account and the Operating Account.

(b) SANUS is hereby authorized to make payment to itself and its Affiliates of any amounts due to it or any of them by Practice under this Agreement or otherwise, including, without limitation, the Management Fee, reimbursement of expenses and repayment of any advances, and Practice acknowledges that any amounts due to SANUS under this Agreement, including without limitation, any Management Fee, shall be of the same priority as, and shall not be subordinate to the payment of, any amount due to any other creditor of Practice.

(c) Within thirty (30) days after the end of each calendar month during the Term of this Agreement, SANUS shall transfer any funds in the Operating Account that remain after payment of Management Fees and expenses to SANUS and setting aside the amount of capital to which SANUS is to have access in accordance with Section 3.06 above, to such account as Practice may from time to time designate.

Section 3.08. Reimbursement of Expenses; Advances by SANUS.

(a) Except as otherwise expressly provided in this Agreement, Practice shall be solely, fully and individually financially responsible for all liabilities and expenses arising out of the ownership, operation or maintenance of the Business (including, without limitation, the Management Fee and any other amounts due to SANUS or any of its Affiliates in connection with this Agreement). Practice shall, on demand, reimburse SANUS for all costs, expenses and liabilities paid or satisfied by SANUS in connection with its performance of its obligations under this Agreement.

(b) If Practice fails to satisfy its obligations under Section 3.06 above at any time, SANUS may, in its sole and absolute discretion (it being understood that SANUS shall in no event be obligated to), advance to, or make payments on behalf of Practice all or any portion of the funds necessary to operate the Business, in which case SANUS shall be entitled to interest on such amount at the prime rate (as announced by SANUS's principal lending bank on the last day of the calendar month in which said payment is made), plus two percent (2%) per annum on the outstanding balance of funds owed to SANUS as a result of making such advances. If SANUS decides to advance funds to Practice, SANUS shall first promptly notify Practice that SANUS will be advancing funds to Practice. Practice shall repay any such advance on demand. Practice (or its members, partners or shareholders, as applicable) may prepay in whole or part any such advances without penalty or premium of any kind.

Section 3.09 Management Fee.

(a) As consideration for the services rendered by SANUS hereunder in connection with the Clinic, each calendar month during the Term of this Agreement Practice shall pay to SANUS a fee (the "Management Fee") equal to the greater of: (i) One Hundred Seventy-Five Thousand Dollars ($175,000) per month, or (ii) forty percent (40%) of the Gross Revenues (as defined below) of the Clinic, or (iii) one hundred percent (100%) of the Residual (as defined below), during such calendar month.

(b) For purposes of this Agreement:

(i) "Gross Revenues" shall mean all fees and charges recorded or booked on an accrual basis each month by or on behalf of Practice as a result of dental services furnished to patients by or on behalf of Practice or the Clinic, less a reasonable allowance for uncollectible accounts, professional courtesies and discounts.

(ii) "Residual" shall mean (x) the Gross Revenues and income of any kind derived, directly or indirectly, from the Business during such calendar month, based on the net amount actually collected after taking into account all refunds, allowances, and discounts, less (y) Practice operating expenses, including depreciation, amortization, interest, insurance premiums and compensation and benefits of Practice's employees and staff, all as determined on the cash method of accounting, but excluding the Management Fee payable to SANUS.

(c) Payment of the Management Fee for each calendar month shall be made by the tenth (10th) business day of the following calendar month. SANUS is expressly authorized to make such payment to itself on behalf of the Practice out of the Operating Account.

(d) Payment of the Management Fee is not, and shall not be interpreted, construed or applied as, permitting SANUS to share in Practice's fees from the provision of dental services, but is acknowledged as the parties' negotiated agreement as to the reasonable fair market value of the Services and other items furnished or made available by SANUS pursuant to this agreement, to reasonably compensate SANUS for the services to be provided hereunder, the capital that may be made available hereunder and the considerable business risk assumed by SANUS in providing the items and services that are the subject of this Agreement. The parties acknowledge that: (i) SANUS's administrative expertise will contribute value to the performance of the Clinic; (ii) SANUS will incur substantial costs and business risks in providing or arranging for the Services that are the subject matter of this Agreement; and (iii) certain of such costs and expenses can vary to a considerable degree according to the extent of SANUS's services.

Section 3.10. Accounts Receivable; Security Interest. To secure the timely and complete payment, repayment or reimbursement, as applicable, of the Management Fee, expenses, loans, advances or other amounts owing or payable to SANUS under this Agreement, throughout the term of this Agreement Practice hereby assigns and grants to SANUS a first-priority security interest in all of the present and future accounts receivable, rights to payment and other accounts (as such term is defined in the Uniform Commercial Code) ("Accounts Receivable"), including, without limitation health-care insurance receivables (as defined in the Uniform Commercial Code), and any proceeds, substitutes or replacements for any of the foregoing, that arise or have arisen from the operation of the Business, including, without limitation, the provision of dental treatment and services at or through the Clinic, as well as all equipment, inventory, furniture and fixtures and other assets held by Practice and used in connection with the Business (but excluding patient records, patient contracts, provider agreements, employment agreements and independent contractor agreements with Clinical Staff and other property that SANUS is prohibited from owning under applicable law, and excluding property that is the subject of a lien or securing purchase money indebtedness pursuant to documents that prohibit Practice from granting any other liens in such property, and leases, licenses or other contracts if the grant of such security interest is prohibited by the terms of such lease, license or contract or by applicable law and would result in the termination of such lease, license or contract or give the other parties thereto the right to terminate, accelerate or otherwise adversely alter Practice's rights, titles and interests thereunder), and in all of Practice's rights, title and interest in the foregoing. Practice represents and warrants that all such Accounts Receivable and other assets are and will be free and clear of all liens, security interests and other encumbrances and adverse claims, and covenants that Practice shall not transfer, assign, sell, pledge, encumber or factor any such Accounts Receivable and other assets (in each case except for the interest granted to SANUS herein). In the event any of such monetary obligations are not paid to SANUS in full when due, SANUS may, with or without terminating this Agreement, exercise all rights and remedies afforded a secured party. Practice agrees to cooperate with SANUS, and, upon request, to promptly execute, complete and deliver to SANUS all security agreements, financing statements or other documents which may be necessary or desirable to protect, perfect or maintain SANUS's interest in such Accounts Receivable and other assets. SANUS shall be entitled at any time to file any financing statement in any jurisdiction to perfect such interest.

ARTICLE IV
EMPLOYEE ISSUES

Section 4.01. Employees of the Practice.

(a) Practice agrees that Practice shall be solely responsible for the wages, benefits, employment taxes, unemployment taxes, workers compensation insurance and benefits, and any and all other costs or liabilities associated with or arising out of the employment of Practice employees (including, without limitation, the Clinical Staff), and in no event shall SANUS have any responsibility or liability with respect to such matters. Practice further agrees that it shall be solely responsible for supervising the compliance of Practice employees with any and all internal policies and applicable regulations or laws (whether statutory, common law or otherwise), and in no event shall SANUS have any responsibility or liability with respect to such matters. To the extent that any individual or entity seeks to hold SANUS, or any member, shareholder, director, officer, manager, employee, agent or Affiliate of SANUS (all such parties hereinafter referred to collectively as the "SANUS Parties") in any way responsible or liable for any of the foregoing items provided in this Section 4.01(a) for which Practice is solely responsible, Practice agrees to indemnify and hold harmless the SANUS Parties pursuant to Section 6.02 below.

(b) Practice shall comply with all ethical standards, laws and regulations applying to the dental profession. Practice shall ensure that all Practice employees who are dentists and providing services at the Clinic in such capacity:

(i) hold an unrestricted license to practice dentistry in the State of New Mexico;

(ii) hold an unrestricted prescription writing authority from the Federal Drug Enforcement Agency ("DEA") in the form of an active DEA number;

(iii) hold and maintain an unrestricted New Mexico Medicaid provider number; and

(iv) be in good standing with the New Mexico Board of Dental Examiners.

Section 4.02. Employees of SANUS.

(a) SANUS agrees that it shall be solely responsible for the wages, benefits, employment taxes, unemployment taxes, workers compensation insurance and benefits, and any all other costs or liabilities associated with or arising out of the employment of SANUS employees, except as provided in Section 2.01(d) hereof. SANUS further agrees that it shall be solely responsible for supervising the compliance of SANUS employees with any and all applicable regulations or laws (whether statutory, common law or otherwise), and in no event shall Practice have any responsibility or liability with respect to such matters. To the extent that any individual or entity seeks to hold Practice, its shareholders, officers, directors, employees or agents (all such parties hereinafter referred to collectively to as the "Practice Parties") in any way responsible or liable for any of the foregoing items, SANUS agrees to indemnify and hold harmless the Practice Parties pursuant to Section 6.01 below.

(b) SANUS shall not provide to Practice the services of any dentists, dental hygienists, dental assistants, dental technicians and other auxiliary or extender employees, or similar employees involved in the provision of dental or clinical services at the Clinic, and SANUS shall not have any responsibility to employ, loan funds or otherwise compensate any such individuals.

ARTICLE V
PROPERTY RIGHTS AND CONFIDENTIALITY

Section 5.01. Management Information. In recognition of the confidential and proprietary nature of the information and materials which will be provided to Practice by SANUS, including without limitations, the methods, protocols, manuals, software and related materials provided by SANUS to or for the benefit of Practice and Clinic (collectively, the "Management Information"), Practice agrees to retain in confidence, and to require the other Practice Parties to retain in confidence, all Management Information, and further agrees that it will not disclose to any third party, or permit the use or disclosure to any third party of any Management Information obtained from or revealed by SANUS in the provision of the Services herein, except that Practice may disclose the information to those of the other Practice Parties who need the information for the proper performance of their assigned duties with respect to the operation of the Clinic. In making such information available to the other Practice Parties, Practice shall take reasonable precautions to ensure that all Management Information is used only as permitted by this Agreement and authorized by SANUS. All Management Information shall remain the sole and exclusive property of SANUS. Immediately after termination of this Agreement, Practice shall return to SANUS all Management Information in the possession of Practice, and not retain any copies thereof.

Notwithstanding anything to the contrary in the foregoing provisions, the Management Information may be disclosed (i) if required by any regulatory authorities or governmental agencies; (ii) if required by court order or decree or in the opinion of the Practice's counsel, applicable law; (iii) if the Management Information is obtainable from public or published information; or (iv) if required to establish or defend a claim against or by disclosing party. If Practice or any Practice Parties shall be required to make disclosure of any Management Information pursuant to (i) or (ii) above, such disclosing party shall give SANUS prior notice of the making of such disclosure and shall use all reasonable efforts to afford SANUS an opportunity to contest the making of such disclosure.

Section 5.02. Clinic Records. All business and medical records and information relating to the provision of dental services by Practice at or in connection with the Clinic and payment for such services including, but not limited to, books of accounts, general administrative records, patient medical records, and all information generated and/or contained in management information systems owned by Practice and all systems, manuals, computer software and other materials not provided by SANUS (collectively, the "Clinic Records") shall be and remain the sole and exclusive property of Practice. SANUS acknowledges that the Clinic Records and all other information regarding the Clinic that is competitively sensitive are the property of Practice and Practice would be damaged if such information were revealed to a third party. Accordingly, SANUS agrees to keep strictly confidential and not disclose to any third party Clinic Records, except that SANUS may disclose the information to those of the other SANUS Parties who need the information in connection with the provision of Services (subject to any restrictions or prohibitions under the Health Insurance Portability and Accountability Act of 1996 and the rules and regulations issued pursuant thereto ("HIPAA") and other applicable law). Immediately after termination of this Agreement, SANUS shall return to Practice all Clinic Records in the possession of Practice, and not retain any copies thereof.

Notwithstanding anything to the contrary in the foregoing provisions, the Clinic Records may be disclosed (i) if required by any regulatory authorities or governmental agencies; (ii) if required by court order or decree or in the opinion of the Practice's counsel, applicable law; or (iii) if the Clinic Records are obtainable from public or published information. If SANUS or any SANUS Parties shall be required to make disclosure of any Clinic Records pursuant to (i) or (ii) above, such disclosing party shall give Practice prior notice of the making of such disclosure and shall use all reasonable efforts to afford Practice an opportunity to contest the making of such disclosure.

Section 5.03. Equitable and Legal Remedies. In the event Practice or SANUS breaches any provision of this Article V, the other party shall be entitled to seek and obtain immediate and permanent injunctive and other relief including, but not limited to, temporary restraining orders

and/or preliminary injunctive relief to restrain or enjoin any such breach. These remedies are in addition to all other legal relief for damages available to Practice and SANUS, including, without limitation, court costs, attorneys' fees and expenses of pursuing available remedies.

Section 5.04. HIPAA Compliance. The parties mutually agree that each party shall comply with the applicable requirements of HIPAA and the "HIPAA Business Associate Addendum" attached as Exhibit A hereto and incorporated herein by reference as if set forth in full herein.

Section 5.05. Survival. The terms of this Article V shall survive termination of this Agreement.

ARTICLE VI
INDEMNIFICATION

Section 6.01. Indemnification by SANUS. SANUS shall indemnify, defend and hold harmless the Practice Parties from and against any and all loss, damage, claim, obligation, liability, cost and expense (including, without limitation, reasonable attorneys' fees and costs and expenses incurred in investigating, preparing, defending against or prosecuting any litigation, claim, proceeding or demand), of any kind or character (a "Loss"), arising out of or in connection with any of the following:

(a) any intentional or negligent act or intentional or negligent omission of SANUS or any of the SANUS Parties;

(b) the matters defined as SANUS's responsibilities as provided in Section 4.02 hereof; or

(c) SANUS's breach of any provision of this Agreement.

Section 6.02. Indemnification by Practice. Practice shall indemnify, defend and hold harmless the SANUS Parties from and against any Loss arising out of or in connection with any of the following:

(a) any intentional or negligent act or intentional or negligent omission of Practice or the Practice Parties; or

(b) the matters defined as Practice's responsibilities as provided in Section 4.01 hereof; or

(c) Practice's breach of any provision of this Agreement, including but not limited to, any failure to pay any amount due SANUS hereunder; or

(d) SANUS acting within the scope of authority granted to it under the terms and conditions of this Agreement.

Section 6.03. Notice of Claim. Any party seeking to be indemnified hereunder (the "Indemnified Party") shall notify, within ten (10) business days of incurring any Loss or receiving any threat of a Loss, the party from whom indemnity is sought (the "Indemnity Obligor") in writing of any claim for recovery, specifying in reasonable detail the nature of the Loss. The Indemnified Party shall provide to the Indemnity Obligor as promptly as practicable thereafter all information and documentation reasonably requested by the Indemnity Obligor to verify the claim asserted.

Section 6.04. Defense. If the facts pertaining to a Loss arise out of the claim of any third party, or if there is any claim against a third party available of the circumstances of the Loss, the Indemnity Obligor may, by giving written notice to the Indemnified Party within fifteen (15) days

following its receipt of the notice of such claim, elect to assume the defense or the prosecution of such claim, including the employment of counsel or accountants at its cost and expense. The Indemnified Party shall have the right to employ counsel separate from counsel employed by the Indemnity Obligor in any such action and to participate in such action, but the fees and expenses of such counsel shall be at the Indemnified Party's own expense. Whether or not the Indemnity Obligor chooses so to defend or prosecute such claim all the parties to this Agreement shall cooperate in the defense or prosecution of such claim and shall furnish such records, information and testimony and shall attend such conferences, discovery proceedings and trials as may be reasonably requested in connection therewith.

Section 6.05. Time for Claims. Any claim asserted must be submitted to the Indemnity Obligor in writing, or invoked in official proceedings, not later than three (3) years following the expiration of the term of this Agreement; provided, that claims for Losses associated with the rendition of dental care (or failure to provide such care) shall survive until thirty (30) days past the lapse of all applicable periods of limitation or repose.

Section 6.06. Limitation. Except to the extent included in a claim by a third party, Loss shall not include, and no Indemnity Obligor shall have any liability hereunder or pursuant to any other theory or claim for, an Indemnified Party's consequential, incidental, special, indirect, cover or exemplary damages or lost sales or lost profits.

Section 6.07. Survival. The terms of this Article VI shall survive termination of this Agreement.

ARTICLE VII
ADDITIONAL CLINICS

During the Term of this Agreement, if Practice decides to construct, establish or purchase any additional clinic, location or dental practice (each, an "Additional Clinic"), then Practice shall first provide SANUS with written notice that Practice is constructing, establishing or acquiring an Additional Clinic and the location and other material information regarding such Additional Clinic. SANUS shall have both the exclusive right and the obligation to provide Services for each Additional Clinic pursuant to a separate agreement that is substantially similar to the same terms and conditions set forth in this Agreement.

ARTICLE VIII
TERM/TERMINATION

Section 8.01. Term. The term of this Agreement shall commence effective as of the date hereof and shall continue in perpetuity until terminated as permitted in accordance with Section 8.02 hereof (the "Term"). Any provision of this Agreement, which by its terms so provides shall survive the termination of this Agreement. Upon any termination of this Agreement, Practice shall immediately pay or repay SANUS all Management Fees, expense reimbursement, advances, loans and other amounts then owed to SANUS or its affiliates.

Section 8.02. Termination. This Agreement may be terminated only as follows:

(a) By the mutual written agreement of Practice and SANUS;

(b) By either Practice or SANUS in the event the other party makes an assignment for the benefit of creditors or files any petition for reorganization or voluntary bankruptcy, or is adjudicated bankrupt or insolvent, or if any receiver is appointed for its business or property, or if any trustee in bankruptcy or insolvency is appointed; or

(c) Immediately by either Practice or SANUS in the event of the other party's material breach of any term of this Agreement; provided however, that the terminating party shall have notified the other party in writing of the alleged breach and such other party shall have failed to cure such breach within ninety (90) days after such written notice is given. Notwithstanding the immediately preceding sentence, SANUS shall also have the right to terminate the Agreement immediately if Practice breaches the terms of Section 3.09 and fails to cure such breach within five (5) days after SANUS gives written notice to Practice of such breach.

ARTICLE IX
MISCELLANEOUS

Section 9.01. Notices. All notices, demands and other communications made hereunder shall be in writing and shall be given either by personal delivery, by nationally recognized overnight courier (with charges prepaid), and shall be deemed to have been given or made when personally delivered, the day following the date deposited with such overnight courier service or when transmitted to facsimile machine and confirmed by telephone, addressed as follows:

If to SANUS: Sanus Holdings, LLC
1114 17th Avenue South, Suite 201
Nashville TN 37212
Fax No. [redacted]
Attention: Chief Executive Officer

with a copy to: Waller Lansden Dortch & Davis, LLP
Nashville City Center
511 Union Street, Suite 2700
Nashville, TN 37219
Fax No. [redacted]
Attention: [redacted] Esq.

If to Practice: Small Smiles Dentistry for Children, Albuquerque, P.C.
111 Coors Blvd NW #E-6
Albuquerque, NM 87121

or to such other address, and to the attention of such other person or officer as any party may designate.

Section 9.02. Referral Prohibition. SANUS shall not, directly or indirectly, refer, or arrange for the referral of, patients to the Clinic during the term of this Agreement.

Section 9.03. Modification. This Agreement may not be modified or terminated orally, and no modification, termination or attempted waiver shall be valid unless in writing signed by the authorized representative of the party against whom the same is sought to be enforced.

Section 9.04. Severability. If any provision of this Agreement is determined to be invalid or unenforceable, such invalidity or unenforceability shall not affect the validity or enforceability of any other provisions hereof that can be given effect without the invalid or unenforceable provision, and all unaffected provisions of this Agreement shall remain in full force and effect as if this Agreement has been executed without such invalid or unenforceable provision.

Section 9.05. Benefit. This Agreement shall be binding upon and inure to the benefit of the parties hereto, their successors and assigns.

Section 9.06. Assignment. Neither this Agreement nor any interest herein may be assigned in whole or in part, by either party, without obtaining the prior written consent of the other

party; provided, however, that SANUS may assign, delegate, transfer or convey its rights, benefits and/or obligations hereunder to a parent, subsidiary or Affiliate thereof or to an entity into which SANUS is merged or with which SANUS is consolidated or to a purchaser of all or substantially all of its assets or as part of a corporate reorganization, and SANUS may collaterally assign its rights and benefits hereunder to any lender, for security purposes or as collateral, from which SANUS or its Affiliate obtains financing. A merger, consolidation, change in owners or controlling members, or other reorganization by SANUS shall not be deemed to constitute an assignment of this Agreement.

Section 9.07. Headings; Interpretation. The article and section headings contained in this Agreement are solely for the purpose of reference, are not part of this Agreement and shall not in any way affect the meaning or interpretation of this Agreement. The language in all parts of this Agreement shall be construed, in all cases, according to its fair meaning. The parties acknowledge that each party has reviewed this Agreement and had the opportunity to have it reviewed by their respective counsel, and that the normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Agreement. As used in this Agreement, the term "person" shall mean and include an individual, partnership, joint venture, corporation, limited liability company, trust, unincorporated organization and governmental authority, or any other form of entity; (b) "Affiliate" shall mean any person that, directly or indirectly through one or more intermediaries, Controls, is Controlled by, or is under common Control with another person; (c) "Control" (including the terms "Controlled by" and "under common Control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management policies of a person or entity, whether through the ownership of voting securities, by contract, credit arrangement, as trustee, as executor or otherwise.

Section 9.08. Recitals. The recitals set forth at the beginning of this Agreement are incorporated by reference in, and made part of, this Agreement.

Section 9.09. Requirements for Records Access. SANUS agrees that it shall make available, upon written request of the Secretary of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, this Agreement and any books, documents or records of SANUS as are necessary to certify the nature and extent of the cost of Services provided hereunder, and if SANUS shall carry out any of the duties of this Agreement through a subcontractor with a value of or cost of $10,000.00 or more over a twelve (12) month period, such subcontract shall contain this same requirement. Practice and SANUS agree to notify the other in writing within ten (10) days of the receipt of a request for record access.

Section 9.10. Taxes. Each party shall be responsible for payment of any and all federal, state, local and other taxes which may arise or be imposed as the result of its performance under this Agreement or as the result of the receipt of any compensation or other funds under this Agreement or in connection with the transactions contemplated hereby, if any.

Section 9.11. Legislative/Regulatory Compliance and Modification. The parties hereby agree to each comply with all applicable laws, rules, regulations, licenses, certificates and authorization of any governmental body or authority in the performance or carrying out of its obligations under this Agreement. Each party will obtain and maintain current and in force all licenses, certifications, authorizations and/or permits (and will pay fees therefor) necessary to carry out its duties and responsibilities under this Agreement. In the event any Medicaid law, rule, regulation or payment policy, or any other federal, state or local law, rule, regulation, policy, or any interpretation thereof at any time during the term of this Agreement, is modified, implemented, threatened to be implemented, or determined to prohibit, restrict or in any way materially change the method or amount of reimbursement or payment for Services under this Agreement, or for services to patients of the Clinic as a result of this Agreement or by virtue of the existence of this Agreement, or which indicates that the terms or structure of this Agreement may be in violation of such laws, and which has or is reasonably likely to have a materially adverse effect on the ability of Practice or SANUS to engage in any commercial activity on terms at least as favorable as those

reasonably attributable as of the date hereof (all of the foregoing being hereinafter collectively referred to as a "Change"), then the parties to this Agreement shall negotiate in good faith to amend this Agreement to preserve the underlying economic and financial arrangements between the parties under this Agreement to the greatest extent possible in a manner consistent with any such Change. In addition, if a court or other governmental authority of competent jurisdiction makes a final decision that any term of this Agreement causes SANUS to engage in the practice of dentistry, as defined under the laws of the State of New Mexico, or to otherwise violate the statutes, regulations and other laws governing the practice of dentistry in the State of New Mexico, or if legal counsel to Practice and SANUS mutually conclude the same, then the parties to this Agreement shall negotiate in good faith to amend this Agreement to preserve the underlying economic and financial arrangements between the parties under this Agreement to the greatest extent possible in a manner consistent with any such decision, determination or mutual conclusion, and pending the effectiveness of any such amendment, such term shall be deemed waived and unenforceable and its non-performance shall not constitute a breach or default of this Agreement.

Section 9.12. Governing Law. This Agreement shall be governed by the laws of the State of Tennessee, without giving effect to the principles of choice of law thereof. This Agreement and its subject matter have substantial contacts with Tennessee, and, subject to Section 9.20 hereof, all actions, suits, or other proceedings with respect to this Agreement shall be brought only in a court of competent jurisdiction sitting in Davidson County, Tennessee, or in the U.S. District Court for the Middle District of Tennessee. In any such action, suit, or proceeding, such court shall have personal jurisdiction of all of the parties hereto, and service of process upon them under any applicable statutes, laws and rules shall be deemed valid and good.

Section 9.13. Entire Agreement. This Agreement constitutes the entire agreement between the parties pertaining to the subject matter contained herein, and supersedes all prior and contemporaneous agreements and understandings between the parties, whether oral or in writing, with respect to such subject matter.

Section 9.14. Subcontract Rights. SANUS shall have the unlimited right to subcontract all, or any portion of, its obligations under the terms of this Agreement upon providing prior written notice to Practice of its intent to subcontract such obligations. SANUS's subcontract of any obligations hereunder shall not relieve SANUS of any obligations owed to Practice under the terms of this Agreement.

Section 9.15. SANUS References. All references to "SANUS" included in this Agreement shall mean and include SANUS Holdings, LLC and/or any designee or subcontractor thereof; provided however, that reference to SANUS in Section 3.09 of this Agreement shall mean and include only SANUS Holdings, LLC.

Section 9.16. Attorneys' Fees. In any civil action, arbitration or other proceeding brought to enforce the terms hereof, or to redress a breach of a term hereof, the prevailing party shall be entitled to payment from the non-prevailing party of its reasonable attorneys' fees and expenses in addition to any damages or other relief to which it may become entitled.

Section 9.17. Arms-Length Bargaining. The parties agree that the compensation provided herein has been determined in arm's-length bargaining and is consistent with fair market value in arm's-length transactions and is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to the Clinic or between the parties or any of the undersigned persons or equity holders thereof for which payment may be made in whole or in part under Medicare or any state health care program or under any other payor program.

Section 9.18. Counterparts. The parties may execute this Agreement in two (2) or more counterparts, which shall, in the aggregate, be signed by all the parties; each counterpart shall be

deemed an original instrument as against any party who has signed it. Copies of signatures sent by facsimile transmission shall be deemed to be originals for all purposes of this Agreement.

Section 9.19. Waiver of Jury Trial. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHTS IT MAY HAVE TO DEMAND THAT ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE RELATIONSHIPS OF THE PARTIES HERETO BE TRIED BY JURY. THIS WAIVER EXTENDS TO ANY AND ALL RIGHTS TO DEMAND A TRIAL BY JURY ARISING FROM ANY SOURCE INCLUDING, BUT NOT LIMITED TO, THE CONSTITUTION OF THE UNITED STATES OR ANY STATE THEREIN, COMMON LAW OR ANY APPLICABLE STATUTE OR REGULATIONS. EACH PARTY HERETO ACKNOWLEDGES THAT IT IS KNOWINGLY AND VOLUNTARILY WAIVING ITS RIGHT TO DEMAND TRIAL BY JURY.

Section 9.20. Dispute Resolution. In the event that a dispute arises between the parties under this Agreement, the parties agree not to institute legal proceedings against each other except as provided in this Section, except for an action to seek injunctive relief to prevent or stay a breach of any provision of this Agreement.

(a) If the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by the American Arbitration Association ("AAA") under its Commercial Mediation Rules (the "Rules") before resorting to other dispute resolution procedure. The mediation process shall be initiated by either party giving written notice to the other party of its desire to mediate. Mediation shall take place in Nashville, Tennessee with a mediator chosen in accordance with the listing procedures and Rules of AAA. Each party shall bear its own costs and expenses and an equal share of the mediator's fees and administrative fees of mediation, if any. The mediator shall determine the format for the meetings, and the mediation session shall be private. The mediator will keep confidential all information learned in private caucus with any party unless specifically authorized by such party to make disclosure of the information to the other party. The parties agree that the mediation shall be governed by such rules as the mediator shall prescribe. If the mediator does not prescribe rules, the mediation shall be governed by the relevant provisions of Tennessee law. The mediator shall be disqualified as a witness, expert or counsel for any party with respect to the dispute and any related matters. The entire mediation process is confidential, and such conduct, statements, promises, offers, views and opinions shall not be discoverable or admissible in any legal proceeding for any purpose; provided, however, that evidence which is otherwise discoverable or admissible is not excluded from discovery or admission as a result of its use in the mediation. Both parties agree to participate in the mediation to its conclusion, which shall occur upon the earlier of (i) the execution of a settlement agreement by the parties, or (ii) a declaration of the mediator that mediation is terminated, which shall, unless the parties agree otherwise, be at the conclusion of at least two (2) full days of mediation.

(b) Any controversy or claim arising from or relating to this Agreement or any other agreement between or among any of the parties hereto or the breach of any such agreement that is not resolved through such mediation or negotiation between the parties, shall be settled by arbitration. The arbitration process shall be initiated by either party giving written notice to the other party of its desire to arbitrate. Such arbitration shall be conducted in Nashville, Tennessee, and in accordance with the Commercial Arbitration Rules of the American Arbitration Association, as such rules shall be in effect on the date of delivery of demand for arbitration. The arbitration will be before one neutral arbitrator to be selected by the American Arbitration Association in accordance with its Commercial Arbitration Rules. The arbitrator shall be selected from a panel of persons listed with the American Arbitration Association. The arbitrator shall establish a limited time period for discovery and procedures designed to reduce the cost and time for discovery while allowing the parties an opportunity, in the discretion of the arbitrator, to discover relevant information from the opposing party about the subject matter of the dispute. Any dispute regarding discovery, or the relevance or scope thereof, shall be determined by the arbitrator and shall be governed by the Federal Rules of Civil

Procedure. The arbitration award shall be in writing and shall specify the factual and legal bases for the award. The arbitrator shall have the authority to award any remedy or relief that a court could order or grant, including without limitation, specific performance of any obligation created under any agreement between or among the parties; provided, however, that the mediator shall have no authority to award punitive or other damages not measured by the prevailing party's actual damages, except as may be required by statute. In addition to any other awards, the arbitrator shall award to the prevailing party, if any, as determined by the arbitrator, all of the prevailing party's costs and fees, "Costs and fees" shall include all reasonable pre-award expenses of the mediation, including the arbitrator's fees, administrative fees, the cost of posting a bond (if posted by the prevailing party), travel expenses, out-of-pocket expenses such as copying and telephone, court costs, witness fees and reasonable attorneys' fees. Statements made by any party or any party's representative during the arbitration shall be deemed confidential and no party or party's representative will attempt to use any such statement as evidence in any court or other legal proceeding. The parties also agree and acknowledge that the arbitrator shall not be subject to subpoena to trial or deposition by any party for the purpose of divulging statements made or information disclosed by any party or witness in the arbitration proceedings. The parties further agree that and acknowledge that the arbitrator shall not disclose any matter learned in the arbitration proceedings unless given permission by all of the parties or unless required by law. Arbitration of such issues, including the determination of the amount of any damages suffered by any party, shall be to the exclusion of any court of law and the decision of the arbitrator shall be final and binding upon the parties and their respective personal representatives, heirs, devisees, successors and assignees. Judgment on the award entered by the arbitrator may be entered in and enforced by any court of competent jurisdiction.

(c) Notwithstanding the foregoing provisions to the contrary, nothing in this Section shall be construed to require a party to mediate or arbitrate prior to seeking or receiving equitable or injunctive relief that is necessary to protect the rights or property of that party from irreparable damage or harm, pending the mediated determination of the controversy, and each of the parties shall be entitled to an injunction or injunctions or other equitable relief to prevent breaches of this Agreement and to enforce specifically the terms and provisions thereof, this being in addition to any other remedy to which they are entitled, without submitting such action to mediation or arbitration.

[The remainder of this page is intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, each of the parties has caused this Agreement to be signed by its duly authorized representative, as of the date first set forth above.

"PRACTICE"

SMALL SMILES DENTISTRY FOR CHILDREN, ALBUQUERQUE, P.C.

[redacted]

Title: PRESIDENT

"SANUS"

SANUS HOLDINGS, LLC

By: [redacted]

Title: Chairman + CEO

EXHIBIT A

HIPAA BUSINESS ASSOCIATE ADDENDUM

1. Definitions. For the purposes hereof, the following definitions apply:

"Agreement" shall mean the Management Services Agreement between SANUS and Practice to which this Exhibit is attached.

"Electronic Protected Health Information" shall have the meaning set forth in 45 CFR 160.103.

"Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

"Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

"Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by SANUS from or on behalf of Practice.

"Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

"Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

"Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in SANUS's information system.

Terms used, but not otherwise defined, in this Exhibit shall have the same meaning as those terms in the Agreement.

2. Obligations and Activities of SANUS.

(a) SANUS agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement and this Exhibit or as Required By Law.

(b) SANUS agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Exhibit.

(c) SANUS agrees to mitigate, to the extent practicable, any harmful effect that is known to SANUS of a use or disclosure of Protected Health Information by SANUS in violation of the requirements of this Exhibit.

(d) SANUS agrees to report to Practice any use or disclosure of the Protected Health Information not provided for by this Exhibit of which it becomes aware

(e) SANUS agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by SANUS on behalf of Practice agrees to the same restrictions and conditions that apply through this Exhibit to SANUS

with respect to such information, including the implementation of reasonable and appropriate safeguards to protect Protected Health Information.

(f) SANUS agrees to provide access, at the request of Practice, upon reasonable advance written notice, to Protected Health Information in a designated record set, to Practice Entity or, as directed by Practice, to an Individual in order to meet the requirements under 45 CFR 164.524.

(g) SANUS agrees to make any amendment(s) to Protected Health Information in a designated record set that Practice directs or agrees to pursuant to 45 CFR 164.526 at the request of Practice or an Individual, upon reasonable advance written notice by Practice.

(h) SANUS agrees to make internal practices, books and records, and policies and procedures relating to Protected Health Information and the use and disclosure of Protected Health Information available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Practice's compliance with the Privacy Rule.

(i) SANUS agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Practice to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

(j) SANUS agrees to provide to Practice or an Individual, upon reasonable prior written request, information collected in accordance with Section 2(i) of this Exhibit, to permit Practice to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

(k) SANUS agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of Practice.

(l) SANUS agrees to report to the Practice any Security Incident of which it becomes aware.

3. Permitted Uses and Disclosures by SANUS.

(a) Except as otherwise limited in this Exhibit, SANUS may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Practice as provided for in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Practice or the minimum necessary policies and procedures of Practice.

(b) Except as otherwise limited in this Exhibit, SANUS may use Protected Health Information for the proper management and administration of SANUS or to carry out the legal responsibilities of the SANUS.

(c) Except as otherwise limited in this Exhibit, SANUS may use Protected Health Information to provide data aggregation services to Practice as permitted by 42 CFR 164.504(e)(2)(i)(B).

(d) SANUS may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with Sec. 164.502(j)(1).

4. Obligations of Practice.

(a) Practice shall notify SANUS of any limitation(s) in its notice of privacy practices of Practice in accordance with 45 CFR 164.520, to the extent that such limitation may affect SANUS's use or disclosure of Protected Health Information.

(b) Practice shall notify SANUS of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes may affect SANUS's use or disclosure of Protected Health Information.

(c) Practice shall notify SANUS of any restriction to the use or disclosure of Protected Health Information that Practice has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect SANUS's use or disclosure of Protected Health Information.

5. Permissible Requests by Practice. Practice shall not request SANUS to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Practice.

6. Term.

(a) The term of this Exhibit shall be effective as of the effective date of the Agreement and shall terminate when all of the Protected Health Information provided by Practice to SANUS, or created or received by SANUS on behalf of Practice, is destroyed or returned to Practice, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section. Except as provided in Section 6(b) below, upon termination of the Agreement for any reason, SANUS shall return or destroy all Protected Health Information received from Practice, or created or received by SANUS on behalf of Practice. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of SANUS. SANUS shall retain no copies of the Protected Health Information, except to the extent provided for in Section 6(b) below.

(b) In the event that SANUS determines that returning or destroying the Protected Health Information is infeasible, SANUS shall provide to Practice written notification of the conditions that make return or destruction infeasible. Upon SANUS's provision of written notification to Practice that return or destruction of Protected Health Information is infeasible, SANUS shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as SANUS maintains such Protected Health Information.

7. Miscellaneous.

(a) A reference in this Exhibit to a section in the Privacy Rule means the section as in effect or as amended.

(b) The Parties agree to take such action as is necessary to amend this Exhibit from time to time as is necessary for Practice to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(c) The respective rights and obligations of SANUS under Section 6(b) of this Exhibit shall survive the termination of the Agreement.

(d) Any ambiguity in this Exhibit shall be resolved to permit Practice to comply with the Privacy Rule.

ADDENDUM
TO
AMENDED AND RESTATED MANAGEMENT SERVICES AGREEMENT
Albuquerque, New Mexico

This Addendum ("Addendum") to that certain Amended and Restated Management Services Agreement, dated as of September 26, 2006 (the "Agreement"), is made and entered into as of December 5, 2008, by and between FORBA Holdings, LLC, a Delaware limited liability company ("FORBA"), and Small Smiles Dentistry for Children, Albuquerque, P.C., a New Mexico Professional Corporation ("Practice").

WHEREAS, the parties desire to enter into this Addendum to promote compliance with the statutes, regulations, and written directives of Medicaid, Medicare, and all other State and Federal health care programs applicable to FORBA and Practice ("Health Care Program Requirements").

NOW, THEREFORE, in consideration of the foregoing and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. Notwithstanding anything in the Agreement to the contrary, Practice agrees that, at all times during the term of the Agreement, it shall fully comply, and shall require its owners, officers, dentists and other employees ("Covered Persons") to fully comply, with the applicable requirements of any compliance programs ("Compliance Programs") and Corporate Integrity Agreements ("CIAs") established by and/or entered into by FORBA with the Office of Inspector General (OIG) of the United States Department of Health and Human Services and/or any State regulatory agency relating to Health Care Program Requirements, and all applicable policies and procedures adopted by FORBA in order to implement the requirements of all such Compliance Programs and CIAs ("Policies and Procedures").

2. Practice agrees that a breach by Practice or any Covered Person of the applicable requirements of any Compliance Programs, CIA and/or Policies and Procedures shall be considered a material breach of the Agreement by Practice.

3. Practice agrees that, in the event of any conflicts between the terms of the Agreement and the applicable terms of any Compliance Programs, CIA and/or Policies and Procedures, the applicable terms of the Compliance Programs, CIA and/or Polices and Procedures shall control.

4. The Agreement is hereby amended in accordance with the foregoing provisions of this Addendum. The Agreement, as amended as provided herein, is hereby ratified and shall remain in full force and effect.

5. This Addendum may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

[The remainder of this page is intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, the parties hereto have executed this Addendum as of the date first written above.

[redacted], CEO

Small Smiles Dentistry for Children, Albuquerque, P.C.

By: [redacted]
Vice President and Secretary

COUNTERPART SIGNATURE PAGE
TO
MANAGEMENT SERVICES AGREEMENT
OF
SMALL SMILES DENTISTRY FOR CHILDREN, ALBUQUERQUE, P.C.

The undersigned has reviewed the Management Service Agreement, dated as of September 26, 2006 (as such has been or may be amended from time to time) (the "Agreement"), and by the execution of this counterpart signature page, the undersigned hereby adopts, accepts and joins in the Agreement and agrees to be bound by the terms and provisions thereof.

Dated: October 1, 2010

[redacted]

EXHIBIT 7

KING & SPALDING

King & Spalding LLP
1700 Pennsylvania Ave. NW
Suite 200
Washington, D.C. 20006-4707
Tel: +1 202 737 0500
Fax: +1 202 626 3737
www.kslaw.com

Graciela M. Rodriguez
Partner
Direct Dial: +1 202 626 5508
Direct Fax: +1 202 626 3737
[redacted]
gmrodriguez@kslaw.com

December 16, 2011

HIGHLY CONFIDENTIAL
AND PROPRIETARY INFORMATION
PROVIDED PURSUANT TO SENATE RULE XXIX

VIA HAND DELIVERY

Erika Smith
Senior Investigator, Republican Staff
Senate Judiciary Committee
327 Hart Senate Office Building
Washington, DC 20510

Christopher Law
Investigator
Committee on Finance
Dirksen Senate Office Building, SD-219
Washington, DC 20510

Re: Church Street Health Management -- Production of Ownership Materials

Dear Erika and Chris,

In response to your letter dated November 18, and as discussed during our November 30 meeting, the below and enclosed is information provided by Church Street Health Management (formerly known as FORBA Holdings, LLC and SANUS Holdings, LLC, collectively "CSHM") in response to your request for information about the ownership of the dental centers with Management Services Agreements ("MSAs") with CSHM, and the relationships between the owners of the dental centers and CSHM.

As a general matter, CSHM notes that each of the dental centers is a separate professional corporation or limited liability company and is owned by a licensed dentist. Each center has its

own tax identification number, own workers compensation and general liability policies, and is the tenant party to the office lease for the practice location. Each center also has its own bank account and payroll. The ownership structure of the centers and the forms of the MSAs were vetted by CSHM through its outside counsel, Waller Lansden Dortch & Davis, LLP, prior to CSHM's acquisition of the MSAs in September 2006, and Waller Lansden has continued to advise CSHM on these issues. CSHM believes that the ownership structure of the centers and the MSAs comply with laws governing the corporate practice of dentistry in the various states in which it operates, and believes that other dental centers serving largely Medicaid populations have similar arrangements with other dental management companies (e.g. Kool Smiles).

The Owners of the Dental Centers

From September 26, 2006 to August 12, 2008, all of the dental centers with MSAs were owned by Dr. [redacted] or Dr. [redacted] (other than the centers in Kansas, which were owned by dentists practicing in those centers; the centers in New York, which were owned by Dr. [redacted] and the Louisville, Kentucky center, which was partially owned by Dr. [redacted] Drs. [redacted] and [redacted] also had been associated with "Old FORBA," the entity that was the party to the MSAs prior to the September 2006 asset purchase by CSHM, and they became Senior Vice Presidents of CSHM following the acquisition. In August 2008, Drs. [redacted] and [redacted] transferred ownership of the centers to various dentists who practiced in dental centers with MSAs, generally in a center in the state in which their owned centers were located. From August 2008 through the present, the owners of the centers have not been employed by CSHM.

A list of the owners of the dental centers as of December 1, 2011 is attached hereto at Tab A. As you can see from that list, as of December 1, 2011, 27 dentists owned a total of 74 centers with MSAs.[1] Of these 27 owner dentists, 20 own multiple centers, typically all within one state. For example, a Maryland-licensed dentist owns the Oxon Hill, Maryland center and is its Lead Dentist, and also owns the centers with MSAs located in Baltimore, Maryland.

Ownership Structure/Agreements

Since the acquisition of the MSAs by CSHM in September 2006, the ownership interests in the centers have been conveyed through, and memorialized in, a series of documents, samples of which are enclosed herewith. These documents generally are: (1) Purchase Agreement (sample attached at Tab B); (2) Assignment and Assumption Agreement (sample attached at Tab C); (3) Irrevocable Stock Power (sample attached at Tab D); (4) Buy-Sell Agreement (sample attached at Tab E); (5) Stock Pledge Agreement (sample attached at Tab F); (6) Resignation of Manager, Officer and Director (sample attached at Tab G); (7) Actions by Unanimous Written Consent of the Board of Directors (samples attached at Tabs H and I); (8) Counterpart Signature

[1] We understand that, over the next month, two centers will be closing: Albany, New York and Toledo, Ohio. We also understand that four centers may be sold to other dentists over the next few weeks, and their MSAs terminated: Muncie, Indiana; Omaha, Nebraska; Pueblo, Colorado, and Mission, Texas.

Page to Management Services Agreement (sample attached at Tab J); and (9) Stock Certificate (sample attached at Tab K).

The dentist owners purchased the right, title and interest in the dental center as a professional corporation or limited liability company from the previous dentist owner for some dollar amount, typically $100.00. (*See* Purchase Agreement, attached at Tab B.) The owners typically serve as officers and directors of the professional entities and pay themselves a fixed administrative fee from the practices they own (*see* Tabs H and I). The owners also receive compensation as employees from the centers at which they provide dental services.

In addition to the Purchase Agreement and related stock transfers and assignments, since September 2006, each owner (other than owners of the Kansas centers) has entered into a Stock Pledge Agreement with CSHM, *see* Tab F, under which the owner grants CSHM a security interest in the owner's shares of the professional entity to secure the owner's guaranty of the center's performance under the MSA. If the owner or the center breaches the Stock Pledge Agreement or the MSA, a designated dentist may purchase the owner's shares for $100.

Each owner (other than owners of the Kansas centers) was also a party to a Buy-Sell Agreement in a form similar to that attached at Tab E. The Buy-Sell Agreements currently are between the owner of the center and Dr. [redacted], DDS,[2] although as set forth below, this is in the process of being changed. The Buy-Sell Agreement provides, among other things, that the owner cannot sell any stock or other interest in the center except: (1) pursuant to the terms of the Stock Pledge Agreement; or (2) with the prior consent of the center and Dr. [redacted], to a buyer who is qualified to own the center under the laws of that state and who agrees to be bound by the terms of the Buy-Sell Agreement and executes a Stock Pledge Agreement with CSHM. The Buy-Sell Agreement also provides that in the event of a defined "Event of Transfer" (such as the owner dies, loses his license, or is excluded from Medicaid), the owner must give notice to the center and Dr. [redacted] and then Dr. [redacted] (or his designee) has the irrevocable option to purchase the ownership interests in the center.

Until recently, Dr. [redacted] was also an employee of CSHM. On November 14, 2011, Dr. [redacted] notified CSHM that he would be resigning his position effective December 14, 2011, and would no longer be a party to the Buy-Sell and Stock Pledge Agreements. The Buy-Sell and Stock Pledge Agreements are in the process of being transferred from Dr. [redacted] to other licensed dentists who currently own one or more centers, generally in a neighboring state. A sample of the assignment of the Buy-Sell and Stock Pledge agreements is attached at Tab L.

The ownership documents regarding the Topeka, Kansas and Youngstown, Ohio centers differ from the sample agreements referenced above, and are attached separately hereto at Tabs M and N. With regard to the centers in Wichita, Kansas and Indian Springs, Kansas, they continue to be owned by the original owners who established the practices, and there are no Purchase Agreements, Assignments, Buy-Sell Agreements, Stock Pledge Agreements or related

---

[2] Dr. [redacted] is a practicing dentist in Tennessee.

documents. CSHM is continuing its review to determine if there are other centers that have documentation that differs from the sample agreements enclosed herewith, and they will produce any additional such documents to you.

Dentist Employment Contracts

All owners of centers (except the owner of the Indian Springs, Kansas center) have employment contracts with the centers where they practice dentistry. These agreements generally provide the terms of employment, including compensation and other benefits, and licensing and credentialing obligations. The employment agreements for each of the current owners (except Indian Springs) are attached at Tab O.

Management Services Agreements

As a general matter, CSHM provides business, administrative and other "back office" services to the dental centers. This includes loans and assistance to the centers for the costs and services needed to develop and open the centers, including leases, equipment and all necessary licenses and approvals, as well as bookkeeping, accounting, tax, billing, collection, licensing, legal, compliance and recruiting services. The standard MSA, with addenda, is attached at Tab P. The standard form of MSA has been entered into by all centers except those in Alabama, Kansas, New York, Nevada and Youngstown, Ohio. Sample MSAs for those centers are attached hereto at Tab Q. CSHM is continuing to review the MSAs to determine if there are others that differ from the standard form, and will produce any additional MSAs to you.

This letter and the information and documents enclosed contain or constitute highly confidential and proprietary information of CSHM provided to the Committees pursuant to your requests and pursuant to Rule XXIX of the Standing Rules of the Senate. Accordingly, CSHM has marked all documents produced with the legend "CSHM HIGHLY CONFIDENTIAL AND PROPRIETARY INFORMATION. PROVIDED PURSUANT TO SENATE RULE XXIX." We request that the Committees afford these documents the maximum protection available to information provided to the Committees. CSHM respectfully requests that the Committees, your staff, and all those who may review CSHM's documents, including electronic submissions of information and documents, on behalf of the Committees, protect against the disclosure of this confidential information. CSHM also respectfully requests advance notice of any contemplated disclosure of CSHM's confidential and proprietary information, and a reasonable opportunity to object.

The information herein was provided by CSHM, and as noted above, will be updated by CSHM. CSHM and Waller Lansden believe it would be beneficial to discuss this information and the enclosed documents with the Committee staff at your convenience. Please contact us if you would like to arrange for such a discussion.

Sincerely,

Grace Rodriguez

cc: [redacted]
General Counsel
and Chief Administrative Officer
Church Street Health Management, LLC
(w/o enclosures)

[redacted]
Waller Lansden Dortch & Davis, LLP
(w/o enclosures)

[redacted]
Senior Counsel
Office of Counsel to the Inspector General
(w/o enclosures)

EXHIBIT 8

BUY-SELL AGREEMENT

THIS BUY-SELL AGREEMENT ("Agreement"), dated as of October 1, 2010, is by and among Small Smiles Dentistry for Children, Albuquerque, P.C., a New Mexico professional corporation (the "Company"), [redacted], DDS, DDS, an individual ("Owner"), and [redacted], DDS, an individual ("Buyer").

RECITALS:

WHEREAS, in order to provide for continuity and harmony in the management and policies of the Company, Owner, Buyer and the Company desire to enter into an agreement (i) restricting the ability of the Owner to dispose of its equity interests in the Company; and (ii) to establish their respective rights, obligations and liabilities in connection with ownership of such equity interests.

NOW, THEREFORE, for and in consideration of the mutual covenants and promises contained herein, and other good and valuable consideration, including, without limitation, $100 paid by Buyer to Owner, the receipt, adequacy, and sufficiency of which are hereby acknowledged, the Company, for itself, its successors and permitted assigns, and Owner, himself or herself, his or her heirs, personal representatives, executors and permitted assigns, and Buyer, for himself, his heirs, personal representatives, executors and permitted assigns hereby mutually agree as follows:

I. RESTRICTIONS ON TRANSFER; RIGHTS TO PURCHASE UPON CERTAIN EVENTS

1.1 Payment. Buyer hereby delivers to Owner a check in the amount of $100.00.

1.2. General Restrictions on Transfer. Owner shall not, directly or indirectly, sell, assign, encumber, pledge, transfer, bequeath or otherwise dispose of (each, a "Transfer") any shares of capital stock or other equity interests in the Company (the "Ownership Interests"), whether now owned or hereafter acquired, nor any legal or beneficial interest in the Ownership Interests, including, without limitation, any Transfer pursuant to a court order in any bankruptcy, divorce, guardianship, conservatorship or probate proceeding, except:

(a) In accordance with the terms of this Agreement; or

(b) Pursuant to the Stock Pledge Agreement, of even date herewith (the "Pledge Agreement"), between Owner and FORBA Holdings, LLC, a Delaware limited liability company ("FORBA"); or

(c) With the prior, express consent of the Company and Buyer, to a transferee who is qualified to own an interest in the Company under the laws of the State of New Mexico and who, as a condition precedent thereto, executes and delivers to the Company a counterpart to this Agreement agreeing to comply with and be bound by all of the terms and provisions of this Agreement as if named as an "Owner" hereunder, and executes and delivers to FORBA a stock pledge agreement in the form and substance of the Pledge Agreement reasonably satisfactory to FORBA.

1.3. Right to Purchase Ownership Interests of Owner Upon Certain Events.

(a) In the event that any Event of Transfer (as defined in Section 1.3(e) below) shall occur, Owner or Owner's estate, as the case may be, shall promptly give written notice (the "Event Notice") of such Event of Transfer in reasonable detail to the Company and Buyer, including, without limitation, the circumstances of such event. Upon and during the continuance of any such Event of Transfer, Buyer or his designee shall have the irrevocable option (the "Transfer Option"), but not the obligation, to purchase all of the Ownership Interests held beneficially or of record by Owner (the "Affected Interests").

(b) Buyer or his designee may exercise such Transfer Option by giving written notice of such exercise to Owner or his or her legal representative notifying them that Buyer or his designee is exercising the Transfer Option as to all or a specified number or amount of the Affected Interests within 30 days after the later of the occurrence of such Event of Transfer or the giving of the Event Notice.

(c) The purchase price for the Affected Interests shall be a total of $100. The purchase price shall be payable to Owner or his or her personal representative in cash upon transfer of the Affected Interests to Buyer or his designee. The closing of such purchase shall take place promptly following the exercise of such Transfer Option at the time and place designated by Buyer or his designee. At such closing, pursuant to a purchase agreement and/or other documentation between Owner and Buyer or his designee in form and substance requested by and acceptable to Buyer or his designee, Owner shall transfer the Affected Interests and all of Owner's rights, title and interest therein to Buyer or his designee in exchange for the purchase price, free and clear of all Encumbrances (as defined below), and shall deliver to Buyer or his designee all certificates evidencing Ownership Interests, duly endorsed for transfer, and duly executed stock powers with respect to Ownership Interests. Notwithstanding anything to the contrary herein, the parties agree that if Buyer makes available the purchase price at the time and place designated by Buyer or his designee and in the appropriate amount and form, then upon and after such time the Owner shall no longer have any rights as a holder of the Affected Interests (other than the right to receive payment of such consideration in accordance with such notice), and the Affected Interests shall be deemed to have been repurchased in accordance with the applicable provisions hereof, whether or not any documentation therefor or release is delivered.

(d) In the event that Buyer or his designee does not purchase all of the Affected Interests involved in such Transfer, the Company shall have the right to redeem the remainder of such Affected Interests in accordance with the provisions of this Section 1.3. In the event that neither Buyer nor the Company purchase all of the Affected Interests, Owner shall maintain and hold all rights and interests in any Affected Interests not so purchased, subject to the terms of this Agreement.

(e) For purposes of this Agreement, an "Event of Transfer" shall mean the occurrence of one or more of the following events:

(i) Owner's death;

(ii) Owner's license to practice dentistry in the State of New Mexico is revoked, terminated, cancelled, expired, limited or suspended for any reason;

(iii) Owner is excluded, debarred or suspended from participation, or otherwise becomes ineligible to participate, in the Medicare, Medicaid or other federal or New Mexico health care programs, or is convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a) despite the fact that exclusion, debarment, suspension or any other ineligibility from the ability to participate in the Medicare, Medicaid or other federal or state health care program has not yet occurred;

(iv) Owner's Drug Enforcement Administration (DEA) license or comparable license in the State of New Mexico is revoked, terminated, cancelled, expired, limited or suspended for any reason;

(v) Cancellation of Owner's coverage or his or her uninsurability, under the terms and conditions of professional liability insurance with respect to the Company's dental practice;

(vi) Owner is adjudicated incompetent by any court of law or becomes disabled such that Owner is unable to render dental services;

(vii) For any reason, Owner no longer meets the qualifications to be a shareholder of the Company under the laws of the State of New Mexico;

(viii) Owner's employment with the Company (if Owner is employed by the Company on or after the date hereof), or with FORBA or any of its subsidiaries shall terminate or end for any or no reason;

(ix) Owner shall reach the age of 70 years; provided, however, that nothing herein shall be construed to require Owner to retire or otherwise terminate his or her employment with the Company at the age of 70 years or at any other age;

(x) Owner is indicted for, convicted of, or pleads guilty or enters a plea of no contest to any felony offense or any misdemeanor offense involving moral turpitude, dishonesty, theft or any other conduct that could reasonably be expected to impair the reputation of the Company or its affiliates;

(xi) Owner's gross negligence, willful misconduct, fraud, dishonesty, misappropriation, embezzlement or theft with respect to the Company or its affiliates or in the performance of Owner's duties to the Company;

(xii) Owner shall breach any term or provision of this Agreement; or

(xiii) Owner becomes insolvent by reason of his or her inability to pay his or her debts as they mature, is adjudicated bankrupt or insolvent, files a petition in bankruptcy, reorganization or similar proceeding under the bankruptcy laws of the United States or has such a petition filed against him which is not discharged within 30 days, has a receiver or other custodian appointed for his or her business, assets or property, has his or her bank accounts, property or accounts attached, has execution levied against his or her business or property, makes an assignment for the benefit of his or her creditors; or has any of his or her Ownership Interests in the Company attached or levied upon for payment of his or her debts.

1.4. Involuntary Disposition Because of Death, Divorce, Bankruptcy or Otherwise. In the event any involuntary Transfer (collectively, "Involuntary Transfer") by or in which Owner shall be deprived or divested of any right, title or interest in or to any Ownership Interest, including, without limitation, upon the death of Owner, transfer in connection with marital divorce or separation proceedings, levy of execution, transfer in connection with bankruptcy, reorganization, insolvency or similar proceedings, transfers in connection with foreclosures of pledge, or any transfer to a public officer or agency pursuant to any abandoned property or escheat laws, but excluding any Transfer to a designated transferee pursuant to and in accordance with the Pledge Agreement, the following procedures shall apply:

(a) Owner or his or her legal representative, as applicable (in each case, the "Transferor"), shall promptly give written notice ("Involuntary Transfer Notice") of such Involuntary Transfer in reasonable detail to the Company and to Buyer, including, without limitation, the circumstances of such Involuntary Transfer, the number or amount of subject Ownership Interests and the identity of the person or persons who take or propose to take any interest in Ownership Interests (the "Involuntary Transfer Interests") as a result of such Involuntary Transfer (the "Transferee"). The Transferee shall hold such interest subject to the rights of Buyer as set forth in this Section.

(b) Buyer or his designee shall have the irrevocable option (the "Involuntary Transfer Option"), but not the obligation, to purchase the Involuntary Transfer Interests.

(c) Buyer or his designee may exercise the Involuntary Transfer Option by giving written notice of such exercise to the Transferor or his or her legal representative notifying them that Buyer or his designee is exercising the Involuntary Transfer Option as to all or a specified number or amount of the Involuntary Transfer Interests within 30 days after the later of the occurrence of such event or the giving of the Involuntary Transfer Notice.

(d) The purchase price for the Involuntary Transfer Interests shall be a total of $100. The purchase price shall be payable to the Transferor or his personal representative in cash upon transfer of the Involuntary Transfer Interests to Buyer or his designee. The closing of such purchase shall take place promptly following the exercise of such Involuntary Transfer Option at the time and place designated by Buyer or his designee. At such closing, the Involuntary Transfer Interests and all of Transferor's and Transferee's rights, title and interest therein shall be transferred to Buyer or his designee in exchange for the purchase price, free and clear of all Encumbrances, and all certificates evidencing Ownership Interests, duly endorsed for transfer, and duly executed stock powers with respect to Ownership Interests shall be delivered to Buyer or his designee.

(e) In the event that Buyer does not purchase all of the Involuntary Transfer Interests involved in an Involuntary Transfer, the Transferee shall take and hold all rights and interests in any Involuntary Transfer Interests not so purchased, subject to the terms of this Agreement.

1.5. Resignation as Director and Officer and Release Upon Transfer. Upon the Transfer of any Ownership Interests pursuant to Sections 1.3 or 1.4 hereof, Owner or Transferor, as applicable, shall (i) immediately resign all positions held as an officer, manager or director of the Company and (ii) deliver to the Company an executed general release, in a form reasonably satisfactory to the Company, that releases the Company and its affiliates from claims or damages that Owner or Transferor may have against the Company.

1.6. Representations and Warranties About Ownership Interests. Owner hereby represents and warrants to the Company and Buyer: Owner is the record and beneficial holder and owner of such number of amount of Ownership Interests as set forth on Exhibit 1.6 hereto, and except as described on such Exhibit, Owner holds and owns no Ownership Interests in the Company, and no options, warrants, subscriptions, convertible securities or other rights, agreements or commitments to purchase or acquire any Ownership Interests in the Company. Owner holds and owns Ownership Interests, beneficially and of record, free and clear of any restrictions on transfer, taxes, mortgage, pledge, lien, encumbrance, charge or other security interest, option, warrant, purchase rights, contracts, commitments, equities, claims and demands (collectively, "Encumbrances"), other than the terms of this Agreement and the Pledge Agreement. Owner has full, absolute and unrestricted right, power, capacity and authority to sell, transfer, assign and deliver Ownership Interests to Buyer or his designee in accordance with this Article I upon the exercise of a Transfer Option or Involuntary Transfer Option, and the delivery of Ownership Interests to Buyer or his designee upon exercise of any such option will convey to Buyer or his designee valid, marketable and indefeasible title to Ownership Interests, free and clear of any and all Encumbrances. Such Ownership Interests are duly authorized, validly issued, fully paid and non-assessable and were not issued in violation of any preemptive rights or any right of first refusal or other similar right in favor of any person. Owner is not a party to any option, warrant, purchase right, or other contract or commitment that could require Owner to sell, transfer or otherwise dispose of any of Ownership Interests, other than pursuant to this Agreement and the Pledge Agreement. Owner is not a party to any voting trust, proxy or other agreement or understanding with respect to the voting of any of Ownership Interests with any party.

1.7. Compliance with Securities Laws. Any Transfer of Ownership Interests shall be effected in compliance with federal and applicable state securities laws.

1.8. Effect of Nonconforming Transfer. Any Transfer made in violation of any provision of this Agreement is void *ab initio*. The Company shall not transfer or recognize on its books or records any Transfer that violates any provision of this Agreement.

1.9. Certificate Legend. All certificates, if any, representing shares of Ownership Interests owned by Owner or subsequently issued to Owner, shall be marked with a legend reading substantially as follows, and such legend shall be maintained on each and every such certificate so long as this Agreement remains in effect:

> The shares evidenced by this certificate are subject to the provisions of a Buy-Sell Agreement, dated as of September 26, 2006, among Small Smiles Dentistry for Children, Albuquerque, P.C. (the "Company") and [redacted], DDS, a copy of which is on file in the offices of the Company and is incorporated herein by reference, and such shares may be transferred, assigned, pledged or otherwise disposed of only upon compliance with the provisions of such Buy-Sell Agreement. Any disposition in violation of the Buy-Sell Agreement is invalid.

Each party covenants that any and all certificates representing Ownership Interests which are subject to this Agreement shall bear this legend. Notwithstanding this requirement, all Ownership Interests Company shall be held subject to the provisions of this Agreement regardless of whether Ownership Interests are certificated or not, and whether any such certificate bears this legend, a similar legend or no legend at all.

1.10. After Acquired Ownership Interests. In the event of any issuance or Transfer of any Ownership Interests hereafter to Owner (including, without limitation, in connection with any stock split, stock dividend, option or warrant exercises, recapitalization, reorganization or the like, or a Transfer from any other owner of equity interests in Company, Buyer or his designee), such Ownership Interests shall become subject to this Agreement and shall be endorsed with the legend set forth in Section 1.9.

II. RESTRICTIVE COVENANTS

2.1. Non-Solicitation of Patients. Owner hereby agrees with Buyer and the Company that, during the period in which Owner owns any Ownership Interests in the Company and for a period of one year thereafter, Owner will not, directly or indirectly, solicit any of the Company's patients. Solicitation of the Company's patients shall be defined as Owner, directly or indirectly, contacting the Company's patients directly, either in writing or verbally, with notice of Owner or his or her affiliate's new practice address and with an affirmative effort on behalf of Owner to attract or entice the Company's patients to Owner's or his or her affiliate's practice. In the event Owner breaches this section, the Company shall be entitled to seek injunctive relief and monetary damages against Owner. The prevailing party in any action to enforce this provision shall be entitled to all reasonable costs and expenses, including reasonable attorneys' fees and accountants' fees.

2.2. Non-Solicitation of Employees. Owner hereby agrees with Buyer and the Company that, during the period in which Owner owns any Ownership Interests in the Company and for a period of one year thereafter, Owner will not, directly or indirectly, solicit any employee (professional or otherwise) of the Company to terminate his or her employment with the Company.

2.3. Confidential Information. Owner hereby agrees with Buyer and the Company that, during the period in which Owner owns any Ownership Interests in the Company and at all times subsequent thereto, except as required in Owner's duties to the Company, Owner will not, directly or indirectly, use, disseminate or disclose any confidential information ("Confidential Information") concerning the business or patients of the Company. Confidential Information means information disclosed to Owner or known by Owner as a consequence of Owner's relationship with or ownership in the Company, not generally known in the profession about the Company's services or processes, but shall include, without limitation, all information relative to patient lists, patient names and addresses, patient records, pricing policies, financial information and the Company's procedures, systems and processes relating to its practice. Owner agrees that the Company's Confidential Information is in the nature of trade secrets and should not be made available to any other dentist or dental professional, or any present or potential competitor, including Owner, without regard to whether or not said Confidential Information may or may not be defined as a trade secret pursuant to the Uniform Trade Secrets Act. In the event Owner misappropriates any of the Company's Confidential Information, the Company shall have all rights and remedies available to the Company pursuant to applicable law, including the Uniform Trade Secrets Act.

2.4. Covenant Not to Compete. Owner acknowledges that the Company has invested a great deal of resources, including, without limitation, time, experience and money, in the development of the business model which allows the Company to provide access to dental services to the traditionally underserved, specifically, Medicaid or State Children's Health Insurance Program ("SCHIP") eligible children, twenty (20) years of age and/or younger. Owner acknowledges that the Company and Buyer would not have entered into this Agreement unless Owner agrees to enter into and be bound by the terms and conditions of this section. Owner hereby agrees with Buyer and the Company that, during the period in which Owner owns any Ownership Interests in the Company and for a period of five years thereafter, Owner shall not, directly or indirectly, enter into or engage in the practice of dentistry, general or specialty dentistry, which treats Medicaid or SCHIP patients, whether as a sole proprietor, partner, shareholder, officer, director, employee or independent contractor of any corporation, limited liability company, partnership or any other entity, or in any manner become associated with, affiliated with or financially interested in any business or enterprise engaged in the practice of dentistry (general or special) that provides dental services for Medicaid or SCHIP patients within a twenty five (25) mile aerial radius of the location(s) at which the Company's dental practice is located during the term in which Owner is a party hereto, or the Company's practice location(s) on the date of termination if the Company has moved its location(s), or at any of the Company's related practices located in various cities throughout the United States. The above covenant and restriction applies only to Owner directly or indirectly engaging in the practice of dentistry relating to one or more practices or clinics that receive fifty-one percent (51%) or more of their respective net revenues during any month from one or more Medicaid or SCHIP programs, and does not restrict Owner from practicing dentistry in any other capacity at any location after termination of this Agreement.

2.5. Conduct of Business. During the term of this Agreement, the Company shall conduct its business and operations in the ordinary course consistent with past practice and reasonable business judgment and in compliance in all material respects with applicable law, and, without limitation, (i) the Company and Owner shall not amend,

If to Buyer:

[redacted] DDS
618 Church Street, Suite 520
Nashville TN 37219
[redacted]

or to such other address, and to the attention of such other person or officer as any party may designate.

4.2. Arbitration. Except for claims for injunctive relief, all disputes arising out of or in connection with this Agreement shall be settled by binding arbitration in Nashville, Tennessee. Evidentiary matters shall be determined in accordance with the Federal Rules of Evidence. The arbitrator shall be selected by mutual agreement of the parties or, failing such agreement, shall be a single qualified (in light of the subject matter hereof) arbitrator selected by the American Arbitration Association. Following a demand for arbitration, the parties shall have discovery rights in accordance with the Federal Rules of Civil Procedure. Judgment upon the award entered by the arbitrator may be entered in any court having jurisdiction hereof. The prevailing party shall be entitled to an award of reasonable costs of arbitration, including reasonable attorneys' fees, incurred in connection therewith as determined by the arbitrator.

4.3. Consent of Spouse. If Owner is married on the date of this Agreement, then Owner's spouse shall concurrently execute and deliver to the Company a consent of spouse in the form of Exhibit 4.3 hereto ("Consent of Spouse"), effective on the date hereof. Notwithstanding the execution and delivery thereof, such consent shall not be deemed to confer or convey to the spouse any rights in the Ownership Interests that do not otherwise exist by operation of law or the agreement of the parties. If Owner should marry or remarry subsequent to the date of this Agreement, then Owner shall within 30 days thereafter obtain his or her new spouse's acknowledgement of and consent to the existence and binding effect of all restrictions contained in this Agreement by causing such spouse to execute and deliver a Consent of Spouse acknowledging the restrictions and obligations contained in this Agreement and agreeing and consenting to the same.

4.4. Miscellaneous. This Agreement: (i) shall be governed by Tennessee law, without reference to its conflict of law principles; (ii) sets forth the entire understanding and agreement of the parties, and supersedes all prior oral or written understandings and agreements, with respect to the subject matter hereof; (iii) shall not be amended or terminated nor any provision hereof waived unless in a writing signed by all parties that expressly sets forth such amendment, termination or waiver; (iv) shall not be transferred or assigned by Owner, in whole or part, without the prior written consent of Buyer; (v) shall be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns; (vi) if held to be invalid or unenforceable, in whole or part, such term or provision shall be ineffective only to the extent of such invalidity or unenforceability without invalidating or rendering unenforceable the remaining terms and provisions of this Agreement; and (vii) may be executed in counterparts, each of which shall be deemed an original and which together shall constitute one and the same instrument. It is the intent of the parties that each part hereof shall be given its plain meaning, and that rules of construction that would construe any ambiguity against the draftsman, by virtue of being the draftsman, shall not apply. In the event of litigation relating to this Agreement, the prevailing party shall be entitled to recover attorneys' fees and costs of litigation in addition to all other remedies available at law or in equity. All expenses incurred in connection herewith shall be borne by the respective party incurring such expense. The representations, warranties and covenants of the parties contained in this Agreement shall survive the date hereof and shall not be extinguished thereby notwithstanding any investigation or other examination by any party.

[The remainder of this page is intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by themselves or their duly authorized representative as of the day and year first written above.

COMPANY

Small Smiles Dentistry for Children, Albuquerque, P.C.

By: [redacted]

[redacted] DDS

Vice President and Secretary

OWNER

[redacted] DDS, DDS

BUYER

[redacted]

[redacted] DDS

EXHIBIT 1.6

OWNERSHIP INTERESTS

[redacted] DDS, DDS:

Address: [redacted] Albuquerque, NM 87120-3852

Ownership Interests: 100 shares of common stock

EXHIBIT 4.3

FORM OF CONSENT OF SPOUSE

I, [redacted], am the spouse of [redacted], DDS, DDS ("Owner"), and hereby acknowledge that I have read the Buy-Sell Agreement, dated as of October 1, 2010, by and among Small Smiles Dentistry for Children, Albuquerque, P.C. (the "Company"), [redacted] DDS and Owner, to which a form of this Consent is attached as an Exhibit (the "Agreement"), and that I know the contents of the Agreement. Capitalized terms herein that are not otherwise defined shall have the meanings ascribed thereto in the Agreement.

I am aware that the Agreement contains provisions regarding rights of parties upon an Event of Transfer or Involuntary Transfer with respect to Ownership Interests in the Company which my spouse may own, including any interest I might have therein.

I hereby agree that my interest, if any, in any Ownership Interests in the Company subject to the Agreement shall be irrevocably bound by the Agreement and further understand and agree that any community property interest I may have in Ownership Interests shall be similarly bound by the Agreement.

I am aware that the legal, financial and related matters contained in the Agreement are complex and that I am free to seek independent professional guidance or counsel with respect to this Consent. I have either sought such guidance or counsel or determined after reviewing the Agreement carefully that I will waive such right.

Dated as of October 1, 2010.

[redacted]

EXHIBIT 9

[redacted]
Tuesday, May 24, 2011
8:33 PM

Dr. [redacted]

From: Dr. [redacted] **Sent:** Fri 5/20/2011 11:00 AM
To: [redacted]
Cc:
Subject: FW: verbal warning
Attachments:

fyi

From: [redacted]
Sent: Thursday, May 19, 2011 4:57 PM
To: Dr. [redacted]
Cc: [redacted]
Subject: RE: verbal warning

Understood. Then please allow me the authority to dictate the schedule here as I see best for my pts and my staff. As far as the compliance report, in order to satisfy,management expectations and needs of the community, it was unfortunate that I did miss numerous webinars and did not feel comfortable to adequately complete the report. I believe the last quarterly report was done by the previous regional manager. Back to team building, I highly doubt that this center could accomplish what it has and continues to do so without proper leadership and teamwork orchestrated by myself. Every member of my staff is familiar and functions at my high level of expectation in this center. As far as [redacted], she has our staff and my full support; however, I do expect that after three weeks, the only two forms pts have to fill out during check in should be a familiar task to anyone in that position. If not, perhaps her training was inadequate.

As you have mentioned how important teamwork is, I can assure you that every center is not the same as you once said to me. In addition, I can also assure you that when regional managers come to your center and keep their door shut the entire stay, well, that definitely is not a team building effort and not a good reflection of our company's "open door policy".

I apologize I will be out of center during your visit next week.

Sincerely,

Dr. [redacted]

Access Dentistry
ALBANY

[redacted]

From: Dr. [redacted]
Sent: Thursday, May 19, 2011 4:06 PM
To: [redacted]
Cc: [redacted]
Subject: RE: verbal warning

Dr. [redacted],

[redacted] has been in the center for just a couple of weeks. You yourself pointed out that she is new and your center is understaffed. With that in mind, it is likely to be unnecessary to consider her for a documented verbal warning. Of course, it appears appropriate to reiterate the need for completeness of paperwork. ALL in your center should be stepping up to ensure compliance in the center as [redacted] acclimates to her position and always. This is a team effort.

You also mention your duty as the LD to ensure compliance protocol is followed. However, just days ago you refuse to complete the acknowledgment of quarterly compliance. Also, in the absence of an OM the LD is the Compliance Liaison, to which you acted as if you were unaware—despite multiple conf calls and webinars. Perhaps clarity is needed to what appears to be a 'selective' duty to Compliance.

[redacted] was in your center this week. I know that interviews have taken place, with potential training next week. I will also be in your center next week. If your issues are around completeness of HIPPAA forms and medical histories, you must pull together as team to ensure completeness. You are averaging 22 patients per day at this point—this is manageable with your current staff acting as a true team. You are the leader of your day to day operations and thus the most important factor in the success or failure of your team.

As a management company we are here to assist those who are willing and capable of working together to support efforts. We WILL continue to monitor best practices, and monitor the obligation to provide items and services of a quality that meets professionally recognized standards of healthcare.

From: [redacted]
Sent: Thursday, May 19, 2011 3:12 PM
To: [redacted]

Cc: [redacted]
Subject: RE: verbal warning

To specifically answer your question, about half a dozen pts without hippa and many more with incomplete medical histories. If [redacted] has not asked you for assistance, I have to do my duty as the LD here to ensure proper compliance protocol is followed. Despite numerous reminders, she continues to struggle with basic tasks, and my understanding is that because she is overwhelmed. I do appreciate her efforts, but I don't believe the State wants to know about efforts, the job just has to get done. Please consult with HR if a documented warning is appropriate. If not, please send the proper management support immediately as requested.

Dr. [redacted]

Access Dentistry
ALBANY

[redacted]

From: Dr. [redacted]
Sent: Thursday, May 19, 2011 2:29 PM
To: [redacted]
Cc: [redacted]
Subject: RE: verbal warning

Coincidentally, I did already speak with her.

From: [redacted]
Sent: Thursday, May 19, 2011 2:25 PM
To: Dr. [redacted]
Cc: [redacted]
Subject: RE: verbal warning

Yes Dr [redacted]

[redacted] has told me several times, she cannot do her job functions alone. She has also mentioned that she has

told [redacted] she needs additional assistance. Dr. [redacted], I don't think you should be questioning my "work environment".when the fact is that yes we are understaffed, Compare our numbers and staffing among other centers. I have lost an OM and my best DA because of lack of management support for front office. I have sacrificed my DA on numerous occasions to assist OM up front, and work by myself without a DA. I will not be help responsible for errors in my center when we have asked for help numerous times. Please speak to [redacted] yourself if you are in question of "perception".

Thank you.

Dr. [redacted]

Access Dentistry
ALBANY

[redacted]

From: Dr. [redacted]
Sent: Thursday, May 19, 2011 12:10 PM
To: [redacted]
Cc: [redacted]
Subject: RE: verbal warning

Does your "New OM" have a name? As we discussed yesterday, the patient load will not be reduced without collaboration from CSHM. Please quantify how often you have had this HIPAA form issue happen? Please be mindful that she is brand new and working the front office alone. As a leader, are you assisting her in creating an environment in which she can function well?

From: [redacted]
Sent: Thursday, May 19, 2011 11:13 AM
To: [redacted]
Cc: Dr. [redacted]
Subject: verbal warning

Good Morning

New OM still needs reminders to have pts complete HIPPA forms, and medical history. I cannot focus on pts

when such continous errors are being made. I will proceed with documented verbal warning if she cannot handle tasks at front desk, and will reduce schedule pt load if she is not capable to handle her tasks.

Sincerely,

Dr. [redacted]

Access Dentistry
ALBANY

[redacted]

EXHIBIT 10

FORBA, LLC

MIC MEMORANDUM

June 2006

ARCAPITA

Table of Contents

Table of Exhibits

Table of Appendices

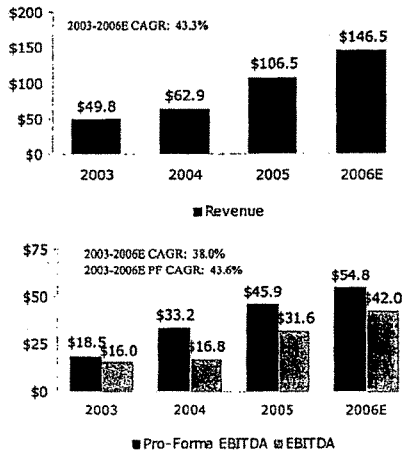
1. Investment Summary

INVESTMENT OVERVIEW

Arcapita has the opportunity to partner with a highly successful and proven healthcare management team to acquire the operating assets of FORBA, LLC ("FORBA" or the "Company"), the leading Dental Practice Management ("DPM") company that focuses on Medicaid/SCHIP eligible children and operates 44 clinics across 14 states. This acquisition will require approximately $211 million in Arcapita equity for a 93.9% ownership interest in the acquiring entity. The total enterprise value for 100% of the Company's assets is estimated to be $470.0 million (excludes fees and expenses), which translates into 11.2x 2006 estimated EBITDA and 8.6x pro-forma 2006 estimated EBITDA (pro-forma for the mature ramp-up of the 12 clinics expected to open in 2006).

EXHIBIT 1

HISTORICAL PERFORMANCE ($ IN MILLIONS)



Headquartered in Pueblo, Colorado, FORBA is the largest dental practice management ("DPM") company that exclusively serves the needs of children eligible for dental care benefits under Medicaid and the State Children's Health Insurance Plan ("SCHIP").

Medicaid is a federally mandated, state managed program that provides comprehensive healthcare benefits to all individuals who qualify based upon household income. However, nearly 75% (28.5 million) of the 38.4 million children eligible for dental benefits under Medicaid and SCHIP do not receive dental care. Untreated dental disease causes several social and economic consequences and leads to higher overall healthcare costs. Government public service campaigns warn of these risks and encourage proper care. FORBA's mission is to provide better access to high-quality dental care for this underserved population. New states and markets openly welcome its affiliated clinics.

With approximately 775,000 annual patient visits, FORBA is over 3x larger than its nearest competitor. FORBA is currently affiliated with 44 clinics in 14 states across the U.S. and expects to be affiliated with 50 clinics in 17 states by the end of 2006, driven by its highly successful, highly profitable de novo clinic growth strategy.

Due to state regulations prohibiting the corporate practice of dentistry, FORBA does not technically provide dental care to the patient, own any interest in its affiliated practices, or employ the dentists in the clinics. However, FORBA selects the new sites, negotiates the lease, oversees construction of the clinic, purchases the equipment, installs the IT and billing infrastructure, employs the staff, recruits the dentists and receives all of the income. Thus, it effectively owns and manages the clinics.

Nearly 100% of the revenue generated by dental clinics affiliated with FORBA is derived from Medicaid and SCHIP. Medicaid rates (unlike Medicare rates) are determined individually on a state by state basis. Medicaid is a stable payor creating visible, strong cash flows in a diversity of states:

- FORBA is currently diversified across 14 states (17 by year end) and no single state represents more than 16% of the

Company's total revenue and that geographic diversity is expanding every year as the Company enters new states.

- Medicaid pays promptly as evidenced by the Company's low DSOs (less than 25).
- Very low bad debt expense creates high-quality revenues and profits.
- Child dental benefits represent less than 1% of the $288 billion Medicaid budget, making it a relatively minor program from which to seek budget savings.
- Children's Medicaid/SCHIP benefits a politically insulated constituency.

FORBA's roots date back to the opening of a solo dental practice in 1928. FORBA began its expansion in the 1990s when it opened its first Medicaid-only affiliated clinics to at the request of Colorado's state government to support Colorado's efforts to increase access to dental care for children covered by Medicaid. The state of Colorado provided FORBA with nearly $400,000 in funds as an inducement to open a clinic focused on Medicaid eligible children. Given the early success of the Colorado clinics and the clear need for improved access to dental care for children, FORBA developed a business plan and assembled a management team to develop child Medicaid/SCHIP dental clinics throughout the U.S.

For the fiscal year ending December 2006, FORBA expects consolidated revenue of $146.5 million and adjusted EBITDA of $42.0 million. Pro Forma adjusted EBITDA (pro forma for the mature ramp-up of the 12 clinics opened during 2006, which occurs during the first six months after opening) is expected to be $54.8 million.

Arcapita has the opportunity to partner with a highly successful and proven management team ("Management") in this rapidly growing, high margin investment opportunity. Management is comprised of the former founders and operators of KEYS Group Holdings, Inc. ("KEYS"), Mike Lindley (CEO), Al Smith (COO) and Rodney Cawood (CFO). These executives grew KEYS into a leading provider of behavioral health facilities for teens and young adults with severe behavioral problems with 55 facilities across 28 states that also focused on Medicaid as a primary payor. Management successfully opened eight de novo facilities and integrated seven acquisitions after founding KEYS in March 2000. KEYS was sold in October 2005

to publicly held Universal Health Services for $207 million, which represented a 100x cash return for initial investors in less than six years and 8x cash return for private equity group Harbert in less than four years.

Since its inception, FORBA has been family owned and operated by the DeRose family. With the help of CIT Capital Securities LLC ("CIT"), Management initiated discussions with FORBA and entered into a purchase agreement with the owners of FORBA for a fixed price of $470 million.

Management and CIT have completely structured the deal, including a competitive staple financing package to be financed by CIT. Management is looking for the best private equity partner in terms of cultural fit and final economics to the management team at exit. The Company was brought to Jack Draughon through his relationship with the CIT's healthcare investment bankers. CIT is currently running a competitive process to choose the right equity partner for Management. Arcapita was among approximately 10 private equity firms invited to make an initial bid on June 12 and among 3 firms invited to participate in Management meetings and the final round of bids, due June 29. If we are selected by Management and CIT as the equity partner, we would expect to sign the Purchase Agreement on June 30 and close the deal on August 4. Prior to requesting bids from private equity partners, Management hired well known third party advisors to conduct extensive financial, legal and clinical due diligence. We have also employed our own third party advisors for all diligence matters and are currently on track to meet this timetable.

Valuation: Approximately $470.0 million (or 11.2x 2006E EBITDA of $42.0 million), excluding estimated Arcapita M&A fee of $4.7 million and other transaction expenses of $15.3 million.

EXHIBIT 2

VALUATION MATRIX

($ in Millions)

		Enterprise Value	PF Tax Savings (1)
		$470.0	$395.0
2006E EBITDA	$42.0	11.2x	9.4x
Pro-Forma 2006E EBITDA	$54.8	8.6x	7.2x
2006E OCF	$39.9	11.8x	9.9x

(1) Enterprise value minus the net present value of the tax deductible goodwill amortization that will be generated over a 15 year period, discounted at 9.0%.

Security Structure: The purchase of the assets of FORBA will be structured as a contribution of equity from Arcapita into a newly formed limited liability company with the Company contributing its operating assets.

Arcapita Ownership: 93.9% fully diluted, assuming a $2.5 million minority equity investment from Management and a 5% Management incentive plan for the other employees of the Company. Management will also share in an equity promote whereby Management will receive an additional 30% of the equity return once the Arcapita equity achieves a gross IRR of 7%.

Financing: CIT has arranged and committed to fund all of the leverage for the transaction. The committed financing consists of: (i) a $50.0 million line of credit, which will be unfunded at closing, (ii) a $170.0 million term financing (representing approximately 4.1x estimated 2006 EBITDA), (iii) $85.5 million in senior second lien notes, and (iv) $21.0 million in junior subordinated Holdco PIK notes, with combined leverage totaling approximately 6.6x estimated 2006 EBITDA.

EXHIBIT 3

PRO-FORMA CAPITALIZATION

($ in Millions)

	Pro Forma	Cum. Multiple 2006E EBITA	% of Total Capital
Revolver	$0.0	-	-
First Lien Term Loan	170.0	4.1x	34.7%
Second Lien Notes	85.5	6.1x	17.4%
Holdco PIK Notes	21.0	6.6x	4.3%
Total Debt	$276.5	6.6x	56.4%
Management Equity	2.5	0.1x	0.5%
Arcapita Equity	211.0	5.0x	43.1%
Total Capitalization	$490.0	11.7x	100.0%
2006E EBITDA	$42.0		

Shari'ah-compliant Structure: There are no known issues regarding Shari'ah compliancy for the transaction.

Summary Base Case Financials

EXHIBIT 4

BASE CASE PROJECTIONS

($ in 000s)

	For the Years Ending December 31,				2003-2006E	For the Years Ending December 31,					2007F-2011F
	2003	2004	2005	2006E	% CAGR	2007F	2008F	2009F	2010F	2011F	% CAGR
Net Revenue	$49,767	$63,906	$104,453	$146,519	43.7%	$188,325	$233,723	$297,494	$346,190	$414,147	22.3%
% Growth		28.4%	63.3%	40.3%		28.5%	24.1%	27.3%	16.3%	19.6%	
Operating Expenses	32,784	46,136	76,897	102,554	45.7%	136,937	171,479	214,375	249,001	294,265	22.1%
% Revenue	67.9%	72.2%	73.6%	70.0%		72.7%	73.4%	72.1%	72.0%	71.1%	
Adjusted EBITDA	$15,982	$16,770	$27,556	$43,965	39.0%	$51,388	$62,243	$83,119	$97,189	$119,882	24.0%
EBITDA Margin	32.1%	26.2%	26.4%	30.0%		27.3%	26.6%	27.9%	28.1%	28.9%	
De Novo Clinic Openings	4	10	12	12		12	15	18	18	18	
Total Clinics Opened in Year End	14	24	36	50		62	77	95	113	131	

Source: Management's projections, as adjusted by Arcapita.

Projected growth is primarily driven by continued expansion of the Company's highly profitable de novo clinic model to take advantage of the Company's largely underserved market opportunity. Nearly 75% (28.5 million) of the 38.4 million children eligible for dental benefits under Medicaid and SCHIP do not receive dental care. This underserved population exists due to lack of convenient facilities that offer dental care for Medicaid patients. The Company identifies states with favorable reimbursement rates and significant Medicaid eligible patients and opens clinics that have historically had 150% cash on cash return within 18 months. FORBA has successfully opened 44 total and is on schedule to open 6 additional clinics in 2006.

Source and Uses

EXHIBIT 5

SOURCES AND USES

($ in 000s)

Sources		Uses	
Revolver (unfunded)	$0	Cash Paid for Equity	$470,000
First Lien Term Loan	170,000	Seller Equity Retained	0
Mezzanine Debt	85,500	Arcapita M&A Fee	4,700
HoldCo. PIK Notes	21,000	Estimated Fees and Expenses	15,300
Seller Equity	0		
Management Equity	2,500		
Arcapita Equity Investment	211,000		
Total Sources	**$490,000**	**Total Uses**	**$490,000**

INVESTMENT THESIS

The investment thesis for FORBA is as follows:

- FORBA is the leading dental practice management provider in a grossly underserved market
  - Nearly 75% of children eligible for dental benefits under Medicaid/SCHIP do not receive dental care
  - Increasing awareness of link between poor dental care and other diseases and social issues
- Impressive historical financial performance
  - 43% sales CAGR, 30% EBITDA margins and cash flow from operations equal to 95% EBITDA
- Outstanding unit economics for de novo clinic build-out
  - Historically, FORBA units have returned all cash within the first 12 months
- Tremendous value proposition to patients and dentists

- The services offered by FORBA are free to its patients
  - Medicaid does not charge a deductible or co-pay
- Convenient locations for low-income patients who have traditionally been ignored
- Increased productivity and flexible hours for dentists
- States ultimately save money because children who do not have access to routine dental care often use the emergency room for their acute dental needs

- Limited reimbursement rate risk
  - Medicaid rates determined by individual states, so rate risk is diversified across 14 states (16 by the end of 2006)
  - Children's dental services represent less than 1% of total Medicaid budget and are therefore not a large source of savings through potential budget cuts

- Arcapita is partnering with proven management
  - Management successfully operated and grew KEYS Group to provide a 100x cash return for initial investors in less than six years and 8x cash return to subsequent private equity investor, Harbert, in less than four years

VALUATION ANALYSIS

Public Comparable Analysis

Management's proposed transaction multiple of 11.2x represents a 9.8% premium to the median public comparable multiple of 10.2x LTM EBITDA. However, FORBA has a lower cost de novo clinic model than its public comparables and its EBITDA margin is approximately 90% greater than its comparables. National Research Corp., the only public comparable with similar margins, currently trades at 13.0x EBITDA. Additionally, if we use Management's assumptions for pro-forma 2006E EBITDA, the 8.7x multiple represents a 16.0% discount to the median public comparable multiple. There are no well known public DPM companies that focus on the Medicaid population. Thus, these companies below are not direct comparables to FORBA, but rather serve as a proxy as to trading multiples generally in the dental practice management space. Finally, FORBA's historical growth rate has surpassed its peers, and consequently would command a premium in the public markets.

The chart on the following page illustrates several valuation metrics for the public comparables.

EXHIBIT 6

PUBLIC COMPARABLE ANALYSIS

Company Name	LTM EBITDA	Enterprise Value	Enterprise Value / EBITDA	EBITDA Margin
American Dental Partners Inc.	$32.2	$194.1	6.0x	15.9%
Birner Dental Management Services Inc.	$5.4	$38.3	7.1x	14.4%
inVentiv Health	$84.2	$943.1	11.2x	13.8%
National Research Corp.	$11.1	$143.7	13.0x	31.3%
PDI Inc.	$9.9	$91.4	9.2x	3.1%
TriZetto Group Inc.	$49.2	$589.8	12.0x	16.1%
Mean			9.8x	15.8%
Median			10.2x	15.2%
FORBA 2006E	$42.0	$470.0	11.2x	28.6%
FORBA Pro-Forma 2006E	$54.8	$470.0	8.6x	36.1%
Variance from Median:				
FORBA 2006E			9.7%	88.7%
FORBA Pro-Forma 2006E			(16.0%)	138.0%

COMPANY HISTORY

FORBA traces its roots to a Pueblo, Colorado dental clinic opened by Dr. Bruno DeRose in 1928. Under the leadership of Dr. Edward DeRose, the Pueblo clinic became known as a high-quality provider of dentistry to children of all means, including those eligible for Medicaid. The clinic treated patients from all over the state of Colorado, as well as Kansas and New Mexico, with some patients commuting 70 to 100 miles for dental appointments. Criticized for not providing adequate access to dental care for children eligible for Medicaid, the state of Colorado requested that FORBA open a clinic in Colorado Springs to improve access to dental services for children in that area in 1995. In 1999, following the success of the Colorado Springs clinic, the state of Colorado provided FORBA with a $100,000 grant to assist in the opening of a clinic in Denver. In 2001, the Company received a $268,222 grant from the state to facilitate the opening of another clinic in Aurora. Today the Company is affiliated with five clinics in Colorado and has developed a close relationship with the Medicaid/SCHIP administrators in that state. The state supports the Company's efforts and includes FORBA's promotional flyers along with its mailings to encourage Medicaid/SCHIP beneficiaries to seek dental care.

Given the success of the original Colorado clinics, the founders of FORBA recognized dental care for Medicaid/SCHIP children was needed beyond Colorado. To address this opportunity, FORBA developed a business plan and assembled a management team to identify, develop

and provide business management services to children's Medicaid/SCHIP dental clinics throughout the U.S. To date, the Company has successfully opened 34 dental clinics outside of Colorado in 13 additional states.

OPERATING MODEL

Dental Practice Management

FORBA is a dental practice management company that provides business and management services to affiliated dental practices that focus exclusively on the needs of children eligible for dental care benefits under Medicaid and SCHIP. Most of the dental care industry still operates under the sole practitioner model, with 65% of the estimated 160,000 active dentists practicing as sole dentists. The DPM segment, which currently represents less than 2% of the total dental market, is estimated to grow at 23% annually, substantially outpacing dental industry growth. The prevalence and visibility of professionally run DPM companies have increased in recent years, raising awareness of the benefits of the model.

The DPM model effectively benefits patients, care providers and third-party payors. Patients have greater access to convenient, high quality dental care. Dentists benefit from reduced capital requirements to purchase equipment, economies of scale and increased productivity, and are able to focus exclusively on practicing dentistry, free from administrative obligations. Finally, payors benefit from lower costs, improved patient accessibility and satisfaction, and a single point of contact for an entire network of practices.

The following table summarizes key benefits of the DPM model to dentists, patients and payors.

EXHIBIT 7

KEY BENEFITS OF DENTAL PRACTICE MANAGEMENT

Dentists	Patients	Third-Party Payors
Resource Allocation	Convenient Locations	Reduced Costs
Marketing/Advertising	Flexible Hours	Expanded Options for Members
Economies of Scale	Greater Access to Dentists	Consistent Quality of Care
Internal Referral Opportunities	Attractive Pricing	Centralized Points of Contact
Shared Best Practices	Increased Payment Options	Enhanced Monitoring Capabilities
Increased Productivity	Formalized Patient Advocacy Process	Increased Plan Design Alternatives
No Capital Requirement		

Ownership Restrictions

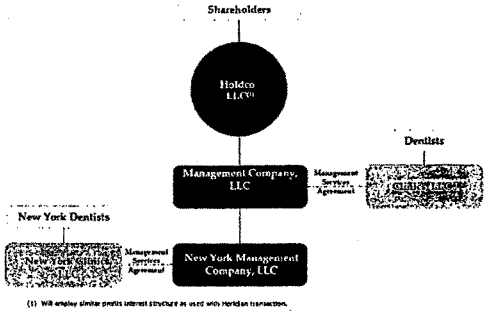
Due to several complex state and federal regulations, the corporate practice of dentistry is generally prohibited by all states. Regulations vary from state to state, but they typically

limit the ability of corporations, such as DPMs, from owning or operating a dental practice or the assets of dental practices. Therefore, licensed dentists must maintain control of each dental practice, including the clinical aspects. Because of these restrictions, instead of acquiring each clinic, the Company acquires selected assets of the dental practices with which it affiliates and enters into long-term service agreements with the affiliated dental clinics. FORBA does not technically provide clinic dental services, own any interest in affiliated practices or employ the dentists in the clinics.

However, under the perpetual term management agreement between FORBA and its affiliated clinics, each of the clinics delegates to FORBA the non-clinical support activities that are required by the clinic in the practice of dentistry, such as marketing, clerical, administrative, management, finance and other functions. FORBA is also responsible for business development functions including state/site selection and design of de novo clinics along with internal audit, consolidated accounting, cash management, recruiting and human resources. FORBA receives a fee from each clinic for providing such services equal to the greater of (i) $175,000 per month, (ii) 40% of booked patient revenue and (iii) 100% of operating profit (residual collections minus dentist compensation and other clinic operating expenses).

EXHIBIT 8

FORBA OWNERSHIP AND LEGAL STRUCTURE



GROWTH STRATEGY

The Company's growth strategy is driven by the continuation of its proven, highly profitable de novo clinic expansion strategy. The Company has successfully opened 44 total clinics

since January 2002, including six through June 22, 2006, and is on schedule to open six more clinics in 2006. Going forward, Management expects to continue the successful expansion strategy by opening at least 12 to 18 clinics per year over the next five years. The table below illustrates the Company's de novo expansion since 2002 as well as projected openings through 2011:

EXHIBIT 9

FORBA DE NOVO EXPANSION
2002-2011E

Clinics	2002	2003	2004	2005	2006E	2007E	2008E	2009E	2010E	2011E
Beginning Year	7	12	16	26	38	50	62	77	95	113
De Novo	5	4	10	12	12	12	15	18	18	18
End-of-Year	12	16	26	38	50	62	77	95	113	131

FORBA has standardized and optimized its de novo site selection and execution process to identify the markets or states in which to open a de novo clinic, find the optimal location, negotiate real estate leases, plan the design and construction, and execute pre-opening procedures.

Site Selection

Management first ranks all 50 states based on a weighted average Medicaid rate for the 28 most common procedures performed at FORBA's clinics, which comprise 95% of all procedures.

EXHIBIT 10

FORBA STATE RANKINGS

Rank	State	Rank	State	Rank	State	Rank	State
1	District of Columbia	14	Maine	27	Nebraska	40	Missouri
2	Alaska	15	Vermont	28	Iowa	41	Rhode Island
3	Connecticut	16	Montana	29	Washington	42	Kentucky
4	Massachusetts	17	Maryland	30	Idaho	43	Michigan
5	New Hampshire	18	Oklahoma	31	Pennsylvania	44	Louisiana
6	Wyoming	19	New York	32	Ohio	45	Florida
7	Arizona	20	Kansas	33	Oregon	46	Utah
8	North Carolina	21	North Dakota	34	Wisconsin	47	California
9	Indiana	22	South Carolina	35	Illinois	48	New Jersey
10	Tennessee	23	Alabama	36	Minnesota	49	West Virginia
11	Virginia	24	Colorado	37	Texas	50	Delaware
12	Georgia	25	New Mexico	38	Mississippi		
13	Nevada	26	South Dakota	39	Arkansas		

Cities opened prior to 2006

2006 opened and planned clinics

Planned and proposed 2007 clinics

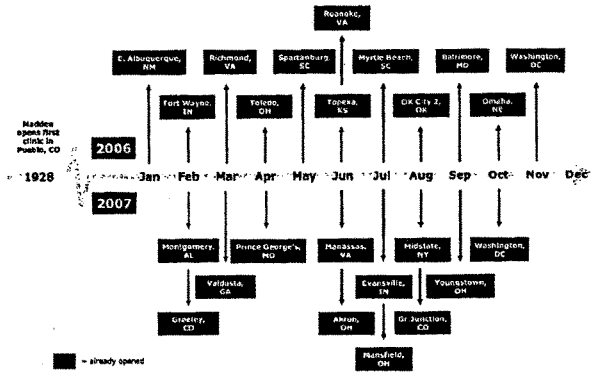
After assessing the state ranking, the Company turns to its proprietary market ranking matrix that evaluates the attractiveness of each state based on 20 key factors, which include:

- Eligibility requirements within the state;
- Number of eligible Medicaid and SCHIP children;
- MSAs within the state with at least 12,000 Medicaid eligible children;
- Number of dentists that accept Medicaid;
- Actual number of Medicaid and SCHIP dental visits;
- Regulatory and clinic ownership requirements; and
- Dental schools/programs in each state.

Within each state, FORBA prioritizes markets based on potential patient demand, population density, average household income, access to public transportation and degree of Medicaid dental competition. As part of the extensive de novo site selection process, the Company compiles a detailed due diligence compendium, complete with demographic and market information for the city as a whole for each potential site, competitive assessment, site photos and renderings and other relevant analysis. See Appendix A for the compendium that ranks each MSA in the 39 most attractive states. The Company also considers its ability to expand in a scalable and efficient manner for advertising, field operations and professional recruitment. Management performs highly detailed analyses of a large number of potential markets for entry or expansion before deciding on optimal locations for de novo clinics. As the following chart details, FORBA has already identified the locations for its 2006 and 2007 site openings and every clinic has been opened on schedule.

EXHIBIT 11

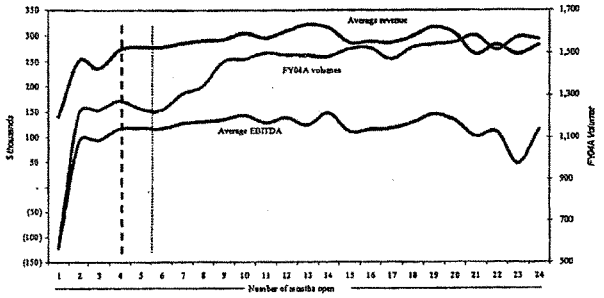
2007 GROWTH PLAN



FORBA's de novo clinics are highly profitable, require limited up-front investment and ramp up very quickly. The Company has invested an average of approximately $950,000 for its historical clinic openings through 2005. This excludes initial operating losses of approximately $150,000. Due to the high free cash flow of these clinics, the payback period has typically been less than 12 months, and profitability is achieved within the first two months because the new office typically addresses and attracts a large number of underserved patients. Moreover, many of these early patients require significant amounts of work due to their traditional lack of access to affordable child dental care. As a result, on average, new clinics have experienced rapid growth in revenue from month 1 through month 4.

EXHIBIT 12

CLINIC MATURATION CYCLE



As the clinic matures and its presence becomes more established in the community, the patient profile constitutes a more balanced mix of children who require more general dentistry and children still requiring significant work. The clinics typically experience stabilized patient volumes in four to five months and earn, on average, clinic level EBITDA of approximately $1.5 million in the first 12 months of mature operations.

Management's projections conservatively assume that the cost of developing de novo clinics will increase to $1.2 million, a 33% increase over historical costs (excluding conservatively projected initial operating losses of $300,000 vs. $150,000 for historical clinics). In addition, Management has conservatively projected future de novo mature EBITDA of $1.2 million, which is approximately $300,000 or 20% less than the average historical FORBA mature de novo EBITDA. It is also approximately equal to the low end of any annual class of clinic openings. The following table outlines the projected unit economics for the Company's de novo clinics.

EXHIBIT 13

PROJECTED DE NOVO ECONOMICS ($ IN THOUSANDS)

De Novo Clinic Economics	
Investment	
Tenant Improvements	$917
Dental Equipment	186
IT Upgrade	50
Computers	31
Furniture & Fixtures	16
Total Investment	$1,200

	Year 1	Year 2	Year 3
Revenue	$2,481	$3,415	$3,533
Expenses:			
Salaries & Benefits	1,185	1,411	1,460
Supplies	333	342	354
General Operating	317	328	339
Rent & Lease	98	120	120
Bad Debt	24	34	35
Total Expenses	1,957	2,235	2,308
Clinic EBITDA	$524	$1,180	$1,225
Margin	*21.1%*	*34.6%*	*34.7%*

Positive EBITDA in Month 2 | **Cumulative Breakeven EBITDA in Month 5** | **Capex Payback in 17 Months**

INVESTMENT MERITS

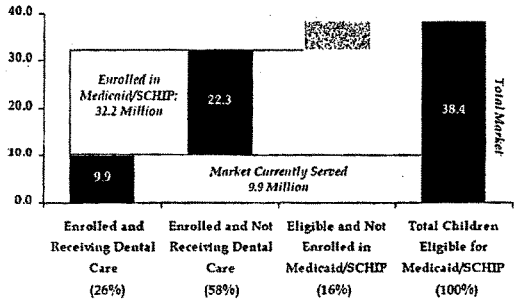
Leader in a Large, Underserved Market

FORBA's target market is largely underserved with very few competitors. More than one-third of children born in the U.S. receive healthcare under Medicaid. Currently, approximately 32.2 million children are enrolled in Medicaid or SCHIP, but nearly 22.3 million do not receive dental care. Additionally, approximately 6.2 million uninsured children qualify for Medicaid or SCHIP but are not enrolled in either program. Consequently, approximately 28.5 million children (nearly 75%) in the U.S. who should be receiving dental care services under Medicaid or SCHIP go untreated. The American Dental Association ("ADA") concluded: "There is a vast, drastic difference between the number of children who are eligible for dental treatment under the Medicaid program and those who actually receive treatment."

EXHIBIT 14

TREATMENT GAP IN MEDICAID/SCHIP ELIGIBLE CHILDREN

Number of Children (in millions)



Source: Centers for Medicare and Medicaid Services

The ADA also concluded that the largest cause of the disparity between need and treatment in low-income children is lack of access to dental care providers. The National Conference of State Legislatures reports that only one-in-six dental service providers who participated in Medicaid have annual Medicaid billings in excess of $10,000, which indicates the minimal participation in the program. Medicaid and SCHIP reimbursement rates, which vary by state and are almost uniformly lower than commercial rates, are partially responsible for the lack of participation. While states recognize the social and political benefits of providing regular dental care, they have generally managed expenditures by paying reimbursement rates below market.

Most dental practices cannot profitably treat Medicaid/SCHIP patients due to lack of scale, workflow efficiencies and expertise required to succeed in a relatively low reimbursement environment. FORBA has a proven business model of building large, efficiently designed clinics that profitably operate in the Medicaid/SCHIP environment. As a result, FORBA is the leading DPM providing access to high-quality dental care for children eligible under the Medicaid/SCHIP programs. As of June 22, 2006, FORBA's affiliated practices had 189 dentists in 44 clinics across 14 states and are projecting over 775,000 patient visits in 2006. Kool Smiles, the only other DPM in the country serving this market exclusively, operates 15 clinics in Georgia, Indiana, Massachusetts, and Virginia. FORBA will continue its aggressive

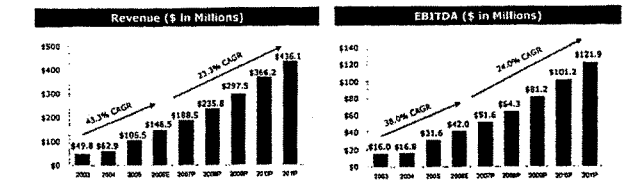
de novo growth strategy to enhance its market penetration, create better patient access and affiliate with dental practices that provide high-quality care to needy patients.

Impressive Historical Financial Performance and Cash Flow Generation

FORBA has demonstrated exceptional top line growth and profitability. Including year-end 2006 projections, over the past three years, net revenue will have grown at a compound annual rate of 43.3% and EBITDA will have grown at a compound annual rate of 38.0%. EBITDA margins have consistently been above 30.0% and for 2005 and 2006E, year over year EBITDA growth was 83.9% and 32.9%, respectively. FORBA also generates high-quality earnings as unlevered cash flow from operations has historically been over 95% of Adjusted EBITDA. This is a product of low working capital needs and minimal maintenance capital expenditures. This strong cash flow will continue to fund future de novo growth.

EXHIBIT 15

FINANCIAL PERFORMANCE



Outstanding Unit Level Economics

FORBA's highly successful de novo strategy is a powerful economic model that generates high returns with limited investment. The Company's new clinics have typically returned all investment capital within the first year, which has allowed it to finance its expansion strategy solely through operating cash flows. Management projects continued strong returns, but we are conservatively projecting a longer cash return cycle, with 100% cash-on-cash returns in 15 months. This still compares very favorably to several other Arcapita portfolio companies that rely on similar site development growth models as shown in the chart below. FORBA's year two cash-on-cash returns are also significantly better than McDonald's (41%), which is widely considered to have the most cost-efficient site development model in the restaurant industry.

EXHIBIT 16

CASH-ON-CASH RETURNS

($ in 000s)

	Year 2 EBITDA	Store Level Capex	Cash-on-Cash Return
FORBA Historical Openings	$1,470	$934	157%
FORBA Projected Openings	1,169	1,200	97%
Other Arcapita Portfolio Companies			
Lochmann's	$440	$1,520	29%
Caribou (1)	73	350	21%
Church's	115	350	33%

(1) Represents financials for non-Minnesota store openings.

Successful Management Team with Proven Track Record

Arcapita is partnering with a proven healthcare management team that previously has generated tremendous value for a private equity sponsor. Management has met with many members of Arcapita's direct investments team, including Charlie Ogburn, Stockton Croft, Jack Draughon, Scott Buschmann and Anna Tye, as well as and Kevin Keough from the Portfolio Management Group. We are highly confident that the team has the experience and motivation to execute FORBA's de novo clinic growth strategy and build a solid platform that will result in an attractive investment for our investors.

Michael Lindley, Al Smith and Rodney Cawood previously founded KEYS Group Holdings, Inc. and grew it into the leading provider of residential and non-residential behavioral health facilities, treating teens and young adults with severe behavioral problems. The KEYS business model was very similar to that of FORBA. Like FORBA, KEYS was committed to providing care to children within the Medicaid environment. However, the KEYS model represented a more complex, riskier and high acuity business model.

EXHIBIT 17

COMPARISON OF KEYS AND MADDEN

Metric	KEYS	FORBA
Number of Sites	55	43
Payor Source	Medicaid, Various State/Local Agencies	Medicaid, SCHIP
Payors per Facility	1-30	1-7
Primary Rate Setting	Negotiated	State Determined
Site Revenue	$500K to $13.0MM	$2.5MM to $7.0MM
Site EBITDA	$100K to $3.5MM	$500K to $1.0MM
Billing	Primarily Per Diem	Per Visit
Electronic Billing	Approximately 60%	Approximately 95%
MD/DDS per Site	1-3	3-4
Average Employees per Site	70	25
NIMBY[1] (1-10)	9-10	0
Number of States	28	14
Hours of Operations	24 Hours, 7 Days/Week	8 Hours, 5 Days/Week
Patient Acuity (1-10)	8-10	1-2

[1] *"Not In My Backyard"*

At KEYS, Management successfully operated in a tight credit market and executed a similar de novo growth strategy to FORBA's in a highly regulated environment. The management team built the KEYS platform from 1 to 55 facilities in two years, operating over 2,000 beds and seats. While building KEYS, the team successfully opened eight de novo facilities and integrated seven acquisitions, including taking publicly held Children's Comprehensive Services, Inc. private in January 2002. Less than five years after they founded KEYS, Management structured a sale of KEYS to publicly held Universal Health Services, Inc. for $207 million, achieving approximately an 8x cash return for financial investors in less than four years and approximately a 100x cash return for the initial investors in less than six years.

Tremendous Value Proposition to Patients and Dentists

FORBA offers convenient locations and quality dental care to low-income patients that have previously been ignored. The Company is one of only two dental practice management companies focused solely on providing services to children who qualify for Medicaid. The Company's patients have typically lacked access to dental care providers willing to accept Medicaid reimbursements. As a result, a child's first visit to a FORBA clinic is often the first time he has ever seen a dentist. In addition, because of the Medicaid dental program, all of the Company's services are provided **free** to the patient.

FORBA also provides dental professionals with all of the required administrative and management services to allow them to focus solely on efficiently delivering high-quality patient care. FORBA provides an excellent work environment with state-of-the-art dental equipment and supplies. The following are among the benefits that the Company's model provides its affiliated dentists:

- Increases productivity
  - Dentists no longer have to focus on time consuming administrative functions. The average non-DPM dentist can spend 15%-30% of his or her time on administrative tasks
- Eliminates capital needed to acquire and maintain state-of-the-art dental equipment
- Dentist does not have to build client base
  - Patients come to FORBA clinics for quality dental care, not to see a specific dentist

Barriers to Entry

Most dental care providers lack the size, scope, workflow efficiencies and expertise required to profitably serve the Medicaid/SCHIP market, which has unique market characteristics. The following barriers to entry explain many of the issues that would prevent other dentists or DPM providers from focusing on Medicaid/SCHIP eligible patients:

- Geographic Barriers – The Medicaid/SCHIP demographic often lacks means of transportation and there are a limited number of practices near the Medicaid population.
- Personal Behaviors/Cultural Barriers – Many dentists are hesitant to mix patient populations in their practices.
- Frequency of Broken Appointments - The percentage of broken dental appointments by children on Medicaid is 33% on average, which sole proprietor dentists are not positioned to mitigate.
- Administrative Procedures – Medicaid procedures require a heightened level of processing and unique claims forms to receive payment.
- Language Barriers – Many Medicaid beneficiaries do not speak English as their primary language and most dental practices are not equipped with the multi-lingual employees necessary to bridge the communication gap.

The FORBA DPM model significantly mitigates these challenges. Pre-opening activities focus on building out an attractive clinic with state-of-the-art equipment, recruiting motivated and dedicated staff (including multi-lingual staff) and creating market awareness. Unlike general dental practices, FORBA affiliated clinics are located near Medicaid/SCHIP patients with the size and configuration to uniquely handle the significant number of broken appointments. Importantly, FORBA's unique business model mitigates the 33% broken appointment challenge in that patients are not scheduled to have appointments with specific dentists.

Instead, any one of four dentists at a clinic can see a patient. Therefore, since FORBA employs a minimum of three to four dentists per clinic, FORBA can leverage its critical mass of dentists and over-schedule appointments by 25%. Since patients are assigned "chairs," not individuals, the usual bottle-necks of appointment run-overs are cleared because the next available dentist simply sees the next patient. The Company also is an expert in efficiently determining Medicaid/SCHIP eligibility, processing claims, confirming appointments, and following up with patients who break appointments. FORBA has successfully replicated this model through its de novo growth strategy from seven clinics at the beginning of 2002 to an expected 50 by the end of 2006.

Limited Rate Risk

FORBA primarily derives its revenue from Medicaid payors, which represent approximately 99% of the Company's total revenue. Under Early and Periodic Screening, Diagnostic and Treatment ("EPSDT"), a comprehensive Medicaid child health program that defines mandatory service requirements for state Medicaid programs, dental service coverage is a required benefit for Medicaid-eligible individuals under the age of 21. Since Medicaid dental services are an entitlement under federal law, it would take an act of Congress to alter the entitlement. Politicians are reluctant to attack a program that assists children of lower-income families, and state governments recognize the social and political benefits of providing regular dental care to children of low-income families. Further, child dental benefits represent less than 1% of the $288 billion Medicaid budget, making it a relatively minor program from which to seek budget savings. Consequently, Medicaid is a very stable payor for child dental health care. As the following chart shows, Medicaid dental reimbursement rates have been increasing not only in the states where FORBA has clinics, but across the U.S. as a whole.

EXHIBIT 18

MEDICAID REIMBURSEMENT

	CAGR		Weighted Avg. CAGR	
	All Medicaid Reimbursement		Medicaid Dental Reimbursement	
FORBA States	1993-1998	1998-2003	2001-Current	2004-Current
New York	(0.6%)	5.1%	0.0%	0.0%
Georgia	(0.3%)	(0.5%)	(0.2%)	(0.6%)
Ohio	3.2%	3.0%	(0.4%)	(1.3%)
Arizona	NA	4.1%	(0.2%)	(0.6%)
Indiana	2.1%	3.1%	0.0%	0.0%
Oklahoma	(0.7%)	3.2%	0.0%	0.0%
Virginia	(4.9%)	0.2%	8.6%	17.8%
South Carolina	0.9%	6.8%	0.0%	0.0%
Maryland	0.0%	3.8%	6.9%	0.0%
Massachusetts	(0.5%)	7.9%	4.5%	13.7%
New Mexico	2.0%	2.2%	(0.7%)	(1.1%)
Colorado	4.8%	1.1%	(0.2%)	0.0%
Kansas	(0.7%)	0.0%	0.0%	0.0%
Nevada	4.7%	5.5%	4.7%	(0.1%)
Nebraska	5.2%	11.8%	1.7%	2.8%
Idaho	2.4%	0.0%	0.0%	0.0%
Washington, DC	(0.8%)	1.6%	34.5%	40.0%
Total U.S.	0.9%	5.0%	2.7%	3.0%

Source: ADA, state Medicaid websites and FORBA.

FORBA's reimbursement rates are also protected by the fact that although Medicaid is a federally mandated program, reimbursement rates are determined at the individual state level. Therefore, FORBA's rate risk is diversified across the 14 states in which it currently operates. Additionally, no single state represents more than 16% of the Company's total revenue and that geographic diversity is expanding every year as the Company enters new states. Furthermore, FORBA's large and growing geographic footprint mitigates any potential adverse state-specific reimbursement or regulatory changes. The Company will continue to add 12 to 18 clinics a year in new states and new markets, further diversifying its revenue and profit generating business model.

EXHIBIT 19

REVENUE BY STATE

($ in 000s)

State	2005A Clinics	2005A Revenue	2005A % Total
Colorado	5	$16,618	15.6%
Massachusetts	5	7,172	6.7%
South Carolina	4	15,555	14.6%
Ohio	4	4,946	4.6%
Georgia	4	13,453	12.6%
Indiana	3	8,711	8.2%
Oklahoma	2	12,144	11.4%
New York	3	7,370	6.9%
New Mexico	2	5,693	5.3%
Kansas	2	7,158	6.7%
Arizona	2	6,088	5.7%
Nevada	1	440	0.4%
Idaho	1	1,174	1.1%
TOTAL	38	$106,522	100.0%

By the end of 2006, we anticipate that no single state will represent more than 12% of FORBA's revenue.

Increased Awareness of Link Between Poor Dental Care and Other Diseases

According to the Surgeon General's report, "Oral Health in America, 2000", the current level of dental and oral diseases affecting some population groups, and most significantly underprivileged children and low income elderly Americans, amounts to a "silent epidemic." Socio-economic levels significantly impact the prevalence of tooth decay, with preschoolers in households with income levels less than 100% of the federal poverty level ("FPL") three to five times more likely to have cavities than children from families with incomes equal to or above 300% of FPL. On average, children in households below 200% of FPL (approximately half of the children in the U.S.) suffer from three and a half times more tooth decay than do children from families that are more affluent. Within the highest-risk, lowest income group, four to five million children experience more severe levels of dental disease, often associated with pain, infection and disruption of normal activities, such as attending school and social activities. The Third National Health and Nutrition Examination Survey found that nearly 80% of the decayed teeth in two to five year olds from lower income families went untreated and 40–50% of the decayed primary and permanent teeth in 6-14 year olds from low-income families went untreated.

There are severe social and economic consequences of untreated dental disease and poor oral health in millions of children. Untreated tooth decay leads to delayed overall development among young children affected with severe forms of the disease. Dental disease is associated with systemic health conditions and social consequences, and affected children often have problems with school attendance and performance. Economic consequences include frequent high cost visits to hospital emergency departments (often without definitive resolution of the problem), hospital admissions, and treatment provided in operating rooms for conditions that are either largely preventable or amenable to less costly care had they been treated earlier. The urgency and consequences of poor oral health have led the U.S. government to mount public service campaigns warning of the risks and encouraging proper care. As a result, Medicaid enrollment of children has grown at a 5.5% CAGR from 1998-2003 and overall utilization of dental benefits has grown at 14.2% CAGR for the same period.

INVESTMENT RISKS AND MITIGANTS

Site Selection

FORBA's growth is dependant on the Company's ability to open 81 new clinic locations over the next five years. This de novo clinic growth plan will be significantly affected if the Company is not able to find enough potential locations that have an attractive combination of eligible population, a favorable reimbursement and regulatory environment, and sufficient supply of dentists.

Over the past few years, the Company has developed a highly detailed matrix that ranks the attractiveness of each state based on a number of factors, including the state Medicaid reimbursement environment, number of Medicaid eligible children, number of dentists in the state, and the percentage of dentists already accepting Medicaid fee-for-service reimbursement. Based on this analysis, Management has concluded that 39 states (plus the District of Columbia) represent an attractive environment for the Company's clinics to deliver expected margins and cash-on-cash returns. Please see Appendix A for the complete matrix FORBA has developed.

The Company has further broken down these states to determine the number of cities within each state with a large enough population of Medicaid eligible children to support a FORBA dental clinic. According to Management, a clinic needs more than 12,000 Medicaid eligible children within a serviceable radius to be successful. The following chart details the potential number of clinics that FORBA could open in attractive locations within the top 39 states. Arcapita is working with L.E.K. Consulting to build an independent analysis to verify these numbers, but based on Management's assumption of 12,000 required Medicaid eligible children, the Company's penetration of potential stores in 2011 is less than 26%.

EXHIBIT 20

SITE SELECTION

Required Medicaid Children	Potential Number of Locations	2006E Number of Clinics	2006E "Runway"	2011B Number of Clinics	2011B "Runway"
12,000	516	50	10x	131	4x

Execution of De Novo Build-out Strategy

FORBA anticipates opening 12, 15, 18, 18, 18 new clinics in each year from 2007 to 2011, respectively. Should some of these clinics not open as planned or should they not be as successful as anticipated, FORBA's overall revenue and EBITDA growth will be adversely affected.

This risk is mitigated by the following factors:

- FORBA has a consistent track record of de novo clinic openings and operating performance. The Company has opened 38 clinics since the beginning of 2003 that have averaged year 2 EBITDA of $1.5 million and 157% cash-on-cash returns. In addition, the Company's worst performing clinic is still profitable and will achieve EBITDA in 2006E of approximately $500,000, representing a 50% cash-on-cash return.

EXHIBIT 21

HISTORICAL DE NOVO CLINIC OPENINGS

	2003	2004	2005	2006
Mature De Novo Adjustments:				
De Novo Clinic Openings	4	10	12	12
Mature De Novo EBITDA	$1,288	$1,785	$1,212	$1,466
Total Mature De Novo Adjustment	$5,152	$17,850	$14,544	$17,592
Adjusted EBITDA	$15,983	$17,994	$33,077	$41,965
Mature De Novo Adjustment	5,152	17,850	14,544	17,592
Less: Actual Performance	2,596	2,675	1,744	4,757
Pro Forma Adjusted EBITDA	$18,539	$33,169	$45,877	$54,800

- We have conservatively budgeted the de novo clinics to cost 26% more to open than historical openings and to achieve year 2 EBITDA of $1.2 million, which is below the worst performing annual class that the Company has opened to date.

EXHIBIT 22

DE NOVO COMPARISON

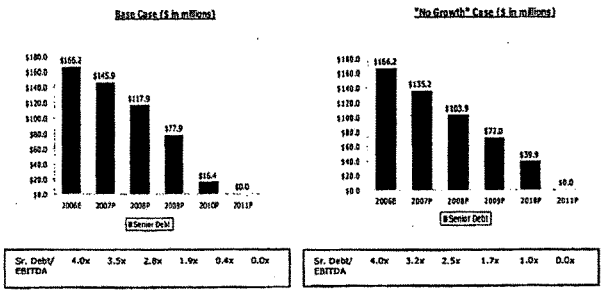
	Avg. Historical	Projected	Conservatism
Capital Expenditures	$950K	$1.2 million	26%
Initial Operating Losses	$150K	$300K	100%
Mature Clinic EBITDA	$1.5 million	$1.2 million	20%
Cash-on-Cash Return	159%	98%	38%
Capex Payback	Month 15	Month 17	13%

- FORBA usually develops and opens a clinic within six months following decision to open. FORBA has historically opened all of its clinics on time and is on track to achieve 12 clinic openings in 2006. In addition, the Company has already identified the locations for all 12 openings in 2007. Further, the main hurdle of securing good real estate that most retailers face when opening new stores does not apply to FORBA. All of FORBA's clinics are close to their patient base and in third or fourth tier real estate locations.

- FORBA generates high levels of free cash flow, with unlevered cash flow from operations equal to 95% of EBITDA. We have modeled a no growth case in which the Company opens no new stores and realizes 0% same store sales growth at its existing clinics. In this scenario, the Company is still able to pay off all of its senior debt.

EXHIBIT 23

STRONG DELEVERING CREATES EQUITY VALUE



Recruiting and Retention of Talented Dentists

FORBA's future performance will also depend on the Company's ability to recruit and retain talented dentists. Based on FORBA's growth projections and historical turnover rates, the Company will need to recruit approximately 250 dentists, up from approximately 110 in 2005. To address this need, the Company has recently recruited a new head of Human Resources that is primarily focused on the recruiting and retention of dentists, hygienists, dental assistants and office managers. Upon arrival, he launched a "Lunch and Learn" program whereby representatives hold information sessions with students at top dental schools around the country. Since the program's inception in October 2005, the Company has already visited 11 of the 56 dental schools in the U.S. In addition, FORBA has increased its starting salary for assistant dentists to $120,000 (excluding bonus) as compared to a national average of $80,000 for dentists directly out of school.

The performance of the Company's individual clinics is highly correlated with dentist turnover. Most clinics that are underperforming have experienced some degree of turnover, whereas clinics that have benefited from continuity at the dentist level have performed well.

After dental school, many top dentists aspire to enter into a private practice on their own or with another dentist or attend graduate school for specialty dentistry. Additionally, many dentists want to work close to home and prefer to work with patients that do not need the government's support. As a result, turnover at FORBA is 40% (same as industry average).

The incoming management team is keenly focused on decreasing the turnover rate at FORBA through a restructured incentive/bonus plan (only 30% of dentists currently qualify), deferred compensation arrangement, flexible hours and increased vacation, as well as exit interviews and detailed satisfaction analysis. Management believes that this is an area that has been under-managed by FORBA and that these simple changes, which were not offered by the prior management team, can have a significant effect on the Company's turnover rates.

Further, FORBA has recently qualified for a student loan repayment program with the National Health Service Corp. whereby the NHSC will pay up to $35,000 annually to repay the student loans for dentists who work in designated "shortage" areas. Currently, approximately one-third of the Company's clinics are located in these shortage areas and the management team is working to qualify as many of its dentists for the program as possible.

In addition, Arcapita (through L.E.K. Consulting) is conducting surveys with current FORBA dentists, former FORBA employees and placement officers at the leading dental schools to gain a better understanding of the Company's reputation, ability to recruit and the attractiveness of the work environment. To date, the results of these interviews have been very positive, with over 50% of respondents having a positive response to the Company and less than 20% with negative reactions. Of these 20%, the majority are pre-disposed against the DPM model in general.

Turnover Associated with Relocation of Headquarters

Management anticipates that they will relocate the headquarters from Pueblo, Colorado to Nashville, TN. Prior to moving headquarters, Management will commute from Nashville to Pueblo. Management is planning on keeping the Pueblo facility as a satellite location. Those who wish to continue to be a part of "headquarters" but do not want to move to Nashville may choose to leave FORBA. Additionally, those who were well-aligned with the former management team may feel a stronger loyalty to FORBA in Pueblo, Colorado than to Nashville, TN.

This risk is mitigated by the following factors:

- Management has already spoken with several members of top management who have expressed excitement about making the move to Nashville. Additionally, Management sees the Nashville office more as an "East coast headquarters" and will very much treat Pueblo as the "West coast headquarters".
- FORBA headquarters is largely comprised of regional directors. It would logically make more sense for these directors to work out of their respective regions, as opposed to headquarters.

- The Pueblo, Colorado facility will still remain a part of the company's operations and will be where a large part of the administrative work takes place.
- Many members of the current management team are excited that our executives are taking over the company. In the past, many talented executives were not given equity or promotion opportunities because they were not related to the DeRose family.

DUE DILIGENCE

CIT has already completed due diligence with several advisors, including Waller Lansden Dortch & Davis (legal), Ernst & Young (financial), McBee Associates (clinical, industry and market) and Lockton Companies (insurance). Arcapita has also engaged advisors to review the work of CIT's advisors and to perform due diligence of our own, including King & Spalding (legal), L.E.K. Consulting (industry and market), and Marsh (insurance). We expect these groups to complete a large portion of their due diligence and subsequently provide us with reports of their findings by June 26. If selected as the exclusive bidder thereafter, these advisors will continue their due diligence over the next several weeks to confirm their initial findings. All of these advisors have provided positive preliminary feedback thus far, stating that FORBA is an extremely "clean" business. As such, we do not expect any of these advisors to uncover significant issues that would cause us to question whether or not to proceed with the transaction.

2. Financial Overview

BASIS OF PRESENTATION

This Memorandum contains the Company's historical financial information from 2003 through 2005, as well as Arcapita's "base case" projections for the fiscal years 2006 through 2011. FORBA is a management company that is owned by seven members (Dan DeRose – 18.5%, Eddie DeRose – 18.5%, Mike DeRose – 18.5%, Padula Family LLP – 18.5%, William Mueller – 18.5%, Mike Roumph – 5% and Rich Lane – 2.5%).

HISTORICAL FINANCIAL INFORMATION

EXHIBIT 24

SUMMARY HISTORICAL OPERATING INFORMATION

($ in thousands)	Actual						
	For the Years Ended December 31,			For the Three Months Ended		LTM	Q1 2006
	2003	[1] 2004	2005	3/31/05	3/31/06	3/31/06	Annualized
Total Revenues	$69,767	$82,906	$106,493	$24,045	$32,799	$115,247	$131,196
% Growth		18.8%	49.3%		36.4%		
Salaries, wages, and benefits	$28,585	$38,879	$47,409	$10,022	$11,654	$52,840	$58,416
Supplies and purchased services	4,714	9,422	12,472	2,731	3,837	15,378	17,425
General operating expenses	3,686	5,313	6,972	1,844	2,626	8,854	10,304
Rent and lease expenses	1,496	1,936	2,896	355	956	3,493	3,821
Depreciation	792	3,838	4,299	844	1,427	4,862	5,625
Provision for uncollectible accounts	525	563	4,051	138	365	4,256	3,457
Total Operating Expenses	$34,576	$59,971	$78,196	$16,174	$20,863	$90,505	$99,452
EBIT	$15,191	$22,935	$27,297	$7,871	$8,936	$24,362	$35,744
% of Revenue	20.5%	20.6%	25.6%	32.7%	27.2%	24.6%	27.2%
Depreciation	792	3,838	4,299	844	1,427	4,862	5,625
Company EBITDA	$15,983	$26,773	$31,596	$8,715	$10,363	$33,224	$41,372
% of Revenue	22.1%	28.7%	29.7%	36.2%	31.5%	28.8%	31.5%
Net Adjustments [2]	$0	$1,221	$1,481	($563)	$217	$2,563	$217
Adjusted EBITDA	$15,983	$27,993	$33,077	$7,850	$10,580	$35,787	$41,589
% of Revenue	22.1%	29.6%	31.5%	32.6%	32.2%	31.1%	31.7%
Total Capital Expenditures	$4,756	$8,697	$13,449	$1,747	$2,354	$14,046	$9,419
% of Revenue	6.8%	10.5%	12.6%	7.3%	7.2%	12.2%	7.2%
De Novo Clinic Openings	4	10	12	2	3	13	12
Total Number of Clinics (end-of-period)	16	26	38	28	41	41	50

MANAGEMENT DISCUSSION AND ANALYSIS

FORBA manages and operates 44 clinics dedicated to serving children eligible for dental treatment under Medicaid/SCHIP. FORBA earns management fees from each clinic for providing management, finance and administrative support to the clinics.

As previously discussed, the Company adopted a de novo growth strategy to produce significant growth in the number of clinics historically. Management opened 4 clinics in FY03A, 10 clinics in FY04A and 12 clinics in FY05A. Additionally, the Company has opened 7 clinics so far in 2006. This growth strategy includes a detailed process identifying target locales through research of reimbursement rates by state, population of and accessibility to eligible patients and the level of competition present in the market.

Net patient service revenue has increased primarily due to the Company's continuously increasing the number of clinics. Despite the significant increase in revenue, revenue per visit has decreased historically. This is largely due to the continued maturation of the facilities and the large amount of dental work necessary for a first time patient. However, as the clinics mature and build a regular clientele that have repeat visits, the increase in volume from existing and new patients as well as historical year over year Medicaid rate increases have more than offset the decline in the revenue per patient.

2004 to 2005

Clinic rates decreased by $1.2 million from 2004 to 2005, but this was offset by significant increases in volumes of $44.7 million. This netted out to a $43.5 million positive change in clinic revenue from 2004 to 2005. FORBA completed 2005 with record revenue and EBITDA numbers of $106.5 million and $33.1 million, up 69.3% and 84.0%, respectively, from 2004. In 2005, much of FORBA's growth was fueled by the opening 12 de novo clinics. EBITDA margins increased from 28.6% in 2004 to 31.1% in 2005.

2005 to 2006E

Clinic rates are budgeted to decrease by $0.9 million from 2005 to 2006. Volumes are expected to increase by $47.0 million, which will result in a $46.1 million positive change in clinic revenue from 2005 to 2006. FORBA is budgeted to achieve 2006 revenue and EBITDA numbers of $146.5 million and $42.0 million, up 37.6% and 32.8%, respectively, from 2005.

2006 year to date, FORBA is on track to achieve revenue of $146.5 million and EBITDA of $42.0 million, achieving EBITDA margins of 28.6%. The Company is on track to successfully open 12 de novo clinics in 2006.

Operating expenses are expected to remain constant as a percentage of revenue, allowing EBITDA margins to remain in the 27%+ range.

FINANCIAL OVERVIEW – BASE CASE PROJECTIONS

EXHIBIT 25

BASE CASE PROJECTIONS

($ in 000s)

	For the Years Ending December 31,				2003-2006E % CAGR	For the Years Ending December 31,					2007P-2011P % CAGR
	2003	2004	2005	2006E		2007E	2008P	2009P	2010P	2011P	
Net Revenue	$49,767	$62,906	$106,693	$144,519	43.3%	$188,525	$233,772	$297,464	$366,199	$436,147	23.3%
% Growth		26.4%	69.5%	37.6%		30.4%	23.5%	26.3%	23.1%	19.1%	
Operating Expenses	33,784	46,136	74,957	103,154	45.3%	134,937	171,479	216,273	265,001	314,265	23.3%
% Revenue	67.9%	73.3%	70.3%	70.7%		71.6%	73.3%	72.7%	72.4%	72.1%	
Adjusted EBITDA	$15,983	$16,770	$31,736	$41,365	39.0%	$53,588	$62,293	$81,189	$101,199	$121,882	24.0%
EBITDA Margin	32.1%	26.7%	29.7%	28.6%		28.4%	26.6%	27.3%	27.6%	27.9%	
De Novo Clinic Openings	6	10	12	15		13	15	18	18	18	
Total Clinics Opened at Year End	16	26	38	50		62	77	95	113	131	

Source: Management's projections, as adjusted by Arcapita.

Net Revenue

Based on FORBA's de novo clinic growth strategy already in place, we expect net revenue in our Base Case Projections to reach $436.1 million in 2011P, representing a CAGR of 23.3% over the most recent forecasted results for 2007. Growth is a function of continued penetration of new markets with high Medicaid populations, continued retention of talented dentists and continued awareness of the importance of preventative dental care. Additionally, we have shown conservative same store growth of only 2.7% for mature clinics.

We have conservatively ramped up the de novo clinic openings and have budgeted them to cost 26% more to open than historical openings and to achieve year 2 EBITDA of $1.2 million, which is below the worst performing annual class that the Company has opened to date.

Operating Expenses

Operating expenses have increased historically due to overall volume increases associated with new facility openings, but have decreased as a percentage of revenue and on a per visit basis due to the benefits of leveraging the inherent fixed costs of clinics as they mature.

In the coming years, operating expenses are projected to rise only slightly as a percentage of revenue over the period from 2007 to 2011 for the same reasons as stated above. The Company plans to use corporate capital expenditures of $1.3 million over the next five years to increase and expand information and systems technology.

Due to the proven and effective de novo clinic strategy, operating expenses are fairly easy to predict and will experience minor increases as the Company continue to build out more clinics.

EBITDA

Over the period from 2003 to 2006E, EBITDA has grown as a CAGR 38.0% and is expected and on track to reach $42.0 million by 2006 year end. EBITDA growth has historically been driven by entry into new markets and the outstanding de novo economics associated with opening a new clinic.

In our Base Case, we expect EBITDA to reach $121.9 million by FY2011, which represents a 23.3% CAGR from 2007 to 2011 vs. the historical CAGR of 43.3%. EBITDA margins will remain relatively constant in the 27-28% range.

Capital Expenditures

The following chart displays the total capital expenditures for the Company from 2006E through 2011P. Capital expenditures consist of de novo, maintenance and corporate capital expenditures. Historically, maintenance expenditures have been minimal. Management conservatively forecasts average clinic maintenance capital expenditures of $12,000 going forward. Corporate capital expenditures will increase to expand information and systems technology during the next five years.

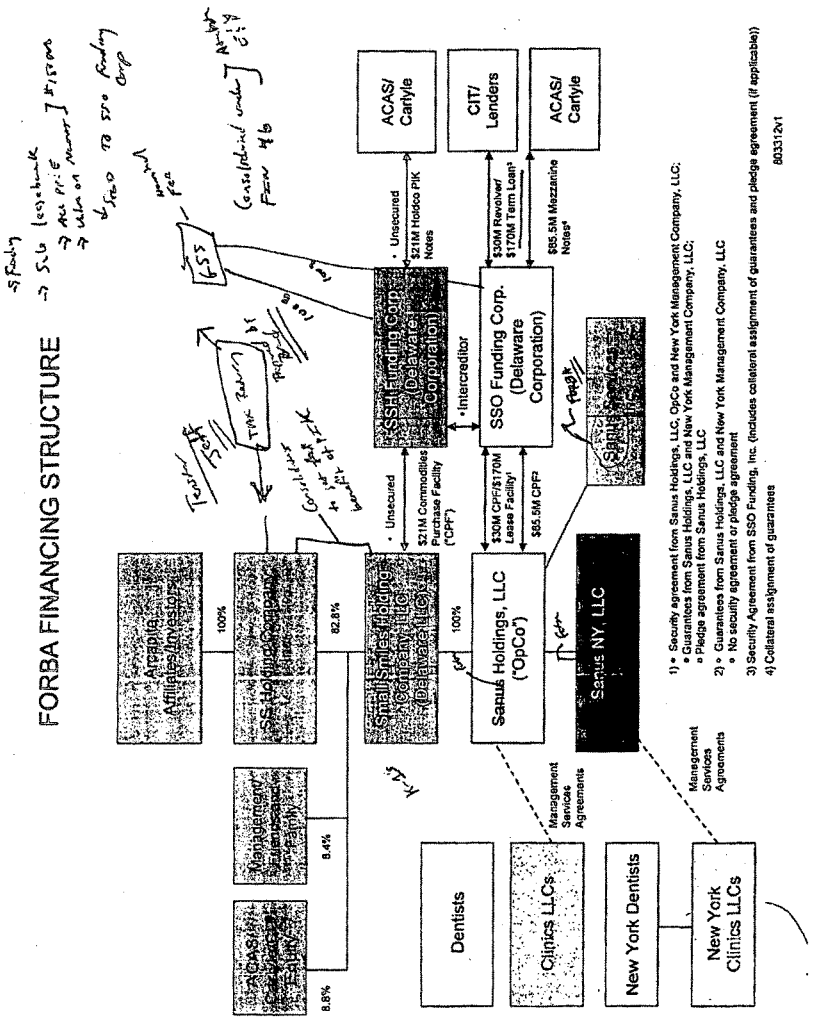
De novo start-up costs comprise the largest component of the Company's capital expenditures. De novo clinics are conservatively projected to require $1.2 million of startup capital, which provides tenant improvements, dental equipment, furniture and systems infrastructure.

EXHIBIT 26

BREAKDOWN OF PROJECTED BASE CASE CAPITAL EXPENDITURES

($ in 000s)

	For the Years Ending December 31,					
	2006E	2007P	2008P	2009P	2010P	2011P
Startup Capex	$14,400	$14,400	$18,000	$21,600	$21,600	$21,600
Maintenance Capex	570	750	930	1,155	1,425	1,695
Corporate Capex	250	250	250	250	250	250
Total Capex	**$15,220**	**$15,400**	**$19,180**	**$23,005**	**$23,275**	**$23,545**
% of Revenue	*10.1%*	*8.1%*	*8.0%*	*7.7%*	*6.3%*	*5.3%*
De Novo Clinic Openings	12	12	15	18	18	18
Total Clinics Opened at Year End	50	62	77	95	113	131


FORBA FINANCING STRUCTURE
Arcapita Affiliates/Investors
100%
82.8%
8.4%
8.8%
100%
Unsecured
$21M Commodities Purchase Facility ("CPF")
Intercreditor
$30M CPF/$170M Lease Facility
$85.5M CPF
Unsecured
$21M Holdco PIK Notes
$30M Revolver/ $170M Term Loan
$85.5M Mezzanine Notes
ACAS/ Carlyle
CIT/ Lenders
ACAS/ Carlyle
SSO Funding Corp. (Delaware Corporation)
Sanus Holdings, LLC ("OpCo")
Sanus NY, LLC
Management Services Agreements
Management Services Agreements
Dentists
Clinics LLCs
New York Dentists
New York Clinics LLCs
1) • Security agreement from Sanus Holdings, LLC, OpCo and New York Management Company, LLC;
• Guarantees from Sanus Holdings, LLC and New York Management Company, LLC;
• Pledge agreement from Sanus Holdings, LLC
2) • Guarantees from Sanus Holdings, LLC and New York Management Company, LLC
• No security agreement or pledge agreement
3) Security Agreement from SSO Funding, Inc. (includes collateral assignment of guarantees and pledge agreement (if applicable))
4) Collateral assignment of guarantees
803312v1

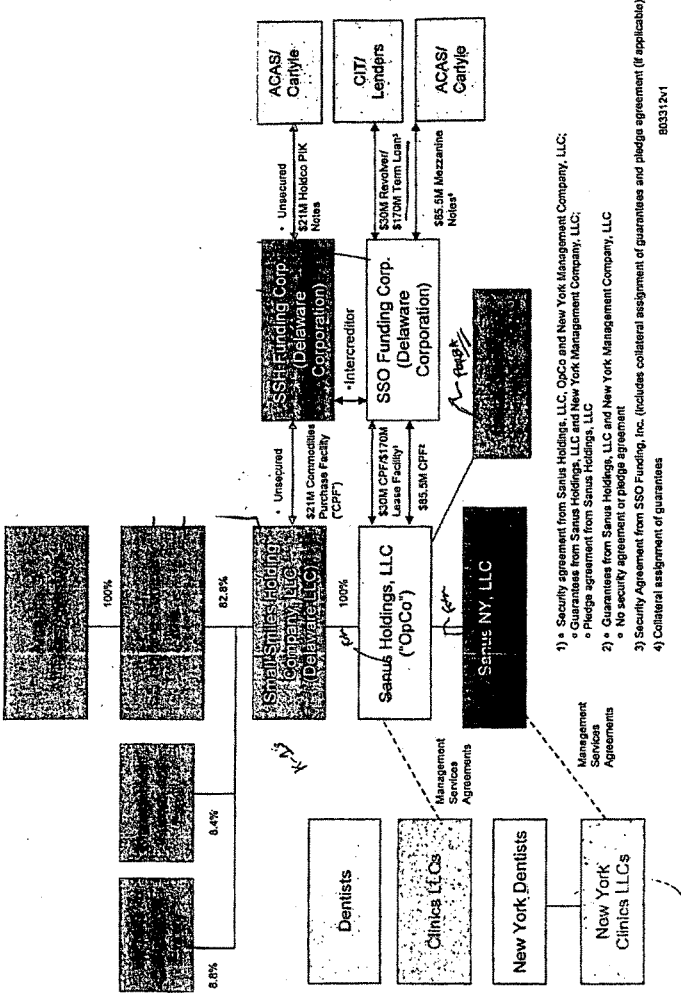

FORBA FINANCING STRUCTURE
100%
82.8%
8.8%
0.4%
Small Smiles Holding Company, LLC ("SmallCo")
100%
Sanus Holdings, LLC ("OpCo")
Sanus NY, LLC
• Unsecured
$21M Commodities Purchase Facility ("CPF")
$30M CPF/$170M Lease Facility
$85.5M CPF
SSH Funding Corp. (Delaware Corporation)
SSO Funding Corp. (Delaware Corporation)
• Intercreditor
• Unsecured
$21M Holdco PIK Notes
$30M Revolver/ $170M Term Loan
$85.5M Mezzanine Notes
ACAS/ Carlyle
CIT/ Lenders
ACAS/ Carlyle
Dentists
Clinics LLCs
New York Dentists
New York Clinics LLCs
Management Services Agreements
Management Services Agreements
1) • Security agreement from Sanus Holdings, LLC, OpCo and New York Management Company, LLC;
◦ Guarantees from Sanus Holdings, LLC and New York Management Company, LLC;
◦ Pledge agreement from Sanus Holdings, LLC
2) • Guarantees from Sanus Holdings, LLC and New York Management Company, LLC
◦ No security agreement or pledge agreement
3) Security Agreement from SSO Funding, Inc. (includes collateral assignment of guarantees and pledge agreement (if applicable))
4) Collateral assignment of guarantees
803312v1

EXHIBIT 11

MARCH MADNESS

What's the goal?
To improve team work and clinic performance while providing quality dental services in a timely manner for low-income children to enhance their health and self esteem.

How will we measure team work and clinic performance?

- # of patients converted from hygiene to operative over goal.
- # of patients seen per day over goal.
- Broken Appointment rate less than goal.
- Daily Average Production over goal.

What are the rules?
All clinic teams will start MARCH MADNESS with their February FOCUS 'bonus points' as their base. Each week clinics will be awarded 200 points for each performance category that exceeds their goal (# of patient's converted and total # of patients seen goals are based on each clinic's latest four month average, broken appointment goals are based on each clinic's BA rate for February and daily average production is based on each clinics actual March budget). Points will be accumulated each week and at the end of the month all clinics will be ranked from first to last. ONLY the top 13 clinics will be awarded prize money.

The clinic team with the most points will be named **2007 National Champions!**
The next 4 clinics team will be named **2007 Final Four Champions!**
The next 8 clinics teams will be named **2007 Elite Eight Champions!**

Who is eligible for this contest?
Everyone!

What do we win?

2007 National Champions Trophy and all clinic staff will be awarded	$1,000.00 !!!!
2007 Final Four Champions Trophy and all clinic staff will be awarded	$ 400.00 !!!
2007 Elite Eight Champions Trophy and all clinic staff will be awarded	$ 100.00 !!

How will we know how we're doing in the MARCH MADNESS contest?
We will take care of all that! [redacted] will provide everyone with weekly MARCH MADNESS updates every Monday. All you need to do is focus on the game and WIN!!!

Good luck and Have Fun!!!

Elite Eight *Final Four* *National Champions*

FORBA 0236058
CONFIDENTIAL

Although all clinics are competing against one another we have assigned coaches to clinics teams. Coaches are to provide Lead Dentists, Office Managers and Lead Dental Assistants with moral support, performance reporting, positive feedback and share best practices to help each clinic reach their full potential throughout MARCH MADNESS.

Western Region Coaches	**Clinic Teams**	
Dr. [redacted]	Denver Broncos	Aurora Drillers
	Tulsa	OKC1
	Oklahoma Canines (OCK2)	Omaha Cavinators
	Colo. Springs Snow Crowns	
[redacted]	Topeka Tooth Fairies	Albuquerque Toothinators
	Phoenix Crowns	Tucson Tooth Warriors
	KCK Dentinators	Wichita Rezainators
[redacted]	Pueblo Crusaders	Santa Fe Molarnators
	Thornton Cavity Terminators	Reno Coronas
	Boise Bicuspids	E. Alb 505 Prophy Anglers
Central Region Coaches	**Clinic Teams**	
Dr. [redacted]	Rochester	Lawrence
	Mattapan Maintainers	Cincinnati Extractors
	Ft.Wayne Smilers	Toledo T Town Tacklers
[redacted]	Gary Steelteeth	Indy 2
	Syracuse Teeth Savers	Roselawn Pulpeteers
	Lynn	
[redacted]	Indy 1 Calculus Crushers	Springfield Springboks
	Columbus Royal Crows	Albany Tight Ends in Motion
	Worcester	Dayton Cavity Busters
Eastern Region Coaches	**Clinic Teams**	
Dr. [redacted]	Atlanta Plaque Attackers	Augusta Masters
	Richmond Cavity Kickers	Myrtle Beach
	Baltimore Explorers	
[redacted]	Columbia Cavity Catchers	Florence Fluoriders
	Savannah	Roanoke Stars
	Montgomery	
[redacted]	Greenville Molars	Charleston Clamdiggers
	Macon Lidocaines	Spartanburg Smile Makers
	Washington DC Fighting Floss	

Company		Conversions Month Average	BA Month Average	Production Average	Pts Seen Month Average
0	Pueblo, CO	12.50	23.7%	$17,795.45	79.27
1	Colorado Springs, CO	7.59	33.6%	$13,450.00	71.05
2	Denver, CO	12.36	31.8%	$13,954.55	66.14
3	Albuquerque, NM	11.45	40.3%	$16,136.36	78.82
4	Santa Fe, NM	8.55	32.6%	$10,254.55	57.45
5	Aurora, CO	16.05	28.5%	$17,081.82	79.00
6	Phoenix, AZ	8.73	32.6%	$12,122.73	57.91
7	Indy 1, IN	7.82	35.3%	$12,036.36	71.50
8	Gary, IN	9.86	46.0%	$12,940.91	68.23
9	Thornton, CO	18.55	32.2%	$19,054.55	72.09
10	Greenville, SC	9.59	31.5%	$15,086.36	83.50
11	Columbia, SC	3.41	46.4%	$13,327.27	75.64
12	Tucson, AZ	11.18	35.2%	$14,281.82	68.23
13	Charleston, SC	17.23	25.5%	$15,159.09	65.50
14	Indy 2, IN	12.82	32.1%	$13,636.36	63.09
15	KCK, KS	8.86	33.8%	$14,231.82	80.91
16	Atlanta, GA	5.36	39.0%	$9,195.45	53.36
17	Florence, SC	2.86	45.2%	$13,068.18	60.68
18	Wichita, KS	17.91	36.5%	$20,222.73	102.50
19	Macon, GA	5.68	47.7%	$15,677.27	69.95
20	Tulsa, OK	16.18	37.5%	$28,881.82	106.77
21	Augusta, GA	7.73	43.2%	$10,877.27	52.05
22	Syracuse, NY	6.27	45.9%	$11,809.09	71.50
23	Savannah, GA	10.32	47.1%	$11,936.36	49.68
24	OKC 1, OK	10.68	28.5%	$30,431.82	101.41
25	Rochester, NY	7.95	39.4%	$15,163.64	81.91
26	Springfield, MA	9.27	36.0%	$22,818.18	92.00
27	Columbus, OH	14.43	46.7%	$21,090.91	91.73
28	Boise, ID	11.32	36.1%	$10,250.00	63.00
29	Albany, NY	4.91	41.4%	$15,327.27	72.64
30	Lawrence, MA	7.32	37.2%	$12,904.55	46.05
31	Worcester, MA	7.36	36.7%	$22,531.82	77.55
32	Roselawn, OH	15.68	43.6%	$10,127.27	47.27
33	Dayton, OH	10.05	33.6%	$20,759.09	90.59
34	Mattapan, MA	7.45	43.5%	$12,109.09	37.14
35	Lynn, MA	1.50	44.2%	$9,140.91	40.77
36	Cincinnati, OH	8.18	52.4%	$8,559.09	53.82
37	Reno, NV	7.95	30.0%	$12,104.55	67.64
38	East Albuquerque, NM	3.68	40.9%	$12,590.91	52.45
39	Fort Wayne, IN	6.14	29.4%	$16,777.27	69.27
40	Spartanburg, SC	6.64	37.4%	$12,254.55	54.82
41	Richmond, VA	2.82	40.4%	$7,727.27	34.00
42	Toledo, OH	28.05	41.4%	$13,500.00	68.45
43	Myrtle Beach, SC	6.14	29.8%	$7,800.00	32.73
44	Topeka, KS	6.14	41.3%	$12,104.55	62.91
45	Roanoke, VA	3.82	51.5%	$15,740.91	77.32
46	OKC 2, OK	4.18	32.7%	$11,786.36	44.82
47	Baltimore, MD	4.77	41.4%	$17,536.36	83.45
48	Omaha, NE	4.15	39.8%	$10,600.00	35.82
49	Washington, DC	2.36	40.3%	$23,063.64	69.14
50	Montgomery, AL	4.68	40.9%	$12,554.55	69.27
	COMPANY AVERAGE	**8.93**	**38.9%**	**$14,678.61**	**67.11**

FORBA 0236060
CONFIDENTIAL

Company	Clinic	3/1/2007	3/2/2007	3/5/2007	3/6/2007	3/7/2007	3/8/2007	3/9/2007	3/12/2007	3/13/2007	3/14/2007	3/15/2007	3/16/2007	3/19/2007	3/20/2007	3/21/2007	3/22/2007	3/23/2007	3/26/2007	3/27/2007	3/28/2007	3/29/2007	3/30/2007	Conversions Month Average
0	Pueblo, CO	11	4	13	10	15	30	12	15	10	15	11	8	10	18	18	9	12	9	12	14	7	12	12.5
1	Colorado Springs, CO	11	4	6	13	7	6	5	8	7	12	6	6	14	8	4	7	1	6	7	9	14	6	7.590909091
2	Denver, CO	5	12	13	11	11	3	10	18	10	12	14	10	16	11	17	15	3	17	25	14	19	6	12.36363636
3	Albuquerque, NM	13	5	3	21	9	10	6	12	14	6	11	2	13	4	20	20	8	26	17	11	13	8	11.45454545
4	Santa Fe, NM	13	10	9	15	10	11	3	5	10	21	8	6	6	13	8	6	8	4	10	2	7	3	8.545454545
5	Aurora, CO	13	12	10	14	17	18	14	12	15	14	20	15	16	15	21	16	26	20	15	22	20	8	16.84545455
6	Phoenix, AZ	12	8	5	7	8	11	5	7	9	15	7	11	17	12	14	12	2	10	2	2	9	7	8.727272727
7	Indy 1, IN	3	3	3	7	14	11	9	6	10	14	5	7	9	9	7	4	8	5	12	12	7	7	7.818181818
8	Gary, IN	16	7	7	7	10	5	10	7	9	11	16	11	7	14	4	7	14	4	11	18	10	12	9.863636364
9	Thornton, CO	18	19	14	27	12	16	16	18	19	18	12	9	15	16	19	21	21	25	25	22	23	23	18.54545455
10	Greenville, SC	1	0	6	12	10	9	7	14	13	13	12	6	7	15	19	9	3	12	13	12	12	6	9.590909091
11	Columbia, SC	5	2	4	8	3	6	0	3	9	2	1	2	6	5	2	2	1	0	3	3	3	5	3.409090909
12	Tucson, AZ	3	11	13	15	13	16	12	16	15	9	5	12	12	9	11	15	10	10	12	14	7	6	11.18181818
13	Charleston, SC	17	12	18	23	10	10	23	15	5	18	17	19	19	21	20	20	21	17	21	11	24	18	17.22727273
14	Indy 2, IN	12	11	13	18	10	14	12	15	15	11	12	13	13	16	12	7	14	6	5	22	14	17	12.81818182
15	KCK, KS	14	7	5	7	11	20	9	6	10	7	11	16	14	12	4	6	10	5	10	5	3	3	8.863636364
16	Atlanta, GA	6	5	4	1	7	4	5	6	3	1	3	7	3	7	4	6	9	10	8	7	6	6	5.363636364
17	Florence, SC	12	0	4	3	1	4	3	5	2	3	3	0	3	4	0	6	1	3	2	1	3	0	2.863636364
18	Wichita, KS	17	15	15	23	20	13	15	18	20	19	29	17	21	15	23	16	11	15	25	14	14	19	17.90909091
19	Macon, GA	5	7	8	2	12	9	3	8	4	7	10	2	5	2	5	3	4	7	10	4	5	3	5.681818182
20	Tulsa, OK	16	19	11	16	9	18	21	14	15	20	18	18	17	16	15	17	5	21	20	13	22	15	16.18181818
21	Augusta, GA	5	3	3	11	5	7	21	6	5	7	8	6	5	7	10	10	10	11	9	7	10	4	7.727272727
22	Syracuse, NY	7	10	12	7	5	4	3	6	2	9	8	2	10	6	8	3	5	5	8	5	4	9	6.272727273
23	Savannah, GA	7	2	14	14	13	19	9	15	13	14	7	11	10	8	11	16	11	10	8	3	5	7	10.31818182
24	OKC 1, OK	11	10	14	16	13	13	15	13	13	18	21	14	2	6	12	6	6	5	7	4	3	13	10.68181818
25	Rochester, NY	5	9	7	8	13	14	4	11	6	7	10	7	4	5	8	5	4	8	6	17	8	9	7.954545455
26	Springfield, MA	7	15	10	5	14	7	11	7	12	11	8	2	9	11	10	6	8	9	5	8	11	18	9.272727273
27	Columbus, OH	14	15	14	22	23	18	20	15	19	16	14		8	15	12	11	12	11	14	10	10	10	14.42857143
28	Boise, ID	5	11	8	13	12	14	10	16	12	10	12	6	18	6	10	15	7	17	11	14	11	11	11.31818182
29	Albany, NY	6	6	4	6	8	3	1	6	6	5	6	8	5	3	4	4	2	7	7	4	4	3	4.909090909
30	Lawrence, MA	6	8	6	5	2	8	6	9	11	10	10	3	9	7	7	6	8	7	9	6	9	9	7.318181818
31	Worcester, MA	3	3	6	11	6	9	6	9	10	13	7	4	10	8	9	7	7	10	9	7	4	4	7.363636364
32	Roselawn, OH	20	18	14	19	13	15	17	15	16	14	15	13	14	16	11	18	16	24	19	8	17	13	15.68181818
33	Dayton, OH	11	14	10	16	10	10	8	4	10	6	14	3	9	12	11	7	6	13	14	13	7	13	10.04545455
34	Mattapan, MA	5	6	3	7	2	8	14	9	4	7	9	5	8	10	4	7	8	8	8	14	10	8	7.454545455
35	Lynn, MA	1	0	1	2	1	4	2	3	3	0	0	1	1	0	0	5	0	2	4	0	1	2	1.5
36	Cincinnati, OH	8	4	8	18	6	5	3	6	10	6	6	7	12	9	7	13	12	10	11	7	2	10	8.181818182
37	Reno, NV	11	7	1	13	8	4	3	12	8	12	12	7	11	9	5	4	14	11	3	6	4	10	7.954545455
38	East Albuquerque, NM	6	5	1	6	4	3	3	0	6	4	1	1	0	6	4	6	4	7	5	4	3	2	3.681818182
39	Fort Wayne, IN	10	4	6	2	4	2	5	4	6	3	10	3	8	8	5	6	8	13	9	5	4	10	6.136363636
40	Spartanburg, SC	9	8	7	11	9	7	5	5	5	10	13	7	6	5	4	8	6	0	6	3	9	3	6.636363636
41	Richmond, VA	6	3	0	4	0	7	1	6	3	0	1	1	4	1	7	0	2	2	8	4	0	2	2.818181818
42	Toledo, OH	25	26	20	24	36	33	33	40	34	23	21	26	26	13	42	33	29	36	21	29	24	23	28.04545455
43	Myrtle Beach, SC	9	9	11	5	6	3	4	8	6	6	9	4	2	4	4	6	4	9	5	6	8	7	6.136363636
44	Topeka, KS	6	10	10	4	6	5	13	5	7	9	5	9	5	3	7	5	1	4	8	4	3	6	6.136363636
45	Roanoke, VA	6	7	3	5	3	3	2	5	1	7	3	2	4	3	8	1	8	5	1	3	2	2	3.818181818
46	OKC 2, OK	4	4	7	4	5	2	8	4	8	11	6	3	4	4	3	3	0	6	1	1	1	3	4.181818182
47	Baltimore, MD	4	1	5	2	7	10	1	3	3	9	4	2	4	4	2	8	1	3	2	12	11	7	4.772727273
48	Omaha, NE			2	1	3	1	1	8	8	7	3	3	1	3	1	3	4	6	7	6	9	6	4.15
49	Washington, DC, DC	6	0	2	1	4	5	2	1	1	1	0	0	1	3	3	2	4	3	2	4	5	2	2.363636364
50	Montgomery, AL	2	4	6	5	6	3	1	1	4	7	7	3	7	14	3	3	7	6	1	3	3	7	4.681818182
	Company Total	448	395	399	527	466	490	432	480	476	510	481	360	460	451	479	451	406	500	493	449	444	423	455.4545455
	Company Daily Average	8.784314	7.745098	7.823529	10.33333	9.137255	9.607843	8.470588	9.411765	9.333333	10	9.431373	7.058824	9.019608	8.843137	9.392157	8.843137	7.960784	9.803922	9.666667	8.803922	8.705882	8.294118	8.930481283

FORBA 0236061
CONFIDENTIAL

Company	3/1/2007 BA Rate	3/2/2007 BA Rate	3/5/2007 BA Rate	3/6/2007 BA Rate	3/7/2007 BA Rate	3/8/2007 BA Rate	3/9/2007 BA Rate	3/12/2007 BA Rate	3/13/2007 BA Rate	3/14/2007 BA Rate	3/15/2007 BA Rate	3/16/2007 BA Rate	3/19/2007 BA Rate	3/20/2007 BA Rate	3/21/2007 BA Rate	3/22/2007 BA Rate	3/23/2007 BA Rate	3/26/2007 BA Rate	3/27/2007 BA Rate	3/28/2007 BA Rate	3/29/2007 BA Rate	3/30/2007 BA Rate	BA Month Average
0 Pueblo, CO	0.165138	0.301587	0.382114	0.092593	0.165138	0.299145	0.125	40.7%	35.0%	37.5%	26.6%	4.9%	0.325203	0.19469	0.217391	0.190083	0.153846	0.224	0.257813	0.28	0.158333	0.238806	23.7%
1 Colorado Springs, CO	0.466667	0.44	0.324324	0.235849	0.386364	0.324786	0.212121	42.7%	35.9%	31.3%	31.7%	50.0%	0.45	0.320755	0.333333	0.25	0.203704	0.291971	0.416667	0.274074	0.24183	0.302632	33.6%
2 Denver, CO	0.5	0.107143	0.333333	0.319588	0.329114	0.391304	0.075472	36.5%	32.1%	38.5%	27.3%	32.2%	0.288889	0.398438	0.296	0.344444	0.294118	0.331169	0.335484	0.354037	0.358025	0.269231	31.8%
3 Albuquerque, NM	0.47651	0.392405	0.478873	0.51938	0.410959	0.428571	0.203125	40.3%	52.0%	39.2%	52.9%	48.6%	0.416667	0.516129	0.333333	0.335443	0.410256	0.421384	0.347518	0.237805	0.327778	0.283951	40.3%
4 Santa Fe, NM	0.446154	0.246914	0.481818	0.289157	0.269231	0.52	0.35	27.4%	42.7%	41.7%	36.8%	23.4%	0.353535	0.173333	0.35	0.213333	0.315789	0.376344	0.329268	0.273684	0.20202	0.264368	32.6%
5 Aurora, CO	0.354545	0.313559	0.318681	0.351064	0.298969	0.34375	0.178947	15.9%	30.5%	33.0%	40.6%	19.4%	0.333333	0.245283	0.272727	0.321839	0.224299	0.266187	0.277372	0.288889	0.294521	0.190789	28.5%
6 Phoenix, AZ	0.478873	0.472527	0.094118	0.388889	0.383333	0.057143	0.458824	45.7%	39.8%	32.0%	46.3%	32.0%	0.358491	0.313725	0.262626	0.333333	0.252427	0.333333	0.253333	0.2125	0.280488	0.28125	32.6%
7 Indy 1, IN	0.401515	0.482456	0.293651	0.295082	0.452381	0.375887	0.25	36.2%	34.8%	17.8%	28.7%	41.6%	0.349057	0.516393	0.336283	0.228261	0.294118	0.441176	0.410526	0.351648	0.322581	0.377778	35.3%
8 Gary, IN	0.537736	0.61194	0.589041	0.490566	0.452703	0.556522	0.544828	57.7%	39.5%	45.6%	37.3%	50.4%	0.198675	0.262295	0.409091	0.459184	0.540881	0.551948	0.533333	0.469027	0.088889	0.52381	46.0%
9 Thornton, CO	0.424528	0.336066	0.315217	0.315789	0.237113	0.353535	0.422764	37.0%	22.9%	28.4%	43.5%	37.8%	0.327731	0.284483	0.252874	0.340206	0.305556	0.330357	0.31405	0.280702	0.276423	0.262295	32.2%
10 Greenville, SC	0.325	0.381579	0.329193	0.428571	0.301471	0.315385	0.235294	30.2%	35.5%	33.3%	38.6%	26.3%	0.369427	0.198473	0.29771	0.367647	0.179104	0.279221	0.328571	0.34507	0.232143	0.380952	31.5%
11 Columbia, SC	0.561538	0.51145	0.407692	0.434783	0.5125	0.481481	0.414634	44.8%	44.2%	38.5%	42.9%	41.4%	0.482143	0.455782	0.506667	0.468531	0.544118	0.480916	0.444444	0.380165	0.468254	0.544	46.4%
12 Tucson, AZ	0.394231	0.495652	0.378378	0.31068	0.40367	0.428571	0.326316	29.9%	38.9%	35.2%	39.0%	31.6%	0.401786	0.333333	0.309091	0.359649	0.362832	0.271028	0.284211	0.194444	0.285714	0.454545	35.2%
13 Charleston, SC	0.303371	0.329268	0.208791	0.192771	0.26506	0.208333	0.258427	17.6%	51.8%	25.6%	25.9%	25.4%	0.150538	0.086022	0.257143	0.213483	0.2	0.301075	0.256098	0.294737	0.301205	0.32	25.5%
14 Indy 2, IN	0.345679	0.357895	0.382979	0.358491	0.366071	0.37234	0.31	34.6%	25.3%	37.4%	37.8%	39.8%	0.19	0.206522	0.298701	0.191176	0.263736	0.314286	0.43038	0.147368	0.348485	0.43617	32.1%
15 KCK, KS	0.364486	0.394958	0.359649	0.463918	0.425	0.245455	0.366071	35.7%	34.1%	42.5%	26.8%	31.6%	0.255639	0.229167	0.383117	0.354839	0.436709	0.316901	0.304	0.229167	0.40625	0.204545	33.8%
16 Atlanta, GA	0.35	0.2375	0.47619	0.362745	0.467391	0.232558	0.515789	29.0%	37.1%	34.9%	47.8%	24.1%	0.357143	0.5	0.291667	0.547368	0.417582	0.435897	0.363636	0.466667	0.521739	0.30303	39.0%
17 Florence, SC	0.534351	0.646154	0.55	0.416667	0.428571	0.473282	0.435484	61.8%	47.6%	51.1%	46.0%	35.8%	0.380952	0.452381	0.36036	0.491667	0.425532	0.514925	0.380531	0.419355	0.407692	0.213115	45.2%
18 Wichita, KS	0.407643	0.417178	0.375723	0.309859	0.381579	0.377622	0.405714	40.9%	38.6%	30.5%	48.5%	37.0%	0.368421	0.387283	0.41573	0.310734	0.352941	0.310559	0.310559	0.337748	0.348993	0.265306	36.5%
19 Macon, GA	0.57047	0.550336	0.541935	0.469051	0.532895	0.398496	0.364341	49.4%	51.1%	47.0%	50.0%	49.6%	0.422222	0.490066	0.47541	0.541985	0.383838	0.392593	0.473282	0.454545	0.552632	0.4	47.7%
20 Tulsa, OK	0.364198	0.382022	0.393443	0.457317	0.442857	0.309677	0.422857	42.0%	30.7%	39.4%	40.4%	47.4%	0.342697	0.310345	0.484536	0.281437	0.35468	0.333333	0.342657	0.289308	0.310976	0.420455	37.5%
21 Augusta, GA	0.585859	0.473118	0.44186	0.51087	0.48913	0.240506	0.424242	33.3%	33.3%	43.3%	54.5%	38.2%	0.506329	0.337209	0.347826	0.320988	0.398058	0.456311	0.333333	0.482353	0.541284	0.59434	43.2%
22 Syracuse, NY	0.352941	0.616541	0.611111	0.646154	0.461538	0.470149	0.401515	52.0%	44.6%	48.5%	45.7%	39.6%	0.465116	0.410448	0.310078	0.37069	0.414063	0.430769	0.492647	0.435115	0.430894	0.483871	45.9%
23 Savannah, GA	0.607143	0.368421	0.435897	0.488372	0.505376	0.322581	0.531915	50.5%	58.2%	48.9%	53.8%	49.5%	0.490196	0.52	0.421569	0.344086	0.525253	0.346535	0.525773	0.480392	0.515789	0.322917	47.1%
24 OKC 1, OK	0.421875	0.329412	0.315789	0.191304	0.237037	0.40367	0.428571	39.9%	12.1%	3.7%	33.3%	37.8%	0.130719	0.246914	0.375	0.298137	0.257862	0.33758	0.141844	0.214815	0.248	0.414414	28.5%
25 Rochester, NY	0.330935	0.381295	0.451852	0.467153	0.387324	0.401575	0.335938	41.6%	37.1%	38.8%	36.3%	47.8%	0.294574	0.364964	0.411765	0.496241	0.443662	0.408759	0.37594	0.364964	0.416667	0.328244	39.4%
26 Springfield, MA	0.35461	0.478261	0.408451	0.270833	0.388889	0.323741	0.401361	37.8%	27.8%	33.6%	30.5%	45.8%	0.358108	0.377483	0.356643	0.381944	0.496552	0.359477	0.342657	0.268456	0.335664	0.271523	36.0%
27 Columbus, OH	0.594771	0.564706	0.418301	0.416667	0.483871	0.458904	0.531073	46.9%	52.2%	47.4%	46.6%	48.4%	0.393064	0.403226	0.461078	0.401163	0.454054	0.404494	0.528302	0.441718	0.446927	0.455446	46.7%
28 Boise, ID	0.338235	0.475248	0.414141	0.305263	0.43	0.39604	0.228261	45.9%	21.8%	27.6%	39.0%	35.3%	0.352459	0.337349	0.277108	0.384615	0.5	0.344	0.478261	0.338983	0.358491	0.286957	36.1%
29 Albany, NY	0.487395	0.709091	0.4375	0.422764	0.447154	0.381356	0.375	48.9%	41.5%	38.1%	35.4%	49.2%	0.338462	0.372881	0.38806	0.516667	0.310924	0.416	0.395161	0.344262	0.301724	0.336	41.4%
30 Lawrence, MA	0.402778	0.56701	0.461538	0.415385	0.418919	0.314286	0.258621	47.4%	27.4%	34.2%	29.7%	58.8%	0.205882	0.309859	0.434211	0.363636	0.358025	0.421053	0.285714	0.465753	0.246377	0.275	37.2%
31 Worcester, MA	0.342342	0.663366	0.316239	0.336449	0.365217	0.4	0.258065	38.7%	32.5%	39.7%	34.7%	68.6%	0.354839	0.233871	0.324786	0.284404	0.432	0.377049	0.284615	0.338346	0.295775	0.325758	36.7%
32 Roselawn, OH	0.454545	0.509259	0.43	0.412371	0.360465	0.511905	0.369048	53.1%	38.8%	49.3%	52.8%	46.3%	0.443038	0.36	0.621212	0.382716	0.48913	0.337209	0.37931	0.426667	0.225806	0.47191	43.6%
33 Dayton, OH	0.510638	0.347222	0.261194	0.309353	0.217391	0.352113	0.266667	31.5%	31.9%	24.1%	30.6%	34.5%	0.408451	0.351145	0.449275	0.193798	0.441558	0.216	0.419118	0.283784	0.4	0.432624	33.6%
34 Mattapan, MA	0.526316	0.545455	0.561644	0.55	0.522388	0.455696	0.493151	26.8%	39.4%	49.4%	25.9%	61.4%	0.470588	0.396552	0.4375	0.393443	0.385542	0.282051	0.4375	0.467742	0.295455	0.305085	43.5%
35 Lynn, MA	0.5	0.507463	0.552632	0.468354	0.532258	0.395349	0.385714	43.8%	41.2%	41.1%	50.0%	50.0%	0.475	0.289157	0.458333	0.486111	0.360656	0.426571	0.418605	0.428571	0.295775	0.472727	44.2%
36 Cincinnati, OH	0.543103	0.623853	0.605263	0.578125	0.53913	0.398374	0.507576	59.1%	48.1%	53.2%	58.7%	55.0%	0.458015	0.526786	0.455446	0.533333	0.525862	0.561905	0.438095	0.479592	0.444444	0.575221	52.4%
37 Reno, NV	0.360825	0.339806	0.44086	0.206897	0.302083	0.296703	0.302326	32.1%	23.5%	24.8%	32.7%	39.6%	0.136842	0.363636	0.285714	0.202381	0.228571	0.333333	0.38	0.348315	0.3	0.255102	30.0%
38 East Albuquerque, NM	0.402597	0.362637	0.444444	0.358025	0.319149	0.428571	0.275862	45.5%	47.9%	45.8%	50.6%	35.1%	0.495146	0.456522	0.372093	0.233766	0.378788	0.447917	0.395062	0.544554	0.397959	0.444444	40.9%
39 Fort Wayne, IN	0.370787	0.303571	0.378641	0.236559	0.397849	0.367816	0.262626	27.1%	24.2%	26.7%	41.0%	27.1%	0.316327	0.203883	0.117647	0.311828	0.375	0.075472	0.23913	0.217391	0.336957	0.505155	29.4%
40 Spartanburg, SC	0.466667	0.471154	0.428571	0.342593	0.297297	0.336028	0.223404	52.7%	30.8%	33.3%	42.3%	38.6%	0.333333	0.409091	0.253012	0.232558	0.289474	0.558559	0.434211	0.328125	0.38806	0.463768	37.4%
41 Richmond, VA	0.474576	0.528571	0.322581	0.409836	0.326531	0.470588	0.395833	39.7%	43.1%	31.1%	63.6%	44.6%	0.361702	0.3	0.377358	0.384615	0.507463	0.363636	0.301887	0.367347	0.305085	0.462687	40.4%
42 Toledo, OH	0.363636	0.503704	0.451613	0.475728	0.46087	0.392523	0.407692	28.8%	42.3%	43.5%	47.0%	45.5%	0.435897	0.464646	0.356589	0.352	0.359375	0.433071	0.564815	0.311927	0.342857	0.355556	41.4%
43 Myrtle Beach, SC	0.465517	0.326923	0.166667	0.222222	0.254902	0.5	0.333333	18.4%	41.7%	31.5%	14.0%	47.2%	0.369565	0.396226	0.26	0.306122	0.456522	0.025641	0.42	0.255814	0.232558	0.046512	29.8%
44 Topeka, KS	0.56701	0.432624	0.387097	0.532609	0.353535	0.444444	0.357143	46.2%	52.9%	31.1%	32.6%	43.2%	0.387597	0.489051	0.426752	0.459627	0.403846	0.46729	0.308824	0.357143	0.2875	0.361905	41.3%
45 Roanoke, VA	0.496552	0.57764	0.5375	0.514793	0.704819	0.406667	0.512821	42.1%	53.3%	54.6%	50.9%	52.5%	0.521472	0.5	0.544218	0.459259	0.553672	0.561728	0.481928	0.477419	0.474684	0.482143	51.5%
46 OKC 2, OK	0.5	0.3125	0.369863	0.386667	0.447368	0.34375	0.3125	35.8%	35.7%	34.4%	43.3%	24.6%	0.386364	0.333333	0.33871	0.289474	0.264368	0.241379	0.181818	0.169655	0.423077	0.129032	32.7%
47 Baltimore, MD	0.414966	0.38255	0.397351	0.413793	0.590909	0.372093	0.315436	33.1%	40.5%	43.2%	43.7%	49.7%	0.432624	0.458065	0.4	0.445205	0.398496	0.357664	0.416667	0.398496	0.405594	0.406667	41.4%
48 Omaha, NE	1	1	0.512195	0.145161	0.25	0.323077	0.317073	35.1%	38.2%	47.2%	33.9%	31.1%	0.333333	0.413793	0.5	0.263158	0.25	0.44	0.171429	0.326087	0.27027	0.382353	39.8%
49 Washington, DC	0.516868	0.446154	0.358974	0.380531	0.586538	0.340426	0.476992	50.4%	48.2%	40.2%	27.9%	48.8%	0.347826	0.456	0.333333	0.295918	0.363636	0.338843	0.316239	0.312	0.4	0.447619	40.3%
50 Montgomery, AL	0.664516	0.930556	0.326087	0.456376	0.387324	0.514493	0.808824	43.3%	35.8%	42.2%	22.8%	33.3%	0.258065	0.3125	0.243902	0.474138	0.465649	0.365079	0.144737	0.206897	0.364865	0.302632	40.9%
COMPANY TOTAL	0.45	0.468042	0.41094	0.389601	0.410092	0.381997	0.378738	0.404822	0.385122	0.378101	0.403253	0.415799	0.354667	0.350489	0.368141	0.360587	0.38631	0.371955	0.369256	0.368141	0.360587	0.38631	38.9%

FORBA 0236062
CONFIDENTIAL

Company	3/1/2007 Daily Actual	3/2/2007 Daily Actual	3/5/2007 Daily Actual	3/6/2007 Daily Actual	3/7/2007 Daily Actual	3/8/2007 Daily Actual	3/9/2007 Daily Actual	3/12/2007 Daily Actual	3/13/2007 Daily Actual	3/14/2007 Daily Actual
0 Pueblo, CO	$ 21,500	$ 11,400	$ 16,000	$ 19,800	$ 18,600	$ 24,900	$ 14,000	$ 14,500	$ 17,700	$ 19,800
1 Colorado Springs, CO	13,800	6,500	14,200	13,500	17,400	13,400	8,700	15,000	14,300	16,400
2 Denver, CO	7,900	8,800	12,900	12,900	12,200	11,000	10,300	12,600	14,000	11,100
3 Albuquerque, NM	19,100	9,000	13,300	14,800	18,500	18,600	10,500	13,200	15,400	16,300
4 Santa Fe, NM	8,500	11,300	9,700	13,300	10,000	7,500	8,900	10,100	9,100	11,000
5 Aurora, CO	13,700	15,600	12,600	14,000	15,100	17,600	15,700	18,300	15,900	15,800
6 Phoenix, AZ	8,700	13,000	9,300	6,700	9,000	14,900	11,300	7,700	16,400	13,700
7 Indy 1, IN	10,900	8,900	14,800	13,000	12,300	16,600	16,300	13,100	13,300	13,200
8 Gary, IN	12,100	10,400	11,900	13,600	18,200	8,700	13,200	11,400	14,100	13,500
9 Thornton, CO	15,700	19,700	16,100	20,300	19,700	17,400	19,700	17,600	19,500	17,600
10 Greenville, SC	$ 15,800	7,300	17,900	14,800	15,600	16,000	7,100	19,900	16,700	19,300
11 Columbia, SC	10,700	11,700	13,700	14,900	12,600	12,200	16,400	15,000	14,900	13,200
12 Tucson, AZ	11,900	11,000	16,500	14,500	15,200	15,900	13,400	16,000	13,800	15,400
13 Charleston, SC	16,400	14,800	16,500	13,800	14,700	11,900	16,800	18,800	8,000	12,700
14 Indy 2, IN	8,700	13,700	12,400	16,400	16,900	12,400	14,800	13,400	16,000	14,900
15 KCK, KS	12,600	11,300	13,000	11,000	13,400	14,900	12,500	12,200	10,700	10,900
16 Atlanta, GA	9,000	7,400	8,300	8,800	10,300	9,200	6,800	12,400	9,100	7,000
17 Florence, SC	16,800	5,600	15,900	15,500	17,500	16,900	7,200	10,200	13,100	14,900
18 Wichita, KS	18,900	18,200	20,600	20,400	24,300	20,500	17,400	20,800	20,000	20,200
19 Macon, GA	16,100	14,300	17,100	15,800	15,500	19,000	20,900	18,200	14,900	18,900
20 Tulsa, OK	26,700	27,800	37,200	23,800	19,000	26,700	27,600	28,400	27,700	29,300
21 Augusta, GA	9,100	10,700	9,000	11,500	10,300	13,000	14,000	14,900	11,400	11,600
22 Syracuse, NY	15,100	10,000	10,300	8,200	12,500	9,700	11,100	11,900	12,700	12,500
23 Savannah, GA	7,000	8,200	13,600	12,800	12,000	14,800	10,400	10,400	10,600	14,700
24 OKC 1, OK	25,600	20,900	25,000	36,000	29,200	16,000	27,800	25,500	26,900	34,800
25 Rochester, NY	15,800	13,900	13,600	14,800	18,700	15,700	15,100	15,600	15,600	14,500
26 Springfield, MA	21,700	20,700	21,900	21,500	22,500	24,700	22,600	22,800	23,600	24,000
27 Columbus, OH	18,100	20,100	25,300	23,000	21,000	21,400	18,500	20,400	22,000	25,100
28 Boise, ID	8,000	9,300	8,900	9,600	9,000	9,000	10,400	13,400	10,100	9,900
29 Albany, NY	13,600	5,300	14,700	15,500	15,800	13,600	16,300	18,500	14,000	16,500
30 Lawrence, MA	12,500	13,500	11,200	11,100	12,400	12,800	11,500	11,100	11,900	14,900
31 Worcester, MA	20,500	10,400	19,100	24,200	25,300	21,900	28,000	20,700	23,600	26,200
32 Roselawn, OH	10,600	9,900	9,400	12,000	9,000	8,800	10,900	11,100	12,300	9,100
33 Dayton, OH	19,700	19,900	24,800	22,400	22,000	21,700	19,600	18,900	17,200	23,900
34 Mattapan, MA	11,300	10,900	12,200	10,900	8,500	13,500	12,900	14,900	12,400	13,800
35 Lynn, MA	9,300	9,100	9,300	8,000	6,400	15,100	9,300	9,200	9,300	8,400
36 Cincinnati, OH	8,400	7,300	8,200	8,400	7,600	10,600	8,900	8,300	10,300	7,400
37 Reno, NV	11,600	10,300	10,300	15,700	13,100	11,200	9,900	12,100	14,400	12,900
38 East Albuquerque, NM	12,300	12,200	8,900	17,900	13,900	13,600	18,100	15,000	10,100	13,600
39 Fort Wayne, IN	15,300	15,300	17,600	14,600	14,900	12,100	17,200	18,800	16,800	18,600
40 Spartanburg, SC	9,700	15,400	12,600	13,900	13,100	11,300	15,800	13,800	10,300	9,200
41 Richmond, VA	8,900	6,500	9,300	10,200	8,200	9,200	6,400	11,200	8,800	6,300
42 Toledo, OH	12,100	15,800	10,600	10,100	14,600	15,000	16,800	17,900	13,700	12,500
43 Myrtle Beach, SC	9,100	9,300	8,100	8,400	8,200	5,000	8,400	9,100	7,000	9,700
44 Topeka, KS	9,000	14,200	13,600	8,700	11,200	8,900	17,100	12,400	11,100	13,600
45 Roanoke, VA	16,300	13,300	16,100	14,800	12,600	16,900	15,100	16,900	16,400	15,900
46 OKC 2, OK	8,200	10,600	10,500	8,800	10,400	11,800	11,700	11,000	12,100	10,200
47 Baltimore, MD	16,900	17,700	17,600	18,300	16,700	16,200	20,900	19,100	19,900	17,700
48 Omaha, NE			5,400	10,200	10,600	10,100	13,200	12,800	12,200	10,500
49 Washington, DC	19,500	21,400	22,700	22,800	15,300	20,500	21,800	21,100	19,700	39,200
50 Montgomery, AL	8,000	1,000	17,500	13,700	15,400	12,600	3,800	12,900	16,700	11,900
COMPANY TOTAL	678,900	620,800	737,200	749,600	746,400	742,900	733,000	766,500	747,708	794,200
Company Daily Average	13311.76	12172.55	14454.9	14698.04	14635.29	14566.67	14372.55	15029.41	14660.78	15572.55

Company	3/15/2007 Daily Actual	3/16/2007 Daily Actual	3/19/2007 Daily Actual	3/20/2007 Daily Actual	3/21/2007 Daily Actual	3/22/2007 Daily Actual	3/23/2007 Daily Actual	3/26/2007 Daily Actual	3/27/2007 Daily Actual	3/28/2007 Daily Actual	3/29/2007 Daily Actual	3/30/2007 Daily Actual	Production Average
0 Pueblo, CO	$ 18,900	$ 13,500	$ 15,700	$ 19,700	$ 19,700	$ 21,000	$ 13,700	$ 18,800	$ 16,900	$ 22,100	$ 22,200	$ 11,100	$ 17,795
1 Colorado Springs, CO	14,100	6,000	13,600	13,500	13,600	14,700	7,700	15,500	16,800	17,800	17,900	11,500	$ 13,450
2 Denver, CO	11,200	9,600	18,100	16,100	20,300	15,900	4,000	21,200	22,100	20,800	22,800	11,200	$ 13,955
3 Albuquerque, NM	13,700	6,400	17,400	17,900	23,400	20,800	7,900	21,300	21,400	21,800	24,800	9,500	$ 16,136
4 Santa Fe, NM	11,700	9,800	11,300	13,800	7,300	8,700	9,600	9,200	9,100	11,900	14,300	9,500	$ 10,255
5 Aurora, CO	14,500	17,200	15,800	17,300	14,200	12,900	18,500	22,500	22,100	20,400	24,400	23,700	$ 17,082
6 Phoenix, AZ	9,300	11,900	13,900	16,400	15,200	15,300	14,500	8,600	9,600	11,900	15,300	14,100	$ 12,123
7 Indy 1, IN	9,500	10,200	$ 12,400	$ 11,100	$ 12,000	$ 12,600	$ 12,900	$ 9,100	$ 12,500	$ 11,100	$ 10,500	$ 8,500	$ 12,036
8 Gary, IN	13,000	11,300	16,500	12,400	11,800	10,800	15,100	13,400	14,200	12,900	13,200	13,000	$ 12,941
9 Thornton, CO	15,800	19,200	18,800	20,100	18,400	17,600	20,600	20,000	22,000	19,200	23,100	21,100	$ 19,055
10 Greenville, SC	14,400	8,900	$ 16,500	$ 18,900	$ 19,300	$ 15,000	$ 11,000	$ 20,100	$ 17,800	$ 16,600	$ 15,900	$ 7,100	$ 15,086
11 Columbia, SC	10,400	11,300	15,500	17,200	15,800	12,800	9,900	12,800	13,500	12,600	13,700	12,400	$ 13,327
12 Tucson, AZ	11,100	15,800	12,500	12,200	15,500	12,600	13,300	16,400	13,200	17,500	15,900	14,600	$ 14,282
13 Charleston, SC	16,200	13,300	16,700	16,600	16,900	17,500	18,800	14,200	13,800	12,500	12,600	20,000	$ 15,159
14 Indy 2, IN	15,700	10,300	18,700	15,900	16,900	10,200	16,900	14,600	8,500	12,900	9,800	10,000	$ 13,636
15 KCK, KS	11,600	13,500	18,600	18,700	15,900	17,800	15,800	15,800	15,400	16,900	14,500	15,900	$ 14,232
16 Atlanta, GA	7,400	10,800	9,800	9,000	9,500	10,800	10,500	11,400	10,200	9,300	7,900	7,400	$ 9,195
17 Florence, SC	13,700	5,400	15,300	17,200	12,700	13,200	7,500	13,700	15,300	15,400	15,000	9,500	$ 13,068
18 Wichita, KS	20,900	19,000	19,100	20,100	19,000	22,800	19,400	21,100	22,700	20,600	17,700	21,200	$ 20,223
19 Macon, GA	17,900	11,700	18,300	15,400	14,100	10,700	12,000	17,700	16,600	15,600	11,000	13,200	$ 15,677
20 Tulsa, OK	33,700	27,100	42,400	29,200	28,500	27,500	28,600	30,200	23,500	27,700	33,800	29,000	$ 28,882
21 Augusta, GA	7,900	8,800	6,400	11,300	16,000	9,800	11,400	11,000	11,200	14,400	9,400	6,200	$ 10,877
22 Syracuse, NY	12,700	10,400	12,000	13,400	14,900	11,600	13,200	11,400	12,900	11,800	11,100	10,400	$ 11,809
23 Savannah, GA	8,900	13,100	12,000	12,900	13,200	10,700	11,500	18,600	10,500	15,600	7,700	13,400	$ 11,936
24 OKC 1, OK	29,400	20,000	33,400	41,400	31,700	35,000	36,600	30,500	40,200	40,500	29,000	34,100	$ 30,432
25 Rochester, NY	16,000	13,600	15,700	14,300	15,100	12,600	14,200	16,000	14,300	17,900	15,900	14,700	$ 15,164
26 Springfield, MA	23,200	15,000	22,900	26,000	23,900	22,500	23,300	21,900	22,200	25,300	24,400	25,400	$ 22,818
27 Columbus, OH	22,300	19,400	23,000	20,800	18,900	23,500	19,700	21,600	17,000	21,000	18,700	23,200	$ 21,091
28 Boise, ID	7,000	10,100	12,400	9,800	11,600	9,700	7,600	14,900	10,300	12,100	10,400	12,000	$ 10,250
29 Albany, NY	14,100	13,700	16,000	19,200	16,900	16,600	12,800	16,600	13,700	17,000	20,600	18,200	$ 15,327
30 Lawrence, MA	12,200	9,700	14,300	14,800	14,100	12,600	14,500	14,200	14,700	10,700	14,200	15,000	$ 12,905
31 Worcester, MA	24,700	13,000	24,700	24,600	23,400	21,100	19,300	24,100	24,300	26,500	26,200	23,900	$ 22,532
32 Roselawn, OH	10,100	10,700	8,100	9,600	5,800	9,400	11,800	13,800	13,400	6,700	10,200	10,100	$ 10,127
33 Dayton, OH	21,500	19,100	18,900	20,600	19,200	21,100	20,400	22,200	19,000	23,100	19,800	23,700	$ 20,759
34 Mattapan, MA	11,700	9,600	11,300	12,200	9,200	13,100	16,500	15,000	12,200	11,200	10,900	12,200	$ 12,109
35 Lynn, MA	8,300	7,600	9,300	11,100	8,800	10,100	6,000	11,000	10,500	8,900	9,100	7,000	$ 9,141
36 Cincinnati, OH	6,700	9,100	11,500	11,000	7,400	8,000	8,600	6,800	9,400	7,000	10,500	7,200	$ 8,559
37 Reno, NV	14,100	11,100	12,300	10,400	12,100	13,100	15,000	11,300	10,800	11,200	11,700	11,700	$ 12,105
38 East Albuquerque, NM	8,900	7,400	9,700	10,100	12,200	12,900	10,600	11,600	17,100	12,100	16,600	12,200	$ 12,591
39 Fort Wayne, IN	17,600	20,000	18,500	20,400	16,600	16,300	17,000	18,700	15,600	17,000	17,000	13,200	$ 16,777
40 Spartanburg, SC	11,600	14,200	16,300	14,100	12,200	13,600	14,600	9,300	11,300	8,100	11,100	8,100	$ 12,255
41 Richmond, VA	4,500	7,400	6,800	6,300	7,100	5,500	8,400	8,000	8,500	6,200	6,800	9,500	$ 7,727
42 Toledo, OH	12,300	14,900	13,200	9,100	15,500	15,000	16,600	13,400	9,400	14,700	13,200	10,600	$ 13,500
43 Myrtle Beach, SC	10,300	8,000	5,900	5,200	7,200	8,300	5,100	9,900	7,800	5,900	8,000	7,700	$ 7,800
44 Topeka, KS	8,500	10,400	13,000	12,000	18,100	15,000	16,100	9,800	10,800	9,300	9,500	14,000	$ 12,105
45 Roanoke, VA	16,100	14,000	15,500	16,600	16,100	13,800	18,000	16,700	16,900	16,800	14,900	16,600	$ 15,741
46 OKC 2, OK	9,900	12,600	15,300	14,200	10,300	11,400	14,300	13,300	12,900	13,900	8,300	17,600	$ 11,786
47 Baltimore, MD	12,900	13,700	15,500	17,600	15,700	18,400	15,800	18,000	18,300	18,500	19,200	21,200	$ 17,536
48 Omaha, NE	8,900	10,400	12,500	8,900	6,100	11,600	11,200	10,100	8,000	9,500	18,400	11,400	$ 10,600
49 Washington, DC	28,200	21,300	25,100	21,700	24,900	20,300	23,000	28,300	22,700	26,400	22,800	18,700	$ 23,064
50 Montgomery, AL	15,900	12,600	18,100	16,900	16,400	12,300	15,500	15,300	9,200	10,900	8,600	11,000	$ 12,555
COMPANY TOTAL	720,600	643,100	806,500	805,200	780,600	756,100	737,000	810,900	772,300	797,700	790,500	731,700	$ 748,609
Company Daily Average	14129.41	12609.8	15813.73	15788.24	15305.88	14825.49	14450.98	15900	15143.14	15641.18	15500	14347.06	$ 14,679

FORBA 0236063
CONFIDENTIAL

Company	3/1/2007 Daily Patients	3/2/2007 Daily Patients	3/5/2007 Daily Patients	3/6/2007 Daily Patients	3/7/2007 Daily Patients	3/8/2007 Daily Patients	3/9/2007 Daily Patients	3/12/2007 Daily Patients	3/13/2007 Daily Patients	3/14/2007 Daily Patients
0 Pueblo, CO	91	44	76	98	91	82	56	67	80	70
1 Colorado Springs, CO	72	28	75	81	81	79	52	71	75	77
2 Denver, CO	43	50	64	66	53	42	49	61	57	59
3 Albuquerque, NM	78	48	74	62	86	80	51	88	71	93
4 Santa Fe, NM	36	61	57	59	57	36	52	69	55	49
5 Aurora, CO	71	81	62	61	68	63	78	90	66	63
6 Phoenix, AZ	37	48	77	33	37	66	48	44	59	60
7 Indy 1, IN	79	59	89	86	69	88	99	81	75	63
8 Gary, IN	49	52	60	81	81	51	66	60	72	68
9 Thornton, CO	61	61	63	65	74	64	71	63	74	63
10 Greenville, SC	108	47	108	80	95	89	39	104	91	92
11 Columbia, SC	57	64	77	78	78	70	96	95	82	88
12 Tucson, AZ	63	58	69	71	65	56	64	75	66	68
13 Charleston, SC	62	55	72	67	61	57	68	84	41	61
14 Indy 2, IN	53	61	58	68	71	59	69	70	71	62
15 KCK, KS	68	72	73	52	69	83	71	74	60	69
16 Atlanta, GA	52	61	55	65	49	66	46	76	56	56
17 Florence, SC	61	23	63	77	84	69	35	52	66	65
18 Wichita, KS	93	95	108	98	94	89	104	97	97	114
19 Macon, GA	64	67	71	70	71	80	82	78	67	71
20 Tulsa, OK	103	110	111	89	78	107	101	98	113	106
21 Augusta, GA	41	49	48	45	47	60	57	66	56	55
22 Syracuse, NY	88	51	56	46	77	71	79	71	72	70
23 Savannah, GA	33	48	44	44	46	63	44	47	38	47
24 OKC 1, OK	74	57	78	93	103	65	76	86	131	131
25 Rochester, NY	93	86	74	73	87	76	85	80	88	82
26 Springfield, MA	91	72	84	105	88	94	88	89	104	91
27 Columbus, OH	62	74	89	98	80	79	83	95	87	92
28 Boise, ID	45	53	58	68	57	61	71	59	68	63
29 Albany, NY	61	32	72	71	68	73	80	67	72	78
30 Lawrence, MA	43	42	42	38	43	48	43	41	53	50
31 Worcester, MA	73	34	80	71	73	75	92	73	85	76
32 Roselawn, OH	48	53	57	57	55	41	53	38	52	38
33 Dayton, OH	69	94	99	96	108	92	110	85	77	107
34 Mattapan, MA	27	30	32	27	32	43	37	52	40	40
35 Lynn, MA	43	33	34	42	29	52	43	36	40	43
36 Cincinnati, OH	53	41	45	54	53	74	65	52	54	52
37 Reno, NV	62	68	52	69	67	64	60	72	78	82
38 East Albuquerque, NM	46	56	50	52	64	52	63	55	50	58
39 Fort Wayne, IN	56	78	64	71	56	55	73	70	75	77
40 Spartanburg, SC	40	55	56	71	52	47	73	52	54	42
41 Richmond, VA	31	33	42	38	33	38	29	41	37	31
42 Toledo, OH	70	67	51	54	62	65	77	99	75	61
43 Myrtle Beach, SC	31	35	35	35	38	21	34	31	28	37
44 Topeka, KS	42	80	57	43	64	55	81	57	56	62
45 Roanoke, VA	73	68	74	82	49	69	76	95	71	74
46 OKC 2, OK	29	33	46	46	42	42	55	43	45	40
47 Baltimore, MD	86	92	91	85	63	81	102	99	88	75
48 Omaha, NE	0	0	20	53	42	44	56	50	42	28
49 Washington, DC	51	72	75	70	43	62	62	62	59	73
50 Montgomery, AL	52	10	93	81	87	67	26	72	86	67
COMPANY TOTAL	3,014	2,863	3,360	3,381	3,320	3,323	3,366	3,530	3,455	3,459
Company Daily Average	59.09803922	56.1372549	65.88235294	66.29411765	65.09803922	65.15686275	66	69.21569	67.7451	67.82353

Company	3/15/2007 Daily Patients	3/16/2007 Daily Patients	3/19/2007 Daily Patients	3/20/2007 Daily Patients	3/21/2007 Daily Patients	3/22/2007 Daily Patients	3/23/2007 Daily Patients	3/26/2007 Daily Patients	3/27/2007 Daily Patients	3/28/2007 Daily Patients	3/29/2007 Daily Patients	3/30/2007 Daily Patients	Pts Seen Month Aver
0 Pueblo, CO	80	58	83	91	90	98	55	97	95	90	101	51	79
1 Colorado Springs, CO	71	30	66	72	64	78	43	97	84	98	116	53	71
2 Denver, CO	56	40	96	77	88	59	24	103	103	104	104	57	66
3 Albuquerque, NM	72	36	91	75	92	105	48	92	92	125	121	58	79
4 Santa Fe, NM	60	59	64	62	52	59	52	58	55	69	79	64	57
5 Aurora, CO	63	87	76	80	64	59	83	102	99	96	103	123	79
6 Phoenix, AZ	44	68	68	70	73	66	77	54	56	63	59	69	58
7 Indy 1, IN	62	66	69	59	75	71	72	57	56	59	63	56	72
8 Gary, IN	69	63	121	90	65	53	73	69	56	60	82	60	68
9 Thornton, CO	52	69	80	83	65	84	75	75	83	82	89	90	72
10 Greenville, SC	81	56	99	105	92	86	55	111	94	93	86	26	84
11 Columbia, SC	80	78	87	80	74	78	62	68	75	75	67	57	76
12 Tucson, AZ	61	78	67	66	76	73	72	78	68	87	60	80	68
13 Charleston, SC	63	53	79	85	78	70	68	65	61	67	58	68	66
14 Indy 2, IN	56	59	81	73	54	62	67	72	45	81	43	53	63
15 KCK, KS	52	67	99	111	95	100	89	97	87	111	76	105	81
16 Atlanta, GA	48	65	63	44	51	43	53	44	42	40	33	46	53
17 Florence, SC	68	34	78	69	71	61	27	65	70	72	77	48	61
18 Wichita, KS	87	102	108	106	104	122	110	111	111	100	97	106	103
19 Macon, GA	72	63	78	77	64	60	61	82	69	78	51	63	70
20 Tulsa, OK	112	113	117	120	100	120	131	98	94	113	113	102	107
21 Augusta, GA	46	55	39	57	60	55	62	56	54	44	50	43	52
22 Syracuse, NY	75	81	69	79	89	73	75	74	69	74	70	64	72
23 Savannah, GA	42	54	52	48	59	61	47	66	46	53	46	65	50
24 OKC 1, OK	60	56	173	202	105	113	118	104	121	106	94	65	101
25 Rochester, NY	86	72	91	87	80	67	79	81	83	87	77	88	82
26 Springfield, MA	98	71	95	94	92	89	73	98	94	109	95	110	92
27 Columbus, OH	94	94	105	111	90	103	101	106	75	91	99	110	92
28 Boise, ID	50	66	79	55	60	56	49	82	60	78	68	82	63
29 Albany, NY	84	66	88	74	82	58	82	73	75	80	81	83	73
30 Lawrence, MA	45	35	54	49	43	49	52	44	50	39	52	58	46
31 Worcester, MA	81	44	80	95	79	78	71	76	93	88	100	69	78
32 Roselawn, OH	42	43	44	48	25	50	47	57	54	43	48	47	47
33 Dayton, OH	86	91	64	85	76	104	86	98	79	106	81	80	91
34 Mattapan, MA	38	27	36	35	36	37	51	56	36	33	31	41	37
35 Lynn, MA	38	35	42	59	39	37	39	44	50	40	50	29	41
36 Cincinnati, OH	45	54	71	53	55	49	55	46	59	51	55	48	54
37 Reno, NV	72	64	82	63	65	67	81	64	62	58	63	73	68
38 East Albuquerque, NM	38	50	52	50	54	59	41	53	49	46	59	55	52
39 Fort Wayne, IN	62	70	67	82	90	64	65	98	70	72	61	48	69
40 Spartanburg, SC	45	81	78	65	62	66	54	49	43	43	41	37	55
41 Richmond, VA	20	36	30	35	33	32	33	35	37	31	41	38	34
42 Toledo, OH	61	78	66	53	83	81	62	72	47	75	69	58	68
43 Myrtle Beach, SC	37	28	29	32	37	34	25	38	29	32	33	41	33
44 Topeka, KS	41	54	79	70	90	87	93	57	47	45	57	67	63
45 Roanoke, VA	85	76	78	84	67	73	79	71	86	81	83	87	77
46 OKC 2, OK	34	46	54	52	41	54	64	44	45	47	30	54	45
47 Baltimore, MD	71	78	80	84	81	81	80	68	77	80	65	89	83
48 Omaha, NE	41	42	40	34	25	42	45	28	29	31	54	42	38
49 Washington, DC	88	62	75	68	80	69	77	80	80	86	69	58	69
50 Montgomery, AL	95	70	92	88	93	61	70	80	65	69	47	53	69
COMPANY TOTAL	3,229	3,143	3,872	3,786	3,558	3,534	3,371	3,713	3,459	3,681	3,567	3,317	3,423
Company Daily Average	63.31373	61.62745	75.92157	74.23529	69.76471	69.29412	66.09804	72.80392	67.82353	72.17647	69.94118	65.03922	67.11319

FORBA 0236064
CONFIDENTIAL

March Madness 2007

							Week 1 (March 1-9)					Week 2 (March 12-16)					Week 3 (March 19-23)					Week 4 (March 26-30)					
Company	Clinic	Avg Conversions	BA Goal	Production Goal	Avg Patients per Day	February Focus Points	Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 1 Points	Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 2 Points	Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 3 Points	Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 4 Points	Total Points
5	Aurora Drillers	9	33%	$ 14,165.20	66	300	14.0	31%	$ 14,900.00	69.1	800	15.2	28%	$ 15,940.00	74	800	18.8	27.8%	$ 15,740.00	72.4	800	17.8	26%	$ 22,620.00	104.6	800	3500
8	Gary Steelteeth	7	62%	$ 12,160.42	52	240	8.9	54%	$ 12,585.71	63.9	800	10.8	44%	$ 12,660.00	86	800	9.2	37.4%	$ 13,320.00	80.4	800	11.6	43%	$ 13,340.00	65.4	800	3440
33	Dayton Cavity Busters	4	51%	$ 16,749.05	77	220	11.3	32%	$ 21,442.86	95.4	800	7.4	31%	$ 19,720.00	88	800	9.8	36.8%	$ 20,046.00	87	800	12.0	35%	$ 21,560.00	88.8	800	3420
25	Rochester	4	46%	$ 13,059.66	75	180	8.6	39%	$ 15,371.43	82.0	800	8.3	40%	$ 15,860.00	82	800	5.2	40.2%	$ 14,300.00	80.8	800	9.6	38%	$ 19,760.00	83.2	800	3380
26	Springfield Springboks	8	39%	$ 21,826.87	88	120	9.9	38%	$ 23,328.57	88.9	800	8.9	35%	$ 24,133.33	91	800	8.8	38.9%	$ 23,720.00	88.6	800	10.2	33%	$ 23,840.00	101.2	800	3320
47	Baltimore Explorers	3	50%	$ 12,899.68	70	100	4.3	41%	$ 17,757.14	85.7	800	4.3	42%	$ 16,660.00	87	400	3.8	42.7%	$ 16,600.00	81.2	800	7.8	40%	$ 19,040.00	83.8	800	3300
31	Worcester	6	46%	$ 18,125.74	66	80	6.3	30%	$ 21,342.86	71.1	800	9.6	41%	$ 24,644.44	72	800	8.2	33.6%	$ 22,620.00	80.6	800	6.8	32%	$ 25,000.00	89.2	600	3280
14	Indy 2	11	45%	$ 12,392.17	53	80	12.9	36%	$ 13,614.29	62.7	800	13.8	35%	$ 14,060.00	64	800	12.6	23.8%	$ 15,720.00	67.4	800	12.8	34%	$ 11,140.00	58.8	600	3080
39	Fort Wayne Smilers	7	41%	$ 14,323.50	43	280	4.7	33%	$ 15,285.71	64.7	600	5.3	29%	$ 18,360.00	71	600	7.6	28.9%	$ 17,760.00	73.6	800	8.2	27%	$ 16,500.00	67.8	800	3080
27	Columbus Royal Crowns	11	55%	$ 19,966.09	88	120	18.0	50%	$ 21,857.14	80.7	600	16.8	48%	$ 21,840.00	92	800	11.6	42.3%	$ 21,180.00	102	800	11.0	46%	$ 20,300.00	96.2	600	2920
34	Mattapan Maintainers	5	48%	$ 10,723.48	33	120	6.4	52%	$ 11,457.14	32.6	400	6.8	41%	$ 12,480.00	39	800	7.4	41.7%	$ 12,460.00	39	800	9.6	36%	$ 12,300.00	39.4	400	2920
32	Roselawn Pulpsters	13	64%	$ 10,331.78	38	80	16.6	44%	$ 10,085.71	52.0	600	14.6	48%	$ 10,660.00	43	800	15.8	45.9%	$ 8,940.00	42.8	600	16.2	37%	$ 10,840.00	49.8	800	2880
9	Thornton Cavity Terminators	13	33%	$ 14,379.67	71	460	17.4	34%	$ 18,371.43	68.4	400	15.3	34%	$ 17,940.00	64	400	18.4	30.2%	$ 19,100.00	73.4	800	23.6	29%	$ 21,880.00	83.8	800	2860
49	Washington, DC Fighting Floss	3	51%	$ 15,299.89	53	200	2.9	44%	$ 20,571.43	62.1	600	0.6	43%	$ 25,900.00	88	600	2.6	35.9%	$ 25,000.00	73.8	600	3.2	36%	$ 23,780.00	74.6	800	2800
18	Wichita Rootinators	16	36%	$ 19,715.88	95	120	16.9	38%	$ 20,842.86	97.3	600	20.6	59%	$ 28,180.00	98	600	17.2	38.7%	$ 20,080.00	110	600	17.4	31%	$ 20,660.00	105.4	800	2720
29	Albany Tight Ends in Motion	5	50%	$ 13,542.22	62	100	4.9	47%	$ 13,542.86	65.3	600	6.5	43%	$ 15,360.00	73	800	3.6	38.8%	$ 16,300.00	76.4	600	5.0	36%	$ 14,820.00	78.4	600	2700
37	Reno Crowns	5	34%	$ 12,868.17	62	40	6.7	32%	$ 11,728.57	63.1	600	10.2	31%	$ 13,920.00	74	800	8.6	24.3%	$ 12,580.00	71.6	600	6.8	32%	$ 11,340.00	64	600	2640
48	Omaha Carlsmiers	5	40%	$ 8,599.79	34	40	1.6	31%	$ 9,900.00	30.7	400	5.8	37%	$ 10,960.00	41	800	2.4	36.2%	$ 10,060.00	37.2	600	6.8	32%	$ 11,400.00	36.8	800	2640
12	Tucson Tooth Warriors	8	34%	$ 12,092.00	65	200	11.9	39%	$ 14,057.14	63.7	400	11.6	35%	$ 14,420.00	70	600	11.4	35.3%	$ 13,220.00	70.8	400	9.8	30%	$ 15,520.00	70.6	800	2600
13	Charleston Chomdiggers	16	27%	$ 14,880.18	62	420	16.1	25%	$ 14,985.71	62.9	800	14.8	29%	$ 13,800.00	60	-	20.2	18.1%	$ 17,300.00	76	800	18.2	29%	$ 14,620.00	63.8	400	2420
20	Tulsa	17	39%	$ 27,804.44	87	400	15.7	40%	$ 26,971.43	99.9	200	17.0	40%	$ 29,240.00	108	400	14.8	35.8%	$ 31,240.00	127.6	600	18.2	34%	$ 28,840.00	144	800	2400
30	Lawrence	7	38%	$ 13,787.33	41	280	5.9	41%	$ 12,142.86	42.7	200	8.6	40%	$ 11,960.00	46	400	7.4	32.4%	$ 14,660.00	49.4	800	9.8	34%	$ 13,760.00	48.6	600	2280
24	OKC 1	14	31%	$ 20,834.18	83	40	13.1	33%	$ 25,785.71	78.0	200	15.8	25%	$ 27,320.00	97	800	6.4	26.2%	$ 35,620.00	142.2	600	5.4	27%	$ 34,860.00	98	600	2240
7	Indy 1 Calculus Crushers	7	43%	$ 14,063.87	71	220	7.1	36%	$ 13,257.14	81.3	600	8.4	32%	$ 11,860.00	73	600	7.4	34.5%	$ 12,200.00	69.2	400	8.6	38%	$ 10,340.00	58.2	400	2220
46	OKC 2 Oklahoma Canines	3	16%	$ 10,317.72	26	420	4.9	38%	$ 10,285.71	41.9	400	4.4	35%	$ 11,160.00	42	600	2.8	32.2%	$ 13,100.00	53	400	2.4	23%	$ 11,200.00	44	400	2220
6	Phoenix Crowns	9	30%	$ 11,702.05	51	400	8.0	33%	$ 10,414.29	49.1	0	9.8	39%	$ 11,800.00	55	600	11.4	30.4%	$ 15,060.00	70.8	600	6.0	27%	$ 11,900.00	60.2	600	2200
35	Lynn	1	45%	$ 10,937.95	38	180	1.6	46%	$ 9,300.00	39.4	400	1.4	43%	$ 8,560.00	38	400	1.2	41.4%	$ 9,060.00	43.2	600	1.8	41%	$ 9,300.00	42.6	600	2180
15	KCK Draftsters	11	41%	$ 15,334.57	66	280	10.4	37%	$ 12,780.00	69.7	400	10.0	34%	$ 11,780.00	84	200	9.2	33.2%	$ 17,360.00	96.8	600	5.2	29%	$ 15,700.00	95.2	600	2080
50	Montgomery	9	43%	$ 6,727.27	65	240	3.9	38%	$ 10,285.71	59.4	200	4.4	35%	$ 14,060.00	78.0	600	6.8	35%	$ 15,840.00	80.8	600	4.0	28%	$ 11,600.00	62.8	400	2040
3	Albuquerque Toothinators	5	36%	$ 14,275.96	83	140	9.6	42%	$ 14,828.57	64.4	400	9.0	47%	$ 13,000.00	72	700	13.8	40.2%	$ 17,480.00	81.8	400	15.0	32%	$ 19,760.00	97.6	800	1940
2	Denver Broncos	13	35%	$ 15,295.77	66	320	9.3	39%	$ 10,857.14	52.4	200	12.8	33%	$ 11,700.00	56	700	12.4	32.4%	$ 14,880.00	68.8	400	16.2	33%	$ 19,620.00	94.2	800	1920
45	Roanoke Stars	4	48%	$ 15,549.84	55	0	4.1	54%	$ 15,014.29	73.6	400	3.6	31%	$ 15,860.00	80	400	4.8	51.6%	$ 16,800.00	76.2	600	2.6	50%	$ 16,300.00	81.6	400	1800
1	Colorado Springs Snow Crowns	6	31%	$ 15,600.54	74	360	7.4	34%	$ 12,500.00	66.9	200	7.8	38%	$ 13,160.00	65	200	6.8	31.2%	$ 12,620.00	64.6	200	8.4	31%	$ 15,900.00	89.4	800	1760
23	Savannah	8	43%	$ 13,858.82	39	320	11.8	47%	$ 13,257.14	46.8	400	12.0	53%	$ 11,540.00	46	400	11.2	46.9%	$ 12,060.00	53.4	400	6.6	44%	$ 13,180.00	55.2	200	1720
21	Augusta Masters	8	41%	$ 14,773.82	52	480	7.9	45%	$ 11,085.71	49.6	0	6.4	41%	$ 10,920.00	56	400	8.4	38.2%	$ 10,980.00	54.6	600	8.2	48%	$ 10,440.00	49.4	200	1680
22	Syracuse Tooth Savers	9	50%	$ 14,764.69	64	280	6.9	51%	$ 10,985.71	66.9	200	5.4	46%	$ 12,040.00	74	400	6.4	39.4%	$ 13,020.00	77	400	6.2	45%	$ 11,520.00	78.2	400	1680
44	Topeka Tooth Fairies	5	41%	$ 13,797.54	60	280	7.7	44%	$ 11,814.29	60.5	400	7.8	41%	$ 11,200.00	54	400	4.2	43.3%	$ 14,840.00	83.8	400	5.0	34%	$ 10,680.00	34.6	200	1680
43	Myrtle Beach	8	35%	$ 10,131.78	27	260	6.7	32%	$ 8,071.43	32.7	400	6.6	31%	$ 8,820.00	32	400	4.0	35.8%	$ 6,340.00	31.4	200	7.0	29%	$ 7,860.00	34.6	400	1660
19	Macon Lidocaines	4	46%	$ 17,090.91	65	0	6.6	49%	$ 16,957.14	71.1	400	6.2	49%	$ 16,320.00	70	400	3.8	48.3%	$ 14,300.00	68	200	5.8	49%	$ 14,820.00	68.6	600	1600
36	Cincinnati Extractors	11	60%	$ 12,124.68	47	0	7.4	54%	$ 8,485.71	55.8	400	7.0	55%	$ 8,260.00	51	400	10.6	50.0%	$ 9,340.00	56.6	400	8.0	50%	$ 8,180.00	51.8	400	1600
38	East Albuquerque 505 Prophy Anglers	5	37%	$ 11,931.18	47	160	4.0	37%	$ 13,842.86	55.8	600	2.4	45%	$ 11,000.00	50	200	4.0	34.7%	$ 11,100.00	51.2	200	4.2	45%	$ 13,920.00	52.4	400	1560
0	Pueblo Crusiders	9	23%	$ 19,036.85	88	0	13.6	33%	$ 18,028.57	76.9	400	11.8	29%	$ 16,880.00	71	200	13.4	21.4%	$ 17,960.00	83.4	400	10.8	23%	$ 18,220.00	86.6	400	1,400
4	Santa Fe Molarmaniacs	11	38%	$ 12,370.51	60	360	10.1	37%	$ 9,885.71	51.1	200	10.0	34%	$ 10,340.00	58	200	8.2	28.1%	$ 10,140.00	37.8	200	5.2	39%	$ 10,800.00	46	400	1360
16	Atlanta Plaque Attackers	7	41%	$ 12,868.17	44	160	4.6	38%	$ 8,542.86	56.3	400	4.0	35%	$ 9,340.00	64	400	5.8	42.3%	$ 9,920.00	50.8	200	7.4	42%	$ 9,240.00	41	200	1360
11	Columbia Cavity Catchers	9	44%	$ 14,784.10	68	340	4.0	47%	$ 11,171.43	74.3	200	3.4	42%	$ 12,960.00	85	400	3.2	49.1%	$ 14,240.00	75.8	200	7.8	46%	$ 13,000.00	68.4	200	1340
17	Florence Flouriders	4	50%	$ 16,345.68	61	120	3.9	50%	$ 13,628.57	58.9	200	2.6	40%	$ 11,460.00	57	200	2.8	42.2%	$ 13,180.00	61.2	400	1.8	39%	$ 13,780.00	66.4	400	1320
42	Toledo T Town Tacklers	30	50%	$ 14,737.12	66	180	28.3	44%	$ 13,571.43	63.3	200	28.8	41%	$ 14,260.00	78	400	28.6	38.4%	$ 13,880.00	73	400	26.6	40%	$ 12,360.00	64.2	200	1300
28	Boise Bicuspids	13	34%	$ 10,417.09	53	240	10.4	37%	$ 9,371.43	58.7	200	11.2	34%	$ 10,100.00	61	200	11.2	37.0%	$ 10,220.00	59.8	200	12.8	36%	$ 11,340.00	74	400	1240
10	Greenville Molars	14	40%	$ 18,920.00	84	0	6.4	33%	$ 13,500.00	80.9	200	11.6	33%	$ 15,840.00	65	400	10.6	28.2%	$ 16,140.00	87.4	400	11.0	31%	$ 15,500.00	82	200	1200
40	Spartanburg Smile Makers	10	37%	$ 14,701.38	57	240	8.0	37%	$ 13,114.29	56.3	200	8.0	40%	$ 11,820.00	55	-	5.8	30.3%	$ 14,160.00	65	400	4.2	43%	$ 9,580.00	42.6	-	840
41	Richmond Cavity Kickers	5	37%	$ 10,723.48	34	180	3.0	42%	$ 8,385.71	34.3	200	2.2	44%	$ 7,640.00	33	-	2.8	38.8%	$ 6,420.00	32.6	-	3.2	36%	$ 7,800.00	36	400	780
	COMPANY TOTAL	435	41%	$ 733,407.44	3065		434.0	41%	$ 715,542.86	3232.4	400	461.4	40%	$ 734,420.00	3361.2	800	449.4	38.4%	$ 777,080.00	3624.2	800	461.8	37.1%	$ 780,620.00	3547.4	800	2,800

FORBA 0236065
CONFIDENTIAL

Clinic	3/1/2007	3/2/2007	3/5/2007	3/6/2007	3/7/2007	3/8/2007	3/9/2007	Week 1 Average	3/12/2007	3/13/2007	3/14/2007	3/15/2007	3/16/2007	Week 2 Average	3/19/2007	3/20/2007	3/21/2007	3/22/2007	3/23/2007	Week 3 Average	3/26/2007	3/27/2007	3/28/2007	3/29/2007	3/30/2007	Week 4 Average
Pueblo, CO	11	4	13	10	15	30	12	13.57143	15	10	15	11	6	11.8	10	15	18	9	12	13.4	9	12	14	7	12	10.8
Colorado Springs, CO	11	4	6	13	7	6	5	7.428571	8	7	12	6	6	7.8	14	8	4	7	1	6.8	6	7	9	14	6	8.4
Denver, CO	13	5	13	11	11	3	10	9.285714	18	10	12	14	10	12.8	16	11	17	15	3	12.4	17	25	14	19	8	16.2
Albuquerque, NM	13	5	3	21	9	10	6	9.142857	12	14	14	6	11	9	13	4	20	20	8	13	15	17	11	7	3	9.2
Santa Fe, NM	13	13	5	15	10	11	3	10	15	10	21	9	6	12	6	13	4	6	6	8.2	20	17	7	7	5	11.2
Aurora, CO	13	12	10	14	17	18	14	14	12	15	14	20	15	15.2	15	21	14	12	26	18.8	20	15	22	20	8	17
Phoenix, AZ	12	8	5	7	8	11	5	8	7	9	15	15	7	9.8	12	14	12	2	2	11.4	10	2	2	9	7	6
Indy 1, IN	3	3	7	14	11	11	9	9.714286	6	10	14	5	11	8.4	9	7	4	4	14	7.6	5	11	12	12	7	8.6
Cincinnati, OH	16	7	7	10	5	10	10	9.571429	7	9	11	16	14	11.4	7	14	7	14	4	9.2	4	11	15	19	12	11
Thornton, CO	18	19	14	27	12	16	9	17.42857	18	18	18	12	9	15.8	15	16	19	21	21	18.4	23	25	22	23	23	23.6
Greenville, SC	1	0	6	12	10	9	6	6.428571	14	13	13	13	12	11.6	15	19	21	9	3	10.6	12	13	12	12	6	11
Columbia, SC	5	2	4	3	6	3	0	3	9	9	2	9	1	3.4	6	2	2	9	1	3.2	10	3	3	3	5	2.8
Tucson, AZ	3	3	11	13	15	16	12	11.85714	16	15	9	5	12	11.4	12	9	11	15	10	11.4	10	12	14	7	6	9.8
Charleston, SC	17	11	10	18	13	19	10	14.28571	15	15	19	17	19	17	19	21	20	21	21	20.2	17	21	11	24	19	18.4
Indy 2, IN	12	11	13	18	10	14	12	12.85714	15	15	11	12	13	13.2	16	12	7	14	10	12.4	8	5	22	14	17	13.6
KCK, KS	14	7	5	7	7	11	9	10.42857	6	10	7	11	11	9.2	16	12	4	6	10	9.2	5	10	5	3	3	5.2
Atlanta, GA	6	5	4	1	7	4	5	4.571429	5	3	1	3	7	3.8	3	7	4	6	9	5.8	10	8	7	6	6	7.4
Florence, SC	12	0	4	3	4	4	4	3.571429	6	2	3	1	3	3	4	0	6	9	1	4.8	3	2	1	3	0	1.8
Wichita, KS	17	15	15	23	20	13	15	16.57143	16	20	19	20	17	20.6	15	21	15	19	11	17.2	15	25	14	14	19	17.4
Macon, GA	5	7	8	2	12	9	3	6.571429	8	4	7	10	2	6.2	2	5	5	3	4	3.8	7	10	4	5	3	5.8
Tulsa, OK	18	19	11	16	9	18	16	15.71429	14	15	20	18	18	17	17	5	16	15	17	14	5	21	20	13	22	18.2
Augusta, GA	5	3	3	11	5	7	7	5.857143	5	5	7	8	8	6.4	5	7	10	10	5	7.4	9	7	10	4	15	8.2
Knoxville, KY	7	7	7	5	4	4	3	5.571429	6	2	2	2	2	2.8	6	10	3	3	5	5.4	5	8	5	4	5	5.4
Savannah, GA	7	10	14	14	13	19	9	11.14286	15	13	14	7	11	12	10	6	11	10	11	11.2	6	10	3	3	7	6.6
OKC 1, OK	11	10	14	16	13	13	15	13.14286	13	13	16	21	14	15.8	2	6	12	6	6	6.4	5	6	4	3	13	6.4
Rochester, NY	11	8	13	13	14	14	4	8.571429	11	6	12	11	7	9.4	9	11	14	8	5	9.4	6	8	8	6	9	7.4
Springfield, MA	7	15	10	5	14	7	11	9.857143	7	12	11	8	2	8	6	9	11	10	4	8.6	6	8	15	15	18	14.4
Columbus, OH	14	15	14	22	20	19	20	18	15	19	15	14	6	13.8	15	8	15	12	7	11.4	11	10	10	10	11	10.2
Boise, ID	5	11	8	13	12	14	10	11.42857	16	12	10	12	6	11.2	16	6	10	15	7	11.2	11	11	14	11	10	11.4
Albany, NY	6	6	4	6	8	3	1	4.857143	8	6	5	6	8	6.2	5	3	7	4	2	3.6	7	7	4	4	3	5
Lawrence, MA	6	5	5	2	9	3	6	5.285714	9	11	10	10	5	8.6	9	7	7	6	2	6.2	9	6	6	9	4	6.8
Worcester, MA	3	3	6	11	6	9	6	6.285714	9	10	13	7	4	8.6	10	6	9	7	8	8	10	9	7	7	4	7.4
Roselawn, OH	20	18	14	19	13	15	17	16.57143	15	16	14	15	13	14.6	14	16	11	16	16	15	24	19	17	17	13	16.2
Dayton, OH	11	14	10	16	10	10	8	11.28571	4	10	6	14	3	7.4	9	12	11	7	6	9	13	14	13	7	13	12
Mattapan, MA	5	6	3	7	2	8	4	6.428571	9	3	6	9	5	6.8	10	4	7	6	6	7.4	8	14	10	8	13	9.6
Lynn, MA	1	0	1	2	1	5	2	1.714286	3	0	0	0	1	0.8	1	0	1	0	0	0.4	6	4	1	2	1	2.8
Cincinnati, OH	8	4	6	16	6	6	3	7.285714	8	10	6	6	7	7.4	7	5	6	13	12	10.6	10	11	1	1	10	6.6
Reno, NV	11	7	1	13	8	4	3	6.714286	12	8	12	12	9	10.2	11	9	5	4	14	8.6	11	3	2	4	10	6.8
East Albuquerque, NM	6	5	4	6	2	3	2	4	6	4	3	1	1	2.4	0	6	4	4	4	4	7	5	5	3	2	4.2
Fort Wayne, IN	10	8	6	7	4	6	2	5.571429	6	6	4	3	10	5.8	6	5	4	6	6	5.4	7	13	5	4	10	8.2
Spartanburg, SC	9	8	7	11	9	7	1	7.428571	5	5	5	10	13	7.6	7	6	6	6	6	6.2	6	6	3	5	3	4.6
Richmond, VA	6	3	0	4	0	3	1	2.428571	5	3	1	1	1	2.2	4	1	7	0	2	2.8	2	8	4	0	2	3.2
Toledo, OH	25	26	20	24	36	33	33	28.14286	40	34	23	21	21	28.8	26	13	42	33	29	28.6	36	21	29	24	23	26.6
Myrtle Beach, SC	9	9	11	5	6	3	4	6.714286	8	6	6	9	9	7.6	2	4	4	5	4	4.4	8	4	6	6	8	7
Topeka, KS	6	10	10	4	9	5	13	7.714286	5	7	7	9	5	6.6	5	3	7	1	1	3.4	5	6	4	3	7	5
Roanoke, VA	6	7	3	5	3	3	2	4.285714	5	1	5	6	3	4	4	3	6	3	0	3.6	4	1	1	1	2	2.6
OKC 2, OK	4	4	7	4	5	2	8	4.857143	4	8	11	6	3	6.4	4	4	4	2	0	2.8	1	1	1	1	3	1.4
Baltimore, MD	4	1	5	2	7	10	1	4.285714	3	3	9	4	2	4.2	4	4	2	8	1	3.8	2	12	11	7	7	7.8
Omaha, NE	1		2	1	3	1	1	1.714286	1	8	1	3	0	2.6	1	1	3	2	4	2.4	3	7	6	9	6	6.2
Washington, DC, DC	6	0	1	4	5	3	1	2.857143	1	1	7	3	0	2.4	1	1	3	2	4	2.2	6	3	4	5	2	4
Montgomery, AL	2	4	8	5	6	3	2	4	4	1	4	7	7	4.4	7	14	3	3	7	6.8	8	2	3	3	7	4.6
Company Total	448	395	399	527	466	490	432	451	490	476	510	431	360	461.4	460	451	479	451	406	449.4	500	493	449	444	423	461.8

FORBA 0236066
CONFIDENTIAL

Company		3/26/2007 BA Rate	3/27/2007 BA Rate	3/28/2007 BA Rate	3/29/2007 BA Rate	3/30/2007 BA Rate	Average
0	Pueblo, CO	0.224	0.257813	0.28	0.158333	0.238806	23.2%
1	Colorado Springs, CO	0.291971	0.416667	0.274074	0.24183	0.302632	30.5%
2	Denver, CO	0.331169	0.335484	0.354037	0.358025	0.269231	33.0%
3	Albuquerque, NM	0.421384	0.347518	0.237805	0.327778	0.283951	32.4%
4	Santa Fe, NM	0.376344	0.329268	0.273684	0.20202	0.264368	28.9%
5	Aurora, CO	0.266187	0.277372	0.288889	0.294521	0.190789	26.4%
6	Phoenix, AZ	0.333333	0.253333	0.2125	0.280488	0.28125	27.2%
7	Indy 1, IN	0.441176	0.410526	0.351648	0.322581	0.377778	38.1%
8	Gary, IN	0.551948	0.533333	0.469027	0.088889	0.52381	43.3%
9	Thornton, CO	0.330357	0.31405	0.280702	0.276423	0.262295	29.3%
10	Greenville, SC	0.279221	0.328571	0.34507	0.232143	0.380952	31.3%
11	Columbia, SC	0.480916	0.444444	0.380165	0.468254	0.544	46.4%
12	Tucson, AZ	0.271028	0.284211	0.194444	0.285714	0.454545	29.8%
13	Charleston, SC	0.301075	0.256098	0.294737	0.301205	0.32	29.5%
14	Indy 2, IN	0.314286	0.43038	0.147368	0.348485	0.43617	33.5%
15	KCK, KS	0.316901	0.304	0.229167	0.40625	0.204545	29.2%
16	Atlanta, GA	0.435897	0.363636	0.466667	0.521739	0.30303	41.8%
17	Florence, SC	0.514925	0.380531	0.419355	0.407692	0.213115	38.7%
18	Wichita, KS	0.310559	0.310559	0.337748	0.348993	0.265306	31.5%
19	Macon, GA	0.392593	0.473282	0.454545	0.552632	0.4	45.5%
20	Tulsa, OK	0.333333	0.342657	0.289308	0.310976	0.420455	33.9%
21	Augusta, GA	0.456311	0.333333	0.482353	0.541284	0.59434	48.2%
22	Syracuse, NY	0.430769	0.492647	0.435115	0.430894	0.483871	45.5%
23	Savannah, GA	0.346535	0.525773	0.480392	0.515789	0.322917	43.8%
24	OKC 1, OK	0.33758	0.141844	0.214815	0.248	0.414414	27.1%
25	Rochester, NY	0.408759	0.37594	0.364964	0.416667	0.328244	37.9%
26	Springfield, MA	0.359477	0.342657	0.268456	0.335664	0.271523	31.6%
27	Columbus, OH	0.404494	0.528302	0.441718	0.446927	0.455446	45.5%
28	Boise, ID	0.344	0.478261	0.338983	0.358491	0.286957	36.1%
29	Albany, NY	0.416	0.395161	0.344262	0.301724	0.336	35.9%
30	Lawrence, MA	0.421053	0.285714	0.465753	0.246377	0.275	33.9%
31	Worcester, MA	0.377049	0.284615	0.338346	0.295775	0.325758	32.4%
32	Roselawn, OH	0.337209	0.37931	0.426667	0.225806	0.47191	36.8%
33	Dayton, OH	0.216	0.419118	0.283784	0.4	0.432624	35.0%
34	Mattapan, MA	0.282051	0.4375	0.467742	0.295455	0.305085	35.8%
35	Lynn, MA	0.428571	0.418605	0.428571	0.295775	0.472727	40.9%
36	Cincinnati, OH	0.561905	0.438095	0.479592	0.444444	0.575221	50.0%
37	Reno, NV	0.333333	0.38	0.348315	0.3	0.255102	32.3%
38	East Albuquerque, NM	0.447917	0.395062	0.544554	0.397959	0.444444	44.6%
39	Fort Wayne, IN	0.075472	0.23913	0.217391	0.336957	0.505155	27.5%
40	Spartanburg, SC	0.558559	0.434211	0.328125	0.38806	0.463768	43.5%
41	Richmond, VA	0.363636	0.301887	0.367347	0.305085	0.462687	36.0%
42	Toledo, OH	0.433071	0.564815	0.311927	0.342857	0.355556	40.2%
43	Myrtle Beach, SC	0.025641	0.42	0.255814	0.232558	0.046512	19.6%
44	Topeka, KS	0.46729	0.308824	0.357143	0.2875	0.361905	35.7%
45	Roanoke, VA	0.561728	0.481928	0.477419	0.474684	0.482143	49.6%
46	OKC 2, OK	0.241379	0.181818	0.189655	0.423077	0.129032	23.3%
47	Baltimore, MD	0.357664	0.416667	0.398496	0.405594	0.406667	39.7%
48	Omaha, NE	0.44	0.171429	0.326087	0.27027	0.382353	31.8%
49	Washington, DC	0.338843	0.316239	0.312	0.4	0.447619	36.3%
50	Montgomery, AL	0.365079	0.144737	0.206897	0.364865	0.302632	27.7%
	COMPANY TOTAL	0.371955	0.369256	0.368141	0.360587	0.38631	37.1%

FORBA 0236067
CONFIDENTIAL

Company	3/26/2007 Daily Actual	3/27/2007 Daily Actual	3/28/2007 Daily Actual	3/29/2007 Daily Actual	3/30/2007 Daily Actual	Average
0 Pueblo, CO	$ 18,800	$ 16,900	$ 22,100	$ 22,200	$ 11,100	$ 18,220
1 Colorado Springs, CO	15,500	16,800	17,800	17,900	11,500	$ 15,900
2 Denver, CO	21,200	22,100	20,800	22,800	11,200	$ 19,620
3 Albuquerque, NM	21,300	21,400	21,800	24,800	9,500	$ 19,760
4 Santa Fe, NM	9,200	9,100	11,900	14,300	9,500	$ 10,800
5 Aurora, CO	22,500	22,100	20,400	24,400	23,700	$ 22,620
6 Phoenix, AZ	8,600	9,600	11,900	15,300	14,100	$ 11,900
7 Indy 1, IN	$ 9,100	$ 12,500	$ 11,100	$ 10,500	$ 8,500	$ 10,340
8 Gary, IN	13,400	14,200	12,900	13,200	13,000	$ 13,340
9 Thornton, CO	20,000	22,000	19,200	23,100	21,100	$ 21,080
10 Greenville, SC	$ 20,100	$ 17,800	$ 16,600	$ 15,900	$ 7,100	$ 15,500
11 Columbia, SC	12,800	13,500	12,600	13,700	12,400	$ 13,000
12 Tucson, AZ	16,400	13,200	17,500	15,900	14,600	$ 15,520
13 Charleston, SC	14,200	13,800	12,500	12,600	20,000	$ 14,620
14 Indy 2, IN	14,600	8,500	12,900	9,800	10,000	$ 11,160
15 KCK, KS	15,800	15,400	16,900	14,500	15,900	$ 15,700
16 Atlanta, GA	11,400	10,200	9,300	7,900	7,400	$ 9,240
17 Florence, SC	13,700	15,300	15,400	15,000	9,500	$ 13,780
18 Wichita, KS	21,100	22,700	20,600	17,700	21,200	$ 20,660
19 Macon, GA	17,700	16,600	15,600	11,000	13,200	$ 14,820
20 Tulsa, OK	30,200	23,500	27,700	33,800	29,000	$ 28,840
21 Augusta, GA	11,000	11,200	14,400	9,400	6,200	$ 10,440
22 Syracuse, NY	11,400	12,900	11,800	11,100	10,400	$ 11,520
23 Savannah, GA	18,600	10,500	15,600	7,700	13,400	$ 13,160
24 OKC 1, OK	30,500	40,200	40,500	29,000	34,100	$ 34,860
25 Rochester, NY	16,000	14,300	17,900	15,900	14,700	$ 15,760
26 Springfield, MA	21,900	22,200	25,300	24,400	25,400	$ 23,840
27 Columbus, OH	21,600	17,000	21,000	18,700	23,200	$ 20,300
28 Boise, ID	14,900	10,300	12,100	10,400	12,000	$ 11,940
29 Albany, NY	16,600	13,700	17,000	20,600	16,200	$ 16,820
30 Lawrence, MA	14,200	14,700	10,700	14,200	15,000	$ 13,760
31 Worcester, MA	24,100	24,300	26,500	26,200	23,900	$ 25,000
32 Roselawn, OH	13,800	13,400	6,700	10,200	10,100	$ 10,840
33 Dayton, OH	22,200	19,000	23,100	19,800	23,700	$ 21,560
34 Mattapan, MA	15,000	12,200	11,200	10,900	12,200	$ 12,300
35 Lynn, MA	11,000	10,500	8,900	9,100	7,000	$ 9,300
36 Cincinnati, OH	6,800	9,400	7,000	10,500	7,200	$ 8,180
37 Reno, NV	11,300	10,800	11,200	11,700	11,700	$ 11,340
38 East Albuquerque, NM	11,600	17,100	12,100	16,600	12,200	$ 13,920
39 Fort Wayne, IN	18,700	15,600	17,000	17,000	13,200	$ 16,300
40 Spartanburg, SC	9,300	11,300	8,100	11,100	8,100	$ 9,580
41 Richmond, VA	8,000	8,500	6,200	6,800	9,500	$ 7,800
42 Toledo, OH	13,400	9,400	14,700	13,200	10,600	$ 12,260
43 Myrtle Beach, SC	9,900	7,800	5,900	8,000	7,700	$ 7,860
44 Topeka, KS	9,800	10,800	9,300	9,500	14,000	$ 10,680
45 Roanoke, VA	16,700	16,900	16,800	14,900	16,600	$ 16,380
46 OKC 2, OK	13,300	12,900	13,900	8,300	17,600	$ 13,200
47 Baltimore, MD	18,000	18,300	18,500	19,200	21,200	$ 19,040
48 Omaha, NE	10,100	8,000	9,500	18,400	11,400	$ 11,480
49 Washington, DC	28,300	22,700	26,400	22,800	18,700	$ 23,780
50 Montgomery, AL	15,300	9,200	10,900	8,600	11,000	$ 11,000
COMPANY TOTAL	810,900	772,300	797,700	790,500	731,700	780,620

Company		3/26/2007 Daily Patients	3/27/2007 Daily Patients	3/28/2007 Daily Patients	3/29/2007 Daily Patients	3/30/2007 Daily Patients	Average
0	Pueblo, CO	97	95	90	101	51	87
1	Colorado Springs, CO	97	84	98	116	53	90
2	Denver, CO	103	103	104	104	57	94
3	Albuquerque, NM	92	92	125	121	58	98
4	Santa Fe, NM	58	55	69	79	64	65
5	Aurora, CO	102	99	96	103	123	105
6	Phoenix, AZ	54	56	63	59	69	60
7	Indy 1, IN	57	56	59	63	56	58
8	Gary, IN	69	56	60	82	60	65
9	Thornton, CO	75	83	82	89	90	84
10	Greenville, SC	111	94	93	86	26	82
11	Columbia, SC	68	75	75	67	57	68
12	Tucson, AZ	78	68	87	60	60	71
13	Charleston, SC	65	61	67	58	68	64
14	Indy 2, IN	72	45	81	43	53	59
15	KCK, KS	97	87	111	76	105	95
16	Atlanta, GA	44	42	40	33	46	41
17	Florence, SC	65	70	72	77	48	66
18	Wichita, KS	111	111	100	97	108	105
19	Macon, GA	82	69	78	51	63	69
20	Tulsa, OK	98	94	113	113	102	104
21	Augusta, GA	56	54	44	50	43	49
22	Syracuse, NY	74	69	74	70	64	70
23	Savannah, GA	66	46	53	46	65	55
24	OKC 1, OK	104	121	106	94	65	98
25	Rochester, NY	81	83	87	77	88	83
26	Springfield, MA	98	94	109	95	110	101
27	Columbus, OH	106	75	91	99	110	96
28	Boise, ID	82	60	78	68	82	74
29	Albany, NY	73	75	80	81	83	78
30	Lawrence, MA	44	50	39	52	58	49
31	Worcester, MA	76	93	88	100	89	89
32	Roselawn, OH	57	54	43	48	47	50
33	Dayton, OH	98	79	106	81	80	89
34	Mattapan, MA	56	36	33	31	41	39
35	Lynn, MA	44	50	40	50	29	43
36	Cincinnati, OH	46	59	51	55	48	52
37	Reno, NV	64	62	58	63	73	64
38	East Albuquerque, NM	53	49	46	59	55	52
39	Fort Wayne, IN	98	70	72	61	48	70
40	Spartanburg, SC	49	43	43	41	37	43
41	Richmond, VA	35	37	31	41	36	36
42	Toledo, OH	72	47	75	69	58	64
43	Myrtle Beach, SC	38	29	32	33	41	35
44	Topeka, KS	57	47	45	57	67	55
45	Roanoke, VA	71	86	81	83	87	82
46	OKC 2, OK	44	45	47	30	54	44
47	Baltimore, MD	88	77	80	85	89	84
48	Omaha, NE	28	29	31	54	42	37
49	Washington, DC	80	80	86	69	58	75
50	Montgomery, AL	80	65	69	47	53	63
	COMPANY TOTAL	3,713	3,459	3,681	3,567	3,317	3,547

Rank	Clinic
1	Pueblo, CO
2	Colorado Springs, CO
3	Denver, CO
4	Albuquerque, NM
5	Santa Fe, NM
6	Aurora, CO
7	Phoenix, AZ
8	Indy 1, IN
9	Gary, IN
10	Thornton, CO
11	Greenville, SC
12	Columbia, SC
13	Tucson, AZ
14	Charleston, SC
15	Indy 2, IN
16	KCK, KS
17	Atlanta, GA
18	Florence, SC
19	Wichita, KS
20	Macon, GA
21	Tulsa, OK
22	Augusta, GA
23	Syracuse, NY
24	Savannah, GA
25	OKC 1, OK
26	Rochester, NY
27	Springfield, MA
28	Columbus, OH
29	Boise, ID
30	Albany, NY
31	Lawrence, MA
32	Worcester, MA
33	Roselawn, OH
34	Dayton, OH
35	Mattapan, MA
36	Lynn, MA
37	Cincinnati, OH
38	Reno, NV
39	East Albuquerque, NM
40	Fort Wayne, IN
41	Spartanburg, SC
42	Richmond, VA
43	Toledo, OH
44	Myrtle Beach, SC
45	Topeka, KS
46	Roanoke, VA
47	OKC 2, OK
48	Baltimore, MD
49	Omaha, NE
50	Washington, DC
51	Montgomery, AL

Company	3/19/2007 BA Rate	3/20/2007 BA Rate	3/21/2007 BA Rate	3/22/2007 BA Rate	3/23/2007 BA Rate	Average	
0 Pueblo, CO	0.325203	0.19469	0.217391	0.190083	0.153846	21.6%	
1 Colorado Springs, CO	0.45	0.320755	0.333333	0.25	0.203704	31.2%	
2 Denver, CO	0.288889	0.398438	0.296	0.344444	0.294118	32.4%	
3 Albuquerque, NM	0.416667	0.516129	0.333333	0.335443	0.410256	40.2%	
4 Santa Fe, NM	0.353535	0.173333	0.35	0.213333	0.315789	28.1%	
5 Aurora, CO	0.333333	0.245283	0.272727	0.321839	0.224299	27.9%	
6 Phoenix, AZ	0.358491	0.313725	0.262626	0.333333	0.252427	30.4%	
7 Indy 1, IN	0.349057	0.516393	0.336283	0.228261	0.294118	34.5%	
8 Gary, IN	0.198675	0.262295	0.409091	0.459184	0.540881	37.4%	
9 Thornton, CO	0.327731	0.284483	0.252874	0.340206	0.305556	30.2%	
10 Greenville, SC	0.369427	0.198473	0.29771	0.367647	0.179104	28.2%	
11 Columbia, SC	0.482143	0.455782	0.506667	0.468531	0.544118	49.1%	
12 Tucson, AZ	0.401786	0.333333	0.309091	0.359649	0.362832	35.3%	
13 Charleston, SC	0.150538	0.086022	0.257143	0.213483	0.2	18.1%	
14 Indy 2, IN	0.19	0.206522	0.298701	0.191176	0.263736	23.0%	
15 KCK, KS	0.255639	0.229167	0.383117	0.354839	0.436709	33.2%	
16 Atlanta, GA	0.357143	0.5	0.291667	0.547368	0.417582	42.3%	
17 Florence, SC	0.380952	0.452381	0.36036	0.491667	0.425532	42.2%	
18 Wichita, KS	0.368421	0.387283	0.41573	0.310734	0.352941	36.7%	
19 Macon, GA	0.422222	0.490066	0.47541	0.541985	0.383838	46.3%	
20 Tulsa, OK	0.342697	0.310345	0.484536	0.281437	0.35468	35.5%	
21 Augusta, GA	0.506329	0.337209	0.347826	0.320988	0.398058	38.2%	
22 Syracuse, NY	0.465116	0.410448	0.310078	0.37069	0.414063	39.4%	
23 Savannah, GA	0.490196	0.52	0.421569	0.344086	0.525253	46.0%	
24 OKC 1, OK	0.130719	0.246914	0.375	0.298137	0.257862	26.2%	
25 Rochester, NY	0.294574	0.364964	0.411765	0.496241	0.443662	40.2%	
26 Springfield, MA	0.358108	0.377483	0.356643	0.381944	0.496552		38.9%
27 Columbus, OH	0.393064	0.403226	0.461078	0.401163	0.454054	42.3%	
28 Boise, ID	0.352459	0.337349	0.277108	0.384615	0.5	37.0%	
29 Albany, NY	0.338462	0.372881	0.38806	0.516667	0.310924	38.5%	
30 Lawrence, MA	0.205882	0.309859	0.434211	0.363636	0.358025	33.4%	
31 Worcester, MA	0.354839	0.233871	0.324786	0.284404	0.432	32.6%	
32 Roselawn, OH	0.443038	0.36	0.621212	0.382716	0.48913	45.9%	
33 Dayton, OH	0.408451	0.351145	0.449275	0.193798	0.441558	36.9%	
34 Mattapan, MA	0.470588	0.396552	0.4375	0.393443	0.385542	41.7%	
35 Lynn, MA	0.475	0.289157	0.458333	0.486111	0.360656	41.4%	
36 Cincinnati, OH	0.458015	0.526786	0.455446	0.533333	0.525862	50.0%	
37 Reno, NV	0.136842	0.363636	0.285714	0.202381	0.228571	24.3%	
38 East Albuquerque, NM	0.495146	0.456522	0.372093	0.233766	0.378788	38.7%	
39 Fort Wayne, IN	0.316327	0.203883	0.117647	0.311828	0.375	26.5%	
40 Spartanburg, SC	0.333333	0.409091	0.253012	0.232558	0.289474	30.3%	
41 Richmond, VA	0.361702	0.3	0.377358	0.384615	0.507463	38.6%	
42 Toledo, OH	0.435897	0.464646	0.356589	0.352	0.359375	39.4%	
43 Myrtle Beach, SC	0.369565	0.396226	0.26	0.306122	0.456522	35.8%	
44 Topeka, KS	0.387597	0.489051	0.426752	0.459627	0.403846	43.3%	
45 Roanoke, VA	0.521472	0.5	0.544218	0.459259	0.553672	51.6%	
46 OKC 2, OK	0.386364	0.333333	0.33871	0.289474	0.264368	32.2%	
47 Baltimore, MD	0.432624	0.458065	0.4	0.445205	0.398496	42.7%	
48 Omaha, NE	0.333333	0.413793	0.5	0.263158	0.25	35.2%	
49 Washington, DC	0.347826	0.456	0.333333	0.295918	0.363636	35.9%	
50 Montgomery, AL	0.258065	0.3125	0.243902	0.474138	0.465649	35.1%	
COMPANY TOTAL	0.354667	0.350489	0.368141	0.360587	0.38631	36.4%	

Company	3/19/2007 Daily Actual	3/20/2007 Daily Actual	3/21/2007 Daily Actual	3/22/2007 Daily Actual	3/23/2007 Daily Actual	Average
0 Pueblo, CO	$ 15,700	$ 19,700	$ 19,700	$ 21,000	$ 13,700	$ 17,960
1 Colorado Springs, CO	13,600	13,500	13,600	14,700	7,700	$ 12,620
2 Denver, CO	18,100	16,100	20,300	15,900	4,000	$ 14,880
3 Albuquerque, NM	17,400	17,900	23,400	20,800	7,900	$ 17,480
4 Santa Fe, NM	11,300	13,800	7,300	8,700	9,600	$ 10,140
5 Aurora, CO	15,800	17,300	14,200	12,900	18,500	$ 15,740
6 Phoenix, AZ	13,900	16,400	15,200	15,300	14,500	$ 15,060
7 Indy 1, IN	$ 12,400	$ 11,100	$ 12,000	$ 12,600	$ 12,900	$ 12,200
8 Gary, IN	16,500	12,400	11,800	10,800	15,100	$ 13,320
9 Thornton, CO	18,800	20,100	18,400	17,600	20,600	$ 19,100
10 Greenville, SC	$ 16,500	$ 18,900	$ 19,300	$ 15,000	$ 11,000	$ 16,140
11 Columbia, SC	15,500	17,200	15,800	12,800	9,900	$ 14,240
12 Tucson, AZ	12,500	12,200	15,500	12,600	13,300	$ 13,220
13 Charleston, SC	16,700	16,600	16,900	17,500	18,800	$ 17,300
14 Indy 2, IN	18,700	15,900	16,900	10,200	16,900	$ 15,720
15 KCK, KS	18,600	18,700	15,900	17,800	15,800	$ 17,360
16 Atlanta, GA	9,800	9,000	9,500	10,800	10,500	$ 9,920
17 Florence, SC	15,300	17,200	12,700	13,200	7,500	$ 13,180
18 Wichita, KS	19,100	20,100	19,000	22,800	19,400	$ 20,080
19 Macon, GA	18,300	15,400	14,100	10,700	12,000	$ 14,100
20 Tulsa, OK	42,400	29,200	28,500	27,500	28,600	$ 31,240
21 Augusta, GA	6,400	11,300	16,000	9,800	11,400	$ 10,980
22 Syracuse, NY	12,000	13,400	14,900	11,600	13,200	$ 13,020
23 Savannah, GA	12,000	12,900	13,200	10,700	11,500	$ 12,060
24 OKC 1, OK	33,400	41,400	31,700	35,000	36,600	$ 35,620
25 Rochester, NY	15,700	14,300	15,100	12,600	14,200	$ 14,380
26 Springfield, MA	22,900	26,000	23,900	22,500	23,300	$ 23,720
27 Columbus, OH	23,000	20,800	18,900	23,500	19,700	$ 21,180
28 Boise, ID	12,400	9,800	11,600	9,700	7,600	$ 10,220
29 Albany, NY	16,000	19,200	16,900	16,600	12,800	$ 16,300
30 Lawrence, MA	14,300	14,800	14,100	12,600	14,500	$ 14,060
31 Worcester, MA	24,700	24,600	23,400	21,100	19,300	$ 22,620
32 Roselawn, OH	8,100	9,600	5,800	9,400	11,800	$ 8,940
33 Dayton, OH	18,900	20,600	19,200	21,100	20,400	$ 20,040
34 Mattapan, MA	11,300	12,200	9,200	13,100	16,500	$ 12,460
35 Lynn, MA	9,300	11,100	8,800	10,100	6,000	$ 9,060
36 Cincinnati, OH	11,500	11,000	7,400	8,000	8,800	$ 9,340
37 Reno, NV	12,300	10,400	12,100	13,100	15,000	$ 12,580
38 East Albuquerque, NM	9,700	10,100	12,200	12,900	10,600	$ 11,100
39 Fort Wayne, IN	18,500	20,400	16,600	16,300	17,000	$ 17,760
40 Spartanburg, SC	16,300	14,100	12,200	13,600	14,600	$ 14,160
41 Richmond, VA	6,800	6,300	7,100	5,500	8,400	$ 6,820
42 Toledo, OH	13,200	9,100	15,500	15,000	16,600	$ 13,880
43 Myrtle Beach, SC	5,900	5,200	7,200	8,300	5,100	$ 6,340
44 Topeka, KS	13,000	12,000	18,100	15,000	16,100	$ 14,840
45 Roanoke, VA	15,500	16,600	16,100	13,800	18,000	$ 16,000
46 OKC 2, OK	15,300	14,200	10,300	11,400	14,300	$ 13,100
47 Baltimore, MD	15,500	17,600	15,700	18,400	15,800	$ 16,600
48 Omaha, NE	12,500	8,900	6,100	11,600	11,200	$ 10,060
49 Washington, DC	25,100	21,700	24,900	20,300	23,000	$ 23,000
50 Montgomery, AL	18,100	16,900	16,400	12,300	15,500	$ 15,840
COMPANY TOTAL	805,500	805,200	780,600	756,100	737,000	777,080

FORBA 0236072
CONFIDENTIAL

Company	3/19/2007 Daily Patients	3/20/2007 Daily Patients	3/21/2007 Daily Patients	3/22/2007 Daily Patients	3/23/2007 Daily Patients	Average
0 Pueblo, CO	83	91	90	98	55	83
1 Colorado Springs, CO	66	72	64	78	43	65
2 Denver, CO	96	77	88	59	24	69
3 Albuquerque, NM	91	75	92	105	46	82
4 Santa Fe, NM	64	62	52	59	52	58
5 Aurora, CO	76	80	64	59	83	72
6 Phoenix, AZ	68	70	73	66	77	71
7 Indy 1, IN	69	59	75	71	72	69
8 Gary, IN	121	90	65	53	73	80
9 Thornton, CO	80	83	65	64	75	73
10 Greenville, SC	99	105	92	86	55	87
11 Columbia, SC	87	80	74	76	62	76
12 Tucson, AZ	67	66	76	73	72	71
13 Charleston, SC	79	85	78	70	68	76
14 Indy 2, IN	81	73	54	62	67	67
15 KCK, KS	99	111	95	100	89	99
16 Atlanta, GA	63	44	51	43	53	51
17 Florence, SC	78	69	71	61	27	61
18 Wichita, KS	108	106	104	122	110	110
19 Macon, GA	78	77	64	60	61	68
20 Tulsa, OK	117	120	100	120	131	118
21 Augusta, GA	39	57	60	55	62	55
22 Syracuse, NY	69	79	89	73	75	77
23 Savannah, GA	52	48	59	61	47	53
24 OKC 1, OK	173	202	105	113	118	142
25 Rochester, NY	91	87	80	67	79	81
26 Springfield, MA	95	94	92	89	73	89
27 Columbus, OH	105	111	90	103	101	102
28 Boise, ID	79	55	60	56	49	60
29 Albany, NY	86	74	82	58	82	76
30 Lawrence, MA	54	49	43	49	52	49
31 Worcester, MA	80	95	79	78	71	81
32 Roselawn, OH	44	48	25	50	47	43
33 Dayton, OH	84	85	76	104	86	87
34 Mattapan, MA	36	35	36	37	51	39
35 Lynn, MA	42	59	39	37	39	43
36 Cincinnati, OH	71	53	55	49	55	57
37 Reno, NV	82	63	65	67	81	72
38 East Albuquerque, NM	52	50	54	59	41	51
39 Fort Wayne, IN	67	82	90	64	65	74
40 Spartanburg, SC	78	65	62	66	54	65
41 Richmond, VA	30	35	33	32	33	33
42 Toledo, OH	66	53	83	81	82	73
43 Myrtle Beach, SC	29	32	37	34	25	31
44 Topeka, KS	79	70	90	87	93	84
45 Roanoke, VA	78	84	67	73	79	76
46 OKC 2, OK	54	52	41	54	64	53
47 Baltimore, MD	80	84	81	81	80	81
48 Omaha, NE	40	34	25	42	45	37
49 Washington, DC	75	68	80	69	77	74
50 Montgomery, AL	92	88	93	61	70	81
COMPANY TOTAL	3,872	3,786	3,558	3,534	3,371	3,624

Company	Clinic	3/12/2007 Conversions	3/13/2007 Conversions	3/14/2007 Conversions	3/15/2007 Conversions	3/16/2007 Conversions	Average	
0	Pueblo, CO	15	10	15	11	8	11.8	
1	Colorado Springs, CO	8	7	12	6	6	7.8	
2	Denver, CO	18	10	12	14	10	12.8	
3	Albuquerque, NM	12	14	6	11	2	9	
4	Santa Fe, NM	5	10	21	8	6	10	
5	Aurora, CO	12	15	14	20	15	15.2	
6	Phoenix, AZ	7	9	15	7	11	9.8	
7	Indy 1, IN	6	10	14	5	7	8.4	
8	Gary, IN	7	9	11	16	11	10.8	
9	Thornton, CO	18	19	18	12	9	15.2	
10	Greenville, SC	14	13	13	12	6	11.6	
11	Columbia, SC	3	9	2	1	2	3.4	
12	Tucson, AZ	16	15	9	5	12	11.4	
13	Charleston, SC	15	5	18	17	19	14.8	
14	Indy 2, IN	15	15	11	12	13	13.2	
15	KCK, KS	6	10	7	11	16	10	
16	Atlanta, GA	6	3	1	3	7	4	
17	Florence, SC	5	2	3	3	0	2.6	
18	Wichita, KS	18	20	19	29	17	20.6	
19	Macon, GA	8	4	7	10	2	6.2	
20	Tulsa, OK	14	15	20	18	18	17	
21	Augusta, GA	6	5	7	8	6	6.4	
22	Syracuse, NY	6	2	9	8	2	5.4	
23	Savannah, GA	15	13	14	7	11	12	
24	OKC 1, OK	13	13	18	21	14	15.8	
25	Rochester, NY	11	6	7	10	7	8.2	
26	Springfield, MA	7	12	11	8	2	8.9	40
27	Columbus, OH	15	19	16	14		16	
28	Boise, ID	16	12	10	12	6	11.2	
29	Albany, NY	6	6	5	6	8	6.5	31
30	Lawrence, MA	9	11	10	10	3	8.6	
31	Worcester, MA	9	10	13	7	4	9.6	43
32	Roselawn, OH	15	16	14	15	13	14.6	
33	Dayton, OH	4	10	6	14	3	7.4	
34	Mattapan, MA	9	4	7	9	5	6.8	
35	Lynn, MA	3	3	0	0	1	1.4	
36	Cincinnati, OH	6	10	6	6	7	7	
37	Reno, NV	12	8	12	12	7	10.2	
38	East Albuquerque, NM	0	6	4	1	1	2.4	
39	Fort Wayne, IN	4	6	3	10	3	5.2	
40	Spartanburg, SC	5	5	10	13	7	8	
41	Richmond, VA	6	3	0	1	1	2.2	
42	Toledo, OH	40	34	23	21	26	28.8	
43	Myrtle Beach, SC	8	6	6	9	4	6.6	
44	Topeka, KS	5	7	9	5	9	7	
45	Roanoke, VA	5	1	7	3	2	3.6	
46	OKC 2, OK	4	8	11	6	3	6.4	
47	Baltimore, MD	3	3	9	4	2	4.2	
48	Omaha, NE	8	8	7	3	3	5.8	
49	Washington, DC, DC	1	1	1	0	0	0.6	
50	Montgomery, AL	1	4	7	7	3	4.4	
	COMPANY TOTAL	480	476	510	481	360	461	

Company		3/12/2007 BA Rate	3/13/2007 BA Rate	3/14/2007 BA Rate	3/15/2007 BA Rate	3/16/2007 BA Rate	Average		
0	Pueblo, CO	40.7%	35.0%	37.5%	26.6%	4.9%	28.9%		
1	Colorado Springs, CO	42.7%	35.9%	31.3%	31.7%	50.0%	38.3%		
2	Denver, CO	36.5%	32.1%	38.5%	27.3%	32.2%	33.3%		
3	Albuquerque, NM	40.3%	52.0%	39.2%	52.9%	48.6%	46.6%		
4	Santa Fe, NM	27.4%	42.7%	41.7%	36.8%	23.4%	34.4%		
5	Aurora, CO	15.9%	30.5%	33.0%	40.6%	19.4%	27.9%		
6	Phoenix, AZ	45.7%	39.8%	32.6%	46.3%	32.0%	39.3%		
7	Indy 1, IN	36.2%	34.8%	17.8%	28.7%	41.6%	31.8%		
8	Gary, IN	57.7%	39.5%	45.6%	37.3%	50.4%	46.1%		
9	Thornton, CO	37.0%	22.9%	28.4%	43.5%	37.8%	33.9%		
10	Greenville, SC	30.2%	35.5%	33.3%	38.6%	26.3%	32.8%		
11	Columbia, SC	44.8%	44.2%	38.5%	42.9%	41.4%	42.3%		
12	Tucson, AZ	29.9%	38.9%	35.2%	39.0%	31.6%	34.9%		
13	Charleston, SC	17.6%	51.8%	25.6%	25.9%	25.4%	29.3%		
14	Indy 2, IN	34.6%	25.3%	37.4%	37.8%	39.8%	35.0%		
15	KCK, KS	35.7%	34.1%	42.5%	26.8%	31.6%	34.1%		
16	Atlanta, GA	29.0%	37.1%	34.9%	47.8%	24.1%	34.6%		
17	Florence, SC	61.8%	47.6%	51.1%	46.0%	35.8%	48.5%		
18	Wichita, KS	40.9%	38.6%	30.5%	48.5%	37.0%	39.1%		
19	Macon, GA	49.4%	51.1%	47.0%	50.0%	49.6%	49.4%		
20	Tulsa, OK	42.0%	30.7%	39.4%	40.4%	47.4%	40.0%		
21	Augusta, GA	33.3%	33.3%	43.3%	54.5%	38.2%	40.5%		
22	Syracuse, NY	52.0%	44.6%	48.5%	45.7%	39.6%	46.1%		
23	Savannah, GA	50.5%	58.2%	48.9%	53.8%	49.5%	52.2%		
24	OKC 1, OK	39.9%	12.1%	3.7%	33.3%	37.8%	25.3%		
25	Rochester, NY	41.6%	37.1%	38.8%	36.3%	47.8%	40.3%		
26	Springfield, MA	37.8%	27.8%	33.6%	30.5%	45.8%		175.41%	38.98%
27	Columbus, OH	46.9%	52.2%	47.4%	46.6%	48.4%	48.3%		
28	Boise, ID	45.9%	21.8%	27.6%	39.0%	35.3%	33.9%		
29	Albany, NY	48.9%	41.5%	38.1%	35.4%	49.2%		213.03%	44.85%
30	Lawrence, MA	47.4%	27.4%	34.2%	29.7%	58.8%	39.5%		
31	Worcester, MA	38.7%	32.5%	39.7%	34.7%	68.6%		214.13%	47.58%
32	Roselawn, OH	53.1%	38.8%	49.3%	52.8%	46.3%	48.1%		
33	Dayton, OH	31.5%	31.9%	24.1%	30.6%	34.5%	30.5%		
34	Mattapan, MA	26.8%	39.4%	49.4%	26.9%	61.4%	40.8%		
35	Lynn, MA	43.8%	41.2%	41.1%	50.0%	50.0%	45.2%		
36	Cincinnati, OH	59.1%	48.1%	53.2%	58.7%	55.0%	54.8%		
37	Reno, NV	32.1%	23.5%	24.8%	32.7%	39.6%	30.5%		
38	East Albuquerque, NM	45.5%	47.9%	45.8%	50.6%	35.1%	45.0%		
39	Fort Wayne, IN	27.1%	24.2%	26.7%	41.0%	27.1%	29.2%		
40	Spartanburg, SC	52.7%	30.8%	33.3%	42.3%	38.6%	39.6%		
41	Richmond, VA	39.7%	43.1%	31.1%	63.6%	44.6%	44.4%		
42	Toledo, OH	28.8%	42.3%	43.5%	47.0%	45.5%	41.4%		
43	Myrtle Beach, SC	18.4%	41.7%	31.5%	14.0%	47.2%	30.5%		
44	Topeka, KS	46.2%	52.9%	31.1%	32.8%	43.2%	41.2%		
45	Roanoke, VA	42.1%	53.3%	54.6%	50.9%	52.5%	50.7%		
46	OKC 2, OK	35.8%	35.7%	34.4%	43.3%	24.6%	34.8%		
47	Baltimore, MD	33.1%	40.5%	43.2%	43.7%	49.7%	42.0%		
48	Omaha, NE	35.1%	38.2%	47.2%	33.9%	31.1%	37.1%		
49	Washington, DC	50.4%	48.2%	40.2%	27.9%	48.8%	43.1%		
50	Montgomery, AL	43.3%	35.8%	42.2%	22.8%	33.3%	35.5%		
	COMPANY TOTAL	0.404822	0.385122	0.378101	0.403253	0.415799	0.397419		

FORBA 0236075
CONFIDENTIAL

Company	3/12/2007 Daily Actual	3/13/2007 Daily Actual	3/14/2007 Daily Actual	3/15/2007 Daily Actual	3/16/2007 Daily Actual	Average	
0 Pueblo, CO	$ 14,500	$ 17,700	$ 19,800	$ 18,900	$ 13,500	$ 16,880	
1 Colorado Springs, CO	15,000	14,300	16,400	14,100	6,000	$ 13,160	
2 Denver, CO	12,600	14,000	11,100	11,200	9,600	$ 11,700	
3 Albuquerque, NM	13,200	15,400	16,300	13,700	6,400	$ 13,000	
4 Santa Fe, NM	10,100	9,100	11,000	11,700	9,800	$ 10,340	
5 Aurora, CO	16,300	15,900	15,800	14,500	17,200	$ 15,940	
6 Phoenix, AZ	7,700	16,400	13,700	9,300	11,900	$ 11,800	
7 Indy 1, IN	13,100	13,300	13,200	9,500	10,200	$ 11,860	
8 Gary, IN	11,400	14,100	13,500	13,000	11,300	$ 12,660	
9 Thornton, CO	17,600	19,500	17,600	15,800	19,200	$ 17,940	
10 Greenville, SC	19,900	16,700	19,300	14,400	8,900	$ 15,840	
11 Columbia, SC	15,000	14,900	13,200	10,400	11,300	$ 12,960	
12 Tucson, AZ	16,000	13,800	15,400	11,100	15,800	$ 14,420	
13 Charleston, SC	18,800	8,000	12,700	16,200	13,300	$ 13,800	
14 Indy 2, IN	13,400	16,000	14,900	15,700	10,300	$ 14,060	
15 KCK, KS	12,200	10,700	10,900	11,600	13,500	$ 11,780	
16 Atlanta, GA	12,400	9,100	7,000	7,400	10,800	$ 9,340	
17 Florence, SC	10,200	13,100	14,900	13,700	5,400	$ 11,460	
18 Wichita, KS	20,800	20,000	20,200	20,900	19,000	$ 20,180	
19 Macon, GA	18,200	14,900	18,900	17,900	11,700	$ 16,320	
20 Tulsa, OK	28,400	27,700	29,300	33,700	27,100	$ 29,240	
21 Augusta, GA	14,900	11,400	11,600	7,900	8,800	$ 10,920	
22 Syracuse, NY	11,900	12,700	12,500	12,700	10,400	$ 12,040	
23 Savannah, GA	10,400	10,600	14,700	8,900	13,100	$ 11,540	
24 OKC 1, OK	25,500	26,900	34,800	29,400	20,000	$ 27,320	
25 Rochester, NY	15,600	15,600	14,500	16,000	13,600	$ 15,060	
26 Springfield, MA	22,800	23,600	24,000	23,200	15,000	$ 24,133	108,600
27 Columbus, OH	20,400	22,000	25,100	22,300	19,400	$ 21,840	
28 Boise, ID	13,400	10,100	9,900	7,000	10,100	$ 10,100	
29 Albany, NY	18,500	14,000	16,500	14,100	13,700	$ 16,168	76,800
30 Lawrence, MA	11,100	11,900	14,900	12,200	9,700	$ 11,960	
31 Worcester, MA	20,700	23,600	26,200	24,700	13,000	$ 24,044	108,200
32 Roselawn, OH	11,100	12,300	9,100	10,100	10,700	$ 10,660	
33 Dayton, OH	16,900	17,200	23,900	21,500	19,100	$ 19,720	
34 Mattapan, MA	14,900	12,400	13,800	11,700	9,600	$ 12,480	
35 Lynn, MA	9,200	9,300	8,400	8,300	7,600	$ 8,560	
36 Cincinnati, OH	8,300	10,300	7,400	6,200	9,100	$ 8,260	
37 Reno, NV	12,100	14,400	12,900	14,100	11,100	$ 12,920	
38 East Albuquerque, NM	15,000	10,100	13,600	8,900	7,400	$ 11,000	
39 Fort Wayne, IN	18,800	16,800	18,600	17,600	20,000	$ 18,360	
40 Spartanburg, SC	13,800	10,300	9,200	11,600	14,200	$ 11,820	
41 Richmond, VA	11,200	8,800	6,300	4,500	7,400	$ 7,640	
42 Toledo, OH	17,900	13,700	12,500	12,300	14,900	$ 14,260	
43 Myrtle Beach, SC	9,100	7,000	9,700	10,300	8,000	$ 8,820	
44 Topeka, KS	12,400	11,100	13,600	8,500	10,400	$ 11,200	
45 Roanoke, VA	16,900	16,400	15,900	16,100	14,000	$ 15,860	
46 OKC 2, OK	11,000	12,100	10,200	9,900	12,600	$ 11,160	
47 Baltimore, MD	19,100	19,900	17,700	12,900	13,700	$ 16,660	
48 Omaha, NE	12,800	12,200	10,500	8,900	10,400	$ 10,960	
49 Washington, DC	21,100	19,700	39,200	28,200	21,300	$ 25,900	
50 Montgomery, AL	12,900	16,700	11,900	15,900	12,600	$ 14,000	
COMPANY TOTAL	766,500	747,700	794,200	720,600	643,100	734,420	

Company	3/12/2007 Daily Patients	3/13/2007 Daily Patients	3/14/2007 Daily Patients	3/15/2007 Daily Patients	3/16/2007 Daily Patients	Average		
0 Pueblo, CO	67	80	70	80	58	71		
1 Colorado Springs, CO	71	75	77	71	30	65		
2 Denver, CO	61	57	59	56	40	55		
3 Albuquerque, NM	86	71	93	72	36	72		
4 Santa Fe, NM	69	55	49	60	59	58		
5 Aurora, CO	90	66	63	63	87	74		
6 Phoenix, AZ	44	59	60	44	68	55		
7 Indy 1, IN	81	75	83	62	66	73		
8 Gary, IN	60	72	68	69	63	66		
9 Thornton, CO	63	74	63	52	69	64		
10 Greenville, SC	104	91	92	81	56	85		
11 Columbia, SC	95	82	88	80	78	85		
12 Tucson, AZ	75	66	68	61	78	70		
13 Charleston, SC	84	41	61	63	53	60		
14 Indy 2, IN	70	71	62	56	59	64		
15 KCK, KS	74	60	69	52	67	64		
16 Atlanta, GA	76	56	56	48	85	64		
17 Florence, SC	52	66	65	68	34	57		
18 Wichita, KS	97	97	114	87	102	99		
19 Macon, GA	78	67	71	72	63	70		
20 Tulsa, OK	98	113	106	112	113	108		
21 Augusta, GA	66	56	55	46	55	56		
22 Syracuse, NY	71	72	70	75	81	74		
23 Savannah, GA	47	38	47	42	54	46		
24 OKC 1, OK	86	131	131	80	56	97		
25 Rochester, NY	80	88	82	86	72	82		
26 Springfield, MA	89	104	91	98	71		453	$ 101
27 Columbus, OH	95	87	92	94	94	92		
28 Boise, ID	59	68	63	50	66	61		
29 Albany, NY	67	72	78	84	66		367	$ 77
30 Lawrence, MA	41	53	50	45	35	45		
31 Worcester, MA	73	85	76	81	44		359	$ 80
32 Roselawn, OH	38	52	38	42	43	43		
33 Dayton, OH	85	77	107	86	91	89		
34 Mattapan, MA	52	40	40	38	27	39		
35 Lynn, MA	36	40	43	38	35	38		
36 Cincinnati, OH	52	54	52	45	54	51		
37 Reno, NV	72	78	82	72	64	74		
38 East Albuquerque, NM	55	50	58	38	50	50		
39 Fort Wayne, IN	70	75	77	62	70	71		
40 Spartanburg, SC	52	54	42	45	81	55		
41 Richmond, VA	41	37	31	20	36	33		
42 Toledo, OH	99	75	61	61	78	75		
43 Myrtle Beach, SC	31	28	37	37	28	32		
44 Topeka, KS	57	56	62	41	54	54		
45 Roanoke, VA	95	71	74	85	76	80		
46 OKC 2, OK	43	45	40	34	46	42		
47 Baltimore, MD	99	88	75	71	78	82		
48 Omaha, NE	50	42	28	41	42	41		
49 Washington, DC	62	59	73	88	62	69		
50 Montgomery, AL	72	86	67	95	70	78		
COMPANY TOTAL	3,530	3,455	3,459	3,229	3,143	3,363		

Clinic	3/1/2007	3/2/2007	3/5/2007	3/6/2007	3/7/2007	3/8/2007	3/9/2007	Average Conversions
Pueblo, CO	11	4	13	10	15	30	12	13.6
Colorado Springs, CO	11	4	6	13	7	6	5	7.4
Denver, CO	5	12	13	11	11	3	10	9.3
Albuquerque, NM	13	5	3	21	9	10	6	9.6
Santa Fe, NM	13	10	9	15	10	11	3	10.1
Aurora, CO	13	12	10	14	17	18	14	14.0
Phoenix, AZ	12	8	5	7	8	11	5	8.0
Indy 1, IN	3	3	3	7	14	11	9	7.1
Gary, IN	16	7	7	7	10	5	10	8.9
Thornton, CO	18	19	14	27	12	16	16	17.4
Greenville, SC	1	0	6	12	10	9	7	6.4
Columbia, SC	5	2	4	8	3	6	0	4.0
Tucson, AZ	3	11	13	15	13	16	12	11.9
Charleston, SC	17	12	18	23	10	10	23	16.1
Indy 2, IN	12	11	13	16	10	14	12	12.9
KCK, KS	14	7	5	7	11	20	9	10.4
Atlanta, GA	6	5	4	1	7	4	5	4.6
Florence, SC	12	0	4	3	1	4	3	3.9
Wichita, KS	0							0.0
Macon, GA	5	7	8	2	12	9	3	6.6
Tulsa, OK	16	19	11	16	9	18	21	15.7
Augusta, GA	5	3	3	11	5	7	21	7.9
Syracuse, NY	7	10	12	7	5	4	3	6.9
Savannah, GA	7	2	14	14	13	19	8	11.0
OKC 1, OK	11	10	14	16	13	13	15	13.1
Rochester, NY	5	9	7	8	13	14	4	8.6
Springfield, MA	7	15	10	5	14	7	11	9.9
Columbus, OH	14	15	14	22	23	18	20	18.0
Boise, ID	5	11	8	13	12	14	10	10.4
Albany, NY	6	6	4	6	8	3	1	4.9
Lawrence, MA	6	8	6	5	2	8	6	5.9
Worcester, MA	3	3	6	11	6	9	6	6.3
Roselawn, OH	20	18	14	19	13	15	17	16.6
Dayton, OH	11	14	10	16	10	10	8	11.3
Mattapan, MA	5	6	3	7	2	8	14	6.4
Lynn, MA	1	0	1	2	1	4	2	1.6
Cincinnati, OH	8	4	8	18	6	5	3	7.4
Reno, NV	11	7	1	13	8	4	3	6.7
East Albuquerque, NM	6	5	1	6	4	3	3	4.0
Fort Wayne, IN	10	4	6	2	4	2	5	4.7
Spartanburg, SC	9	8	7	11	9	7	5	8.0
Richmond, VA	6	3	0	4	0	7	1	3.0
Toledo, OH	25	26	20	24	36	33	33	28.1
Myrtle Beach, SC	9	9	11	5	6	3	4	6.7
Topeka, KS	6	10	10	4	6	5	13	7.7
Roanoke, VA	6	7	3	5	3	3	2	4.1
OKC 2, OK	4	4	7	4	5	2	8	4.9
Baltimore, MD	4	1	5	2	7	10	1	4.3
Omaha, NE			2	1	3	1	1	1.6
Washington, DC, DC	6	0	2	1	4	5	2	2.9
Montgomery, AL	2	4	6	5	6	3	1	3.9
COMPANY TOTAL	431	380	384	504	446	477	416	434.0

Company	3/1/2007 BA Rate	3/2/2007 BA Rate	3/5/2007 BA Rate	3/6/2007 BA Rate	3/7/2007 BA Rate	3/8/2007 BA Rate	3/9/2007 BA Rate	Average
0 Pueblo, CO	0.165138	0.301587	0.382114	0.092593	0.165138	0.299145	0.125	0.218673
1 Colorado Springs, CO	0.466667	0.44	0.324324	0.235849	0.386364	0.324786	0.212121	0.341444
2 Denver, CO	0.5	0.107143	0.333333	0.319588	0.329114	0.391304	0.075472	0.293708
3 Albuquerque, NM	0.47651	0.392405	0.478873	0.51938	0.410959	0.428571	0.203125	0.415689
4 Santa Fe, NM	0.446154	0.246914	0.481818	0.289157	0.269231	0.52	0.35	0.371896
5 Aurora, CO	0.354545	0.313559	0.318681	0.351064	0.298969	0.34375	0.178947	0.308502
6 Phoenix, AZ	0.478873	0.472527	0.094118	0.388889	0.383333	0.057143	0.458824	0.333387
7 Indy 1, IN	0.401515	0.482456	0.293651	0.295082	0.452381	0.375887	0.25	0.364425
8 Gary, IN	0.537736	0.61194	0.589041	0.490566	0.452703	0.556522	0.544828	0.540476
9 Thornton, CO	0.424528	0.336066	0.315217	0.315789	0.237113	0.353535	0.422764	0.343573
10 Greenville, SC	0.325	0.381579	0.329193	0.428571	0.301471	0.315385	0.235294	0.330927
11 Columbia, SC	0.561538	0.51145	0.407692	0.434783	0.5125	0.481481	0.414634	0.474868
12 Tucson, AZ	0.394231	0.495652	0.378378	0.31068	0.40367	0.428571	0.326316	0.391071
13 Charleston, SC	0.303371	0.329268	0.208791	0.192771	0.26506	0.208333	0.258427	0.252289
14 Indy 2, IN	0.345679	0.357895	0.382979	0.358491	0.366071	0.37234	0.31	0.356208
15 KCK, KS	0.364486	0.394958	0.359649	0.463918	0.425	0.245455	0.366071	0.37422
16 Atlanta, GA	0.35	0.2375	0.47619	0.362745	0.467391	0.232558	0.515789	0.377453
17 Florence, SC	0.534351	0.646154	0.55	0.416667	0.428571	0.473282	0.435484	0.497787
18 Wichita, KS	0.407643	0.417178	0.375723	0.309859	0.381579	0.377622	0.405714	0.382188
19 Macon, GA	0.57047	0.550336	0.541935	0.489051	0.532895	0.398496	0.364341	0.492503
20 Tulsa, OK	0.364198	0.382022	0.393443	0.457317	0.442857	0.309677	0.422857	0.396053
21 Augusta, GA	0.585859	0.473118	0.44186	0.51087	0.48913	0.240506	0.424242	0.452227
22 Syracuse, NY	0.352941	0.616541	0.611111	0.646154	0.461538	0.470149	0.401515	0.508564
23 Savannah, GA	0.607143	0.368421	0.435897	0.488372	0.505376	0.322581	0.531915	0.465672
24 OKC 1, OK	0.421875	0.329412	0.315789	0.191304	0.237037	0.40367	0.428571	0.332523
25 Rochester, NY	0.330935	0.381295	0.451852	0.467153	0.387324	0.401575	0.335938	0.393725
26 Springfield, MA	0.35461	0.478261	0.408451	0.270833	0.388889	0.323741	0.401361	0.375164
27 Columbus, OH	0.594771	0.564706	0.418301	0.416667	0.483871	0.458904	0.531073	0.49547
28 Boise, ID	0.338235	0.475248	0.414141	0.305263	0.43	0.39604	0.228261	0.369598
29 Albany, NY	0.487395	0.709091	0.4375	0.422764	0.447154	0.381356	0.375	0.465751
30 Lawrence, MA	0.402778	0.56701	0.461538	0.415385	0.418919	0.314286	0.258621	0.405505
31 Worcester, MA	0.342342	0.663366	0.316239	0.336449	0.365217	0.4	0.258065	0.383097
32 Roselawn, OH	0.454545	0.509259	0.43	0.412371	0.360465	0.511905	0.369048	0.43537
33 Dayton, OH	0.510638	0.347222	0.261194	0.309353	0.217391	0.352113	0.266667	0.323511
34 Mattapan, MA	0.526316	0.545455	0.561644	0.55	0.522388	0.455696	0.493151	0.522093
35 Lynn, MA	0.5	0.507463	0.552632	0.468354	0.532258	0.395349	0.385714	0.477396
36 Cincinnati, OH	0.543103	0.623853	0.605263	0.578125	0.53913	0.398374	0.507576	0.542204
37 Reno, NV	0.360825	0.339806	0.44086	0.206897	0.302083	0.296703	0.302326	0.321357
38 East Albuquerque, NM	0.402597	0.362637	0.444444	0.358025	0.319149	0.428571	0.275862	0.370184
39 Fort Wayne, IN	0.370787	0.303571	0.378641	0.236559	0.397849	0.367816	0.262626	0.331121
40 Spartanburg, SC	0.466667	0.471154	0.428571	0.342593	0.297297	0.338028	0.223404	0.366816
41 Richmond, VA	0.474576	0.528571	0.322581	0.409836	0.326531	0.470588	0.395833	0.41836
42 Toledo, OH	0.363636	0.503704	0.451613	0.475728	0.46087	0.392523	0.407692	0.436538
43 Myrtle Beach, SC	0.465517	0.326923	0.166667	0.222222	0.254902	0.5	0.333333	0.324224
44 Topeka, KS	0.56701	0.432624	0.387097	0.532609	0.353535	0.444444	0.357143	0.439209
45 Roanoke, VA	0.496552	0.57764	0.5375	0.514793	0.704819	0.406667	0.512821	0.535827
46 OKC 2, OK	0.5	0.3125	0.369863	0.386667	0.447368	0.34375	0.3125	0.381807
47 Baltimore, MD	0.414966	0.38255	0.397351	0.413793	0.590909	0.372093	0.315436	0.412443
48 Omaha, NE	1	1	0.512195	0.145161	0.25	0.323077	0.317073	0.506787
49 Washington, DC	0.518868	0.446154	0.358974	0.380531	0.586538	0.340426	0.478992	0.444355
50 Montgomery, AL	0.664516	0.930556	0.326087	0.456376	0.387324	0.514493	0.808824	0.584025
COMPANY TOTAL	0.45	0.468042	0.41094	0.389601	0.410092	0.381997	0.378738	0.412773

Company	3/1/2007 Daily Actual	3/2/2007 Daily Actual	3/5/2007 Daily Actual	3/6/2007 Daily Actual	3/7/2007 Daily Actual	3/8/2007 Daily Actual	3/9/2007 Daily Actual	Average
0 Pueblo, CO	$ 21,500	$ 11,400	$ 16,000	$ 19,800	$ 18,600	$ 24,900	$ 14,000	$18,028.57
1 Colorado Springs, CO	13,800	6,500	14,200	13,500	17,400	13,400	8,700	$12,500.00
2 Denver, CO	7,900	8,800	12,900	12,900	12,200	11,000	10,300	$10,857.14
3 Albuquerque, NM	19,100	9,000	13,300	14,800	18,500	18,600	10,500	$14,828.57
4 Santa Fe, NM	8,500	11,300	9,700	13,300	10,000	7,500	8,900	$9,885.71
5 Aurora, CO	13,700	15,600	12,600	14,000	15,100	17,600	15,700	$14,900.00
6 Phoenix, AZ	8,700	13,000	9,300	6,700	9,000	14,900	11,300	$10,414.29
7 Indy 1, IN	10,900	8,900	14,800	13,000	12,300	16,600	16,300	$13,257.14
8 Gary, IN	12,100	10,400	11,900	13,600	18,200	8,700	13,200	$12,585.71
9 Thornton, CO	15,700	19,700	16,100	20,300	19,700	17,400	19,700	$18,371.43
10 Greenville, SC	$ 15,800	7,300	17,900	14,800	15,600	16,000	7,100	$13,500.00
11 Columbia, SC	10,700	11,700	13,700	14,900	12,600	12,200	16,400	$13,171.43
12 Tucson, AZ	11,900	11,000	16,500	14,500	15,200	15,900	13,400	$14,057.14
13 Charleston, SC	16,400	14,800	16,500	13,800	14,700	11,900	16,800	$14,985.71
14 Indy 2, IN	8,700	13,700	12,400	16,400	16,900	12,400	14,800	$13,614.29
15 KCK, KS	12,800	11,300	13,000	11,000	13,400	14,900	12,500	$12,700.00
16 Atlanta, GA	9,000	7,400	8,300	8,800	10,300	9,200	6,800	$8,542.86
17 Florence, SC	16,800	5,600	15,900	15,500	17,500	16,900	7,200	$13,628.57
18 Wichita, KS	18,900	18,200	20,600	20,400	24,300	20,500	17,400	$20,042.86
19 Macon, GA	16,100	14,300	17,100	15,800	15,500	19,000	20,900	$16,957.14
20 Tulsa, OK	26,700	27,800	37,200	23,800	19,000	26,700	27,600	$26,971.43
21 Augusta, GA	9,100	10,700	9,000	11,500	10,300	13,000	14,000	$11,085.71
22 Syracuse, NY	15,100	10,000	10,300	8,200	12,500	9,700	11,100	$10,985.71
23 Savannah, GA	7,000	8,200	13,800	12,800	12,000	14,800	10,400	$11,257.14
24 OKC 1, OK	25,600	20,900	25,000	36,000	29,200	16,000	27,800	$25,785.71
25 Rochester, NY	15,800	13,900	13,600	14,800	18,700	15,700	15,100	$15,371.43
26 Springfield, MA	21,700	20,700	21,900	21,500	22,500	24,700	22,600	$22,228.57
27 Columbus, OH	18,100	20,100	25,300	23,000	21,000	21,400	18,500	$21,057.14
28 Boise, ID	8,000	9,300	8,900	9,600	9,000	9,000	10,400	$9,171.43
29 Albany, NY	13,600	5,300	14,700	15,500	15,800	13,600	16,300	$13,542.86
30 Lawrence, MA	12,500	13,500	11,200	11,100	12,400	12,800	11,500	$12,142.86
31 Worcester, MA	20,500	10,400	19,100	24,200	25,300	21,900	28,000	$21,342.86
32 Roselawn, OH	10,600	9,900	9,400	12,000	9,000	8,800	10,900	$10,085.71
33 Dayton, OH	19,700	19,900	24,800	22,400	22,000	21,700	19,600	$21,442.86
34 Mattapan, MA	11,300	10,900	12,200	10,900	8,500	13,500	12,900	$11,457.14
35 Lynn, MA	9,300	9,100	9,300	8,000	6,400	15,100	9,300	$9,500.00
36 Cincinnati, OH	8,400	7,300	8,200	8,400	7,600	10,600	8,900	$8,485.71
37 Reno, NV	11,600	10,300	10,300	15,700	13,100	11,200	9,900	$11,728.57
38 East Albuquerque, NM	12,300	12,200	8,900	17,900	13,900	13,600	18,100	$13,842.86
39 Fort Wayne, IN	15,300	15,300	17,600	14,600	14,900	12,100	17,200	$15,285.71
40 Spartanburg, SC	9,700	15,400	12,600	13,900	13,100	11,300	15,800	$13,114.29
41 Richmond, VA	8,900	6,500	9,300	10,200	8,200	9,200	6,400	$8,385.71
42 Toledo, OH	12,100	15,800	10,600	10,100	14,600	15,000	16,800	$13,571.43
43 Myrtle Beach, SC	9,100	9,300	8,100	8,400	8,200	5,000	8,400	$8,071.43
44 Topeka, KS	9,000	14,200	13,600	8,700	11,200	8,900	17,100	$11,814.29
45 Roanoke, VA	16,300	13,300	16,100	14,800	12,600	16,900	15,100	$15,014.29
46 OKC 2, OK	8,200	10,600	10,500	8,800	10,400	11,800	11,700	$10,285.71
47 Baltimore, MD	16,900	17,700	17,600	18,300	16,700	16,200	20,900	$17,757.14
48 Omaha, NE			5,400	10,200	10,600	10,100	13,200	$9,900.00
49 Washington, DC	19,500	21,400	22,700	22,800	15,300	20,500	21,800	$20,571.43
50 Montgomery, AL	8,000	1,000	17,500	13,700	15,400	12,600	3,800	$10,285.71
COMPANY TOTAL	678,900	620,800	737,200	749,600	746,400	742,900	733,000	715542.9

Company	3/1/2007 Total Patients Seen	3/2/2007 Total Patients Seen	3/5/2007 Total Patients Seen	3/6/2007 Total Patients Seen	3/7/2007 Total Patients Seen	3/8/2007 Total Patients Seen	3/9/2007 Total Patients Seen	Average
0 Pueblo, CO	91	44	76	98	91	82	56	76.9
1 Colorado Springs, CO	72	28	75	81	81	79	52	66.9
2 Denver, CO	43	50	64	66	53	42	49	52.4
3 Albuquerque, NM	78	48	74	62	86	80	51	68.4
4 Santa Fe, NM	36	61	57	59	57	36	52	51.1
5 Aurora, CO	71	81	62	61	68	63	78	69.1
6 Phoenix, AZ	37	48	77	33	37	66	46	49.1
7 Indy 1, IN	79	59	89	86	69	88	99	81.3
8 Gary, IN	49	52	60	81	81	51	66	62.9
9 Thornton, CO	61	81	63	65	74	64	71	68.4
10 Greenville, SC	108	47	108	80	95	89	39	80.9
11 Columbia, SC	57	64	77	78	78	70	96	74.3
12 Tucson, AZ	63	58	69	71	65	56	64	63.7
13 Charleston, SC	62	55	72	67	61	57	66	62.9
14 Indy 2, IN	53	61	58	68	71	59	69	62.7
15 KCK, KS	68	72	73	52	69	83	71	69.7
16 Atlanta, GA	52	61	55	65	49	66	46	56.3
17 Florence, SC	61	23	63	77	84	69	35	58.9
18 Wichita, KS	93	95	108	98	94	89	104	97.3
19 Macon, GA	64	67	71	70	71	80	82	72.1
20 Tulsa, OK	103	110	111	89	78	107	101	99.9
21 Augusta, GA	41	49	48	45	47	60	57	49.6
22 Syracuse, NY	88	51	56	46	77	71	79	66.9
23 Savannah, GA	33	48	44	44	46	63	44	46.0
24 OKC 1, OK	74	57	78	93	103	65	76	78.0
25 Rochester, NY	93	86	74	73	87	76	85	82.0
26 Springfield, MA	91	72	84	105	88	94	88	88.9
27 Columbus, OH	62	74	89	98	80	79	83	80.7
28 Boise, ID	45	53	58	66	57	61	71	58.7
29 Albany, NY	61	32	72	71	68	73	80	65.3
30 Lawrence, MA	43	42	42	38	43	48	43	42.7
31 Worcester, MA	73	34	80	71	73	75	92	71.1
32 Roselawn, OH	48	53	57	57	55	41	53	52.0
33 Dayton, OH	69	94	99	96	108	92	110	95.4
34 Mattapan, MA	27	30	32	27	32	43	37	32.6
35 Lynn, MA	43	33	34	42	29	52	43	39.4
36 Cincinnati, OH	53	41	45	54	53	74	65	55.0
37 Reno, NV	62	68	52	69	67	64	60	63.1
38 East Albuquerque, NM	46	58	50	52	64	52	63	55.0
39 Fort Wayne, IN	56	78	64	71	56	55	73	64.7
40 Spartanburg, SC	40	55	56	71	52	47	73	56.3
41 Richmond, VA	31	33	42	36	33	36	29	34.3
42 Toledo, OH	70	67	51	54	62	65	77	63.7
43 Myrtle Beach, SC	31	35	35	35	38	21	34	32.7
44 Topeka, KS	42	80	57	43	64	55	81	60.3
45 Roanoke, VA	73	68	74	82	49	89	76	73.0
46 OKC 2, OK	29	33	46	46	42	42	55	41.9
47 Baltimore, MD	86	92	91	85	63	81	102	85.7
48 Omaha, NE	0	0	20	53	42	44	56	30.7
49 Washington, DC	51	72	75	70	43	62	62	62.1
50 Montgomery, AL	52	10	93	81	87	67	26	59.4
COMPANY TOTAL	3,014	2,863	3,360	3,381	3,320	3,323	3,366	3232.4

EXHIBIT 12

LEAD DENTIST EMPLOYMENT AGREEMENT
(COLLECTION BASED)

THIS LEAD DENTIST EMPLOYMENT AGREEMENT (Collection Based) (the "Agreement") is entered into on August 30, 2010 by and between Small Smiles Dental Center of [redacted], LLC ("Employer") and Dr. [redacted], DDS ("Employee").

RECITALS

Employer is a Massachusetts Limited Liability Company engaged in the practice of dentistry at [redacted], [redacted], MA [redacted] ("Practice Location"), only through those persons licensed to practice dentistry in the State of Massachusetts ("State").

Employee is licensed to practice dentistry in the State of Massachusetts.

Employer desires to employ Employee to practice dentistry in its office and Employee desires to be employed by Employer.

In order to utilize Employee's skills and promote the business of Employer, to provide opportunity and incentive to Employee, and to define their rights, obligations and duties, the parties desire to enter into this Agreement on the terms and conditions set forth.

In consideration of the mutual covenants, conditions, and terms, the parties agree as follows:

1.0 EMPLOYMENT. Employer agrees to employ Employee, and Employee agrees to accept such employment, to provide dental services as Lead Dentist in Employer's dental practice ("Practice") upon the terms and conditions of this Agreement.

2.0 PROFESSIONAL CONDUCT. Employee shall perform all duties under this Agreement in strict compliance with federal, state and local law, rules and regulations, including without limitation the State Dental Practice Act, the rules and regulations of the State Dental Board, the applicable standards of the American Dental Association and the State Dental Association, the prevailing community standard of care in the community served by Employer, and Employer's policies, procedures and standards.

3.0 TERM. This term of this Agreement shall commence on October 1, 2010 (the date on which the term commences being referred to as the "Effective Employment Date"). The initial term of the Agreement ("Initial Term") shall continue for thirty-six (36) months from the Effective Employment Date unless terminated earlier as set forth in the Agreement. Following the Initial Term, the Agreement shall automatically renew for successive renewal terms of twelve (12) months each ("Renewal Term(s)"), unless no less than ninety (90) days prior to the end of the then-current term, either party notifies the other in writing that it does not intend to renew the Agreement.

4.0 DUTIES OF EMPLOYEE. During the term of this Agreement, Employee shall have the following duties:

4.01 General Duties. Employee faithfully agrees to provide Employee's services in a good, professional and workmanlike manner, to conduct business in such a way as shall serve the best interests of Employer and Employee, and to perform all work in accordance with customary and professional rules of ethics and conduct, to abide by all rules and regulations of the State Dental Board and to comply with all other laws and regulations regulating or pertaining to the practice of dentistry in the State. Employee recognizes that professional regulatory and advisory groups and bodies may from time to time establish ethical standards and requirements with regard to the practice of dentistry by persons licensed to practice dentistry in the State. All restrictions contained in this Agreement with respect to the duties and obligations of Employee shall be subject to said standards and requirements. Further, Employee agrees to comply in all respects with presently existing written office rules and procedures of Employer and those that may be established, in writing, in the future by, or for the benefit of Employer. Employee recognizes and acknowledges that Employee may be required to provide coverage at dental practices other than at Practice Location, which are under common management as Employer. Employee agrees to use the personnel, space, equipment and supplies provided by Employer solely for the purpose of fulfilling Employee's duties under this Agreement.

4.02 Specific Duties. Employee agrees to devote Employee's full time, energy and skill to the performance of the professional services in which Employer is engaged, Monday through Friday, working a minimum of Two Hundred Thirty-five (235) days per 12 month period during the term hereof. Employee is an exempt employee and is not entitled to overtime payments under state or federal laws. In addition to the performance of clinical duties, Employee shall undertake such additional duties and responsibilities as shall be reasonably directed by Employer from time to time. Employee agrees to share the treatment of emergency cases and "on call" duties with all other dentist employees of Employer as reasonably determined by Employer. Please refer to the Small Smiles Resources Manual for more detailed information on the roles and responsibilities of the Lead Dentist as well as the other Clinic Employees.

4.03 Credentialing Requirements. Employee agrees to provide any and all materials requested by Employer's credentialing personnel within seven (7) days after such written request. If Employee fails to provide the requested information within said seven (7) days, then, at the option of Employer, this Agreement may be terminated by Employer. In such event, Employee acknowledges and agrees that Employer shall be relieved of any and all obligations under this Agreement, with the exception of the payment of Orientation Compensation (as hereinafter defined) and Orientation Expenses (as hereinafter defined) if Employee has completed the Orientation Period (as hereinafter defined).

4.04. Employee's Representations and Warranties. Employee makes the following representations and warranties to Employer:

(a) As of the Effective Employment Date, Employee is, and shall remain throughout the term of this Agreement, licensed to practice dentistry without restrictions in the State, and is not subject to any disciplinary or corrective action. Employee shall maintain any additional professional certifications or registrations as Employer may reasonably require from time to time.

(b) As of the Effective Employment Date, Employee is, and shall remain throughout the term of this Agreement, properly credentialed by and enrolled in Medicaid

and those other state and federal programs required by Employer. Employee has not been, and during the term of this Agreement will not be, sanctioned by the Health and Human Services Office of the Inspector General as set forth on the Cumulative Sanctions Report, or excluded by the General Services Administration as set forth on the List of Excluded Providers.

(c) As of the Effective Employment Date, Employee is, and shall remain throughout the term of this Agreement, properly credentialed by and enrolled in those other insurance and third party reimbursement plans required by Employer.

(d) As of the Effective Employment Date, Employee has, and for the term of this Agreement will maintain, all customary state and federal narcotics and controlled substances numbers and licenses, without restriction or subject to any disciplinary or corrective action.

(e) Employee is not, and during the term of this Agreement will not be, in breach of any other contract, obligation, or covenant that would affect Employee's ability to perform hereunder and, as a result of entering into this Agreement, will not breach any such contract, obligation or covenant.

(f) Except as set forth in the Disclosure Schedule attached as Exhibit A to this Agreement, (i) Employee's license to practice dentistry or to prescribe controlled substances in any state has never been restricted, suspended, or revoked; (ii) Employee has never been reprimanded, sanctioned or disciplined by any licensing board or state or local dental society or specialty board; (iii) there has never been entered against Employee a final judgment in a malpractice action and no action, based on an allegation of malpractice by Employee, has ever been settled by payment to the plaintiff; and (iv) there have been no claims threatened or pending against Employee for professional malpractice.

Employee agrees and acknowledges that the representations in this Section 4.04 are continuing representations that are made as of each day during the term of this Agreement and that Employee shall notify Employer immediately in writing if any of the above representations made by Employee are no longer true and correct.

5.0 RESTRICTIONS. During the term of this Agreement, Employer and Employee agree that the following conditions shall prevail:

5.01 Exclusive. Employee shall not directly or indirectly engage in or participate in any other dental practice without Employer's written consent, except that this section shall not apply to the two (2) practices Employee currently owns.

5.02 Outside Activities and Income. Employee may engage in teaching, lecturing or research at any school, university or other institution of learning as long as such activity has been first approved in writing by Employer. Such approval shall not be unreasonably withheld. Personal income of Employee earned in one of these pursuits and not related to the rendering of dental services in the offices of Employer shall belong to Employee individually and will not be deemed compensation by Employer. Employer agrees to allow Employee to continue acting as a visiting professor and consultant for Tufts University and consulting chairman of the Stomatology Department of the Hua Shan Hospital.

5.03 **Contracts**. Employee has no authority to enter into any contracts binding upon Employer or to create any obligations on the part of Employer, except as specifically authorized in writing by Employer.

6.0 **COMPENSATION**. Employer agrees to pay Employee during the term of this Agreement the following compensation:

6.01 **Compensation.**

(a) **Definitions.** As used in this Section 6.01, the following terms shall have the following meanings:

(i) "Ancillary Service Billings" means other fees or income (as meets the Medicare criteria for "incident to") generated by non-dentist employees under Employee's direct supervision and control.

(ii) "Collection Adjustment" means an amount equal to one and a half percent (1.5%) of (i) the Ancillary Service Billings with respect to the calculation of the Estimated Ancillary Service Collections, (ii) the Employee's Gross Billings less the Ancillary Service Billings with respect to the calculation of the Estimated Collections, or (iii) the Practice Location Gross Production with respect to the calculation of the Estimated Practice Location Collections.

(iii) "Employee Base Compensation" equals one hundred percent (100%) of the monthly Estimated Ancillary Service Collections plus eighty percent (80%) of the product of monthly Estimated Collections multiplied by the State Percentage Amount.

(iv) "Employee's Gross Billings" means all charges billed (minus insurance and patient refunds) for patient services provided during the applicable month at the Practice Location that are generated on behalf of the Practice as a result of professional dental services personally furnished to patients by Employee.

(v) "Employee Working Days Calculation" means the number of days the Employee worked at the Practice Location for the applicable month divided by the total number of days all of the dentists employed by the Employer worked for the applicable month at the Practice Location.

(vi) "Estimated Ancillary Service Collections" means the Ancillary Service Billings less the Collection Adjustment.

(vii) "Estimated Collections" means the Employee's Gross Billings less Ancillary Service Billings less the Collection Adjustment.

(viii) "Estimated Practice Location Collections" means the Practice Location Gross Production less the Collection Adjustment.

(ix) "Lead Dentist Compensation" means an amount equal to one and one-tenth percent (1.1%) of the Estimated Practice Location Collections.

(x) "Practice Location Ancillary Service Billings" means other fees or income (as meets the Medicare criteria for "incident to") generated by non-dentist employees at the Practice Location and any designated health services pursuant to 42 USC 1395nn.

(xi) "Practice Location Compensation" equals twenty percent (20%) of the Estimated Practice Location Collections, multiplied by the State Percentage Amount, multiplied by the Employee Working Days Calculation.

(xii) "Practice Location Gross Billings" means the sum of all charges billed (minus insurance and patient refunds) for patient services provided during the applicable month at the Practice Location that are generated on behalf of the Practice as a result of professional dental services, whether provided by Employee or such other professional employee; provided that Practice Location Gross Billings shall not include the charges billed (minus insurance and patient refunds) for patient services provided by specialists.

(xiii) "Practice Location Gross Production" means Practice Location Gross Billings minus Practice Location Ancillary Service Billings.

(xiv) "State Percentage Amount" means Eighteen percent (18%).

(b) **Employee Compensation.** The Employee Compensation shall equal the sum of the Employee Base Compensation (*i.e.,* 100% of monthly Estimated Ancillary Service Collections plus 80% of the monthly Estimated Collections multiplied by State Percentage Amount) plus the Practice Location Compensation (*i.e.,* 20% of the Estimated Practice Location Collections, multiplied by the State Percentage Amount, multiplied by the Employee Working Days Calculation) plus the Lead Dentist Compensation (*i.e.,* 1.1% of the Estimated Practice Location Collections; provided that during the Four (4) month period following the Effective Employment Date, the monthly Employee Compensation shall not be less than Thirteen Thousand Five Hundred Fifty-seven and 38/100 Dollars ($13,557.38) per month. An example of the calculation of Employee Compensation is attached as Exhibit B.

(c) **Quality.** The Employee agrees and acknowledges the importance of providing quality dental services to patients of the Practice. In light of the foregoing, the Employee agrees to comply with the terms and conditions of the quality criteria policies and procedures as established from time to time by Employer ("Quality Criteria"). Exhibit C, which may be modified by Employer in its sole discretion on 30 days prior notice to Employee, includes a copy of the present Quality Criteria.

(d) **Orientation Compensation.** Intentionally Omitted.

6.02 Payment of Employee Compensation. Employee Compensation shall be paid to Employee pursuant to Employer's compensation policies as the same may be modified from time to time by Employer on 30 days written notice to Employee. Employer agrees to pay employer portion of applicable Social Security and employment taxes and will deduct the employee portion of all applicable employment taxes from Employee

Compensation. All Employee Compensation is subject to all federal, state and local taxes and expenses relating to employee compensation.

6.03 Employee's Compensation upon Termination. In the event of termination of this Agreement by either party and for any reason, Employee shall be entitled only to compensation and benefits earned by Employee up to the date of termination. In determining what compensation and benefits are earned, if Employee has elected to receive a monthly draw, the compensation and benefits earned by Employee shall not include any outstanding amounts advanced as draws that exceed Employee's Employee Compensation. Employer shall pay any Employee Compensation (minus the outstanding amount of draws, if any, paid to Employee over and above Employee's Employee Compensation) to which Employee is entitled at Employer's next scheduled pay period after termination.

7.0 EMPLOYER'S OBLIGATIONS. During the term of this Agreement, Employer shall provide the following to Employee:

7.01 Facility, Equipment and Supplies. Employer shall provide Employee access and the right to use Employer's facility, equipment, instruments and supplies that are reasonably necessary for the performance of Employee's duties, as determined by Employer, provided that Employer shall not be required to provide any such items if they are not reasonable or normally used in Employer's practice.

7.02 Personnel. Employer shall provide necessary personnel, including, administrative/clerical personnel, chair side assistant(s) and dental hygienists, as necessary and available that is reasonably necessary for the performance of Employee's duties, as determined by Employer.

7.03 Laboratory Fees. Employer agrees to pay all reasonable laboratory fees and charges coincidental to the provision of services to patients by Employee. However, in the event of any chronic lab remakes as a result of Employee's negligence, actions or inactions, Employee agrees to reimburse Employer for any costs and expenses incurred by Employer. Any amount which Employee is required to pay to Employer shall be paid within ten (10) business days following Employer's written demand for payment. If Employee fails to pay the amount when so demanded, Employer shall have the right to withhold that amount from Employee Compensation.

7.04 Malpractice Insurance. For each twelve-month period of this Agreement, Employer shall provide Employee with and pay the premiums for malpractice insurance coverage insuring Employee and Employer against professional liability caused by Employee, the carrier and the limits to be determined by Employer. Employee shall be responsible for obtaining "tail" insurance at the termination of this Agreement or shall maintain Employee's professional liability insurance which insurance shall continue the coverage through the expiration of any applicable statutes of limitation with respect to Employee's professional activities. The cost of the "tail" or continuation of insurance shall be paid solely by Employee. Employee will be provided with a tail insurance quote by Employer's malpractice carrier thirty (30) days prior to Employee's date of separation ("DOS"). Prior to Employee's DOS, Employee shall provide Employer with proof of purchase of either a tail insurance policy or an professional liability insurance covering Employee

through the expiration of any applicable statutes of limitation with respect to Employee's professional activities while employed by Employer or Employer shall be entitled to purchase tail insurance on behalf of Employee, deducting the quoted premium from Employee's final pay check. In the event this Agreement is terminated prior to the end of any twelve-month period, Employer shall be entitled to any refund relative to the payment of Employee's malpractice premium.

7.05 Disability Insurance. Currently Employer maintains and pays the premiums for a long term disability income policy that provides Employee with income replacement in the amounts specified in the policy in the event of his/her disability. Please see the Summary Plan Description for further information. Employer reserves the right to modify or change the terms of the plan, including the plan benefits and Employee's premium contribution, at its sole discretion. Employer will provide Employee with a minimum of thirty (30) days prior written notice of any changes.

7.06 Health Insurance. Currently Employer maintains and pays the premiums for a group health insurance policy that provides coverage for Employee and Employee's spouse and dependents, as applicable. Please see the Summary Plan Description for further information. Employer reserves the right to modify or change the terms of the plan, including the plan benefits and Employee's premium contribution, at Employer's sole discretion. Employer will provide Employee a minimum of thirty (30) days prior written notice of any changes.

7.07 Retirement Plan. Currently Employer provides a 401(k) retirement plan for its employees. Please see the Summary Plan Description for further information. Employer reserves the right to modify or change the terms of the plan, including Employer's contribution, at Employer's sole discretion. Employer will provide Employee a minimum of thirty (30) days written notice of any changes in its retirement plan.

7.08 Professional Dues/Licenses. For each twelve-month period of this Agreement, Employer shall pay for Employee's American Dental Association and state dental association dues, and further shall pay the fees for Employee's Drug Enforcement Agency registration and state dental license.

7.09 Continuing Education. Employer will provide or arrange for the provision of approved clinical continuing education ("CE") courses required by Employee to fulfill his/her CE requirements under applicable professional licensing laws and regulations. Outside CE courses will be considered for any required CE not available from Employer, or as otherwise necessary and appropriate for Employee's professional education and development. Reimbursement for any outside CE courses attended by Employee must be pre-approved pursuant to Employer's CE policy.

7.10 Absence. When Employee desires to be absent from the Practice Location with respect to all or a portion of the normal operating hours of the Practice Location on any day that the Practice Location is otherwise scheduled to treat patients, such time shall be scheduled so that it allows continuous professional coverage at the Practice Location. All of such Employee absences shall, to the extent reasonably possible, be pre-approved by Employer so that Employee's absence does not disrupt the continuity and business of the Practice at the Practice Location. The Practice Location will be closed for certain holidays

that will be published annually by Employer, and are subject to change at the sole discretion of the Employer.

7.11 Additional Employer Obligations. In addition to the above, Employer agrees to provide the following:

(a) **Office Management Services.** Employer agrees to provide (i) scheduling of appointments; (ii) processing of patient records and maintenance of patient financial records; (iii) billing and collection of payment services; and (iv) other reasonable and normal administrative duties related to patient care.

7.12 No Other Benefits. Employer shall not provide any other benefits to Employee during the term of this Agreement unless specifically agreed to in writing and made part of this Agreement.

7.13 No Accrual of Benefits, Termination and Reimbursement. The benefits provided for in this Agreement are to be provided by Employer to Employee for only the periods of Employee's employment. If any of the above benefits are not used by Employee during their appropriate period, as specified in this Agreement, they shall not accrue and shall not carry over into the next twelve-month period. In the event this Agreement expires or is otherwise terminated prior to any full twelve-month period, Employee shall be entitled to only those benefits accruing up to the date of expiration or termination. Further, in the event Employer has pre-paid any of the benefits provided for in this Agreement, and the Agreement expires or is terminated prior to end of the period for which the benefits have been pre-paid, Employee shall reimburse Employer the amount of the benefits that have been pre-paid for the period following expiration or termination. **(For example: Employer pays Employee's professional liability insurance for twelve months in the amount of $1,200.00 and the Agreement is then terminated after the seventh month of employment. Employee is responsible for reimbursing Employer for five months (the remaining months in the twelve-month period) which in this case would equal $500.00).** Employee authorizes Employer, and Employer shall have the right to withhold any reimbursements as determined above from any compensation owed by Employer to Employee. In the event there is not sufficient compensation due to Employee to reimburse Employer, Employee agrees to pay the total reimbursement to Employer within thirty (30) days from the date of termination.

8.0 EMPLOYEE'S OBLIGATIONS. During the term of this Agreement, Employee shall be responsible for the following:

8.01 Use of Employee's Name. Employer shall be able to use Employee's name in the telephone directories or in other reasonable marketing techniques utilized by Employer. Employee agrees to sign any insurance provider agreements required by Employer's insurance plans or any provider agreements required by Medicaid.

8.02 Employee Expenses. Employee shall be responsible for the payment of all expenses incurred by Employee relating to Employee's employment with Employer that are not paid for by Employer pursuant to this Agreement, including (a) automobile expenses; (b) life insurance; (c) continuing education other than such expenses that Employer agrees to reimburse as provided for in Section 7.09; (d) professional dues other than such expenses

that Employer agrees to reimburse as provided for in Section 7.08; (e) travel and entertainment expenses; and (f) any other benefit or expense not paid for by Employer. Upon the mutual consent of Employer and Employee, Employer shall pay for additional Employee expenses and reduce Employee Compensation by the amount of Employee expenses paid for by Employer.

8.03 Staff. Employee shall supervise the staff assigned to Employee according to the policies and procedures of Employer.

8.04 Forms/Procedures and Medicaid Compliance. Employee shall use and follow all established forms, records, policies and procedures provided by Employer, including Employer's procedures relative to patient payment plans and financing arrangements and further, shall use and follow all forms, records, policies and procedures required by Medicaid and the other plans served by the Practice, as applicable

9.0 FEES. Employer shall have the exclusive authority to set and determine professional fees and any discounts. Employee agrees that all fees received or collected as a result of professional services rendered by Employee shall be the property of Employer. Employee acknowledges that this Agreement does not confer upon Employee any ownership interest in or personal claim upon any fees charged by Employer for Employee's services. Any free, reduced fee or barter arrangement to be provided by Employee must receive the approval of Employer prior to the performance of the related service.

10.0 PATIENT RECORDS.

10.01 Maintenance. Employee shall maintain complete and accurate clinical records for all treatment provided to patients of the Practice. Employer shall maintain the records created by Employee until any applicable statute of limitations has expired.

10.02 Employer's Exclusive Property. All records of patients of Employer, including, without limitation, x-rays, accounts, ledger cards, laboratory reports, recall cards and programs, computer records and programs and any other pertinent information concerning patients of Employer, whether or not the patients were actually treated by Employee or the records prepared by Employee, shall be and shall remain the property of Employer and Employee shall have no property rights in said property. Employee agrees not to take any action that would directly or indirectly damage or impair Employer's rights, title and interest in and to any patient records. Employee agrees not to accept or otherwise acquire to his possession any copy of said records or other confidential patient information of Employer including, by way of example and not limitation, patient lists, except with Employer's written consent.

10.03 Access. Employee shall have full access to and use of the patient records during the term of this Agreement for any and all business purpose related to the performance of Employee's duties. After termination of this Agreement, Employee shall have limited access to the patient records for the defense of any malpractice claim, grievance or any other reasonable and necessary business purpose. The costs of any reproductions shall be paid solely by Employee. Under no circumstance shall Employee remove or copy any patient list, clinical or financial record without the express written consent of Employer.

11.0 SOLICITATION OF EMPLOYER'S PATIENTS. Employee agrees that Employee will not during the term of this Agreement and for two (2) years after the termination of this Agreement solicit any of Employer's patients whom Employee first encountered while employed with Employer. Solicitation of Employer's patients by Employee shall be defined as Employee intentionally contacting Employer's patients directly or indirectly through any other party, either in writing or verbally, with notice of Employee's new practice address and with an affirmative effort by or on behalf of Employee to attract or entice Employer's patients to Employee's practice. Instances in which a patient affirmatively requests that Employee, rather than Employer, continue to provide dental services will not be deemed a breach of this paragraph. In the event Employee breaches this paragraph, Employer shall be entitled to seek injunctive relief and monetary damages against the Employee. The prevailing party in any action to enforce this provision shall be entitled to all reasonable costs and expenses, including reasonable attorneys' fees and accountants' fees.

12.0 SOLICITATION OF EMPLOYER'S EMPLOYEES. During the term of this Agreement and during the one (1) year period following the expiration or termination of this Agreement, Employee covenants that Employee will not solicit employees of Employer to terminate their employment with Employer or hire any such persons. In addition, if Employee hires any employee of Employer within the one (1) year period after the expiration or termination of this Agreement, Employee agrees to pay Employer the amount of Fifteen Thousand Dollars ($15,000) as a finder's fee ("Finder's Fee") plus such other amount(s), if any, a court of competent jurisdiction may determine. The parties agree that because of the cost, expenses and time expended by Employer in training its employees and the time and expense incurred by Employer in connection with training a replacement employee, the Finder's Fee is fair and reasonable and not punitive to Employee. This Finder's Fee shall be paid to Employer within ten (10) business days after the date any such employee of Employer commences working for Employee.

13.0 CONFIDENTIAL INFORMATION. Employee agrees that, except as required in Employee's duties to Employer, Employee will not, during this Employment and for all times subsequent to such Employment, directly or indirectly, use, disseminate, or disclose any confidential information ("Confidential Information") concerning the business or patients of Employer. Confidential Information means information disclosed to Employee or known by Employee as a consequence of Employee's employment with Employer, not generally known in the profession about Employer's services or processes, including information relative to patient lists, patient names and addresses, patient records, pricing policies, financial information and Employer's procedures, systems and processes relating to its Medicaid practice. Employee agrees that Employer's Confidential Information is in the nature of trade secrets and should not be made available to any other dentist or dental professional, or any present or potential competitor, including Employee, without regard to whether or not said Confidential Information may or may not be defined as a trade secret pursuant to the Uniform Trade Secrets Act. In the event Employee misappropriates any of Employer's Confidential Information, Employer shall have all rights and remedies available to Employer pursuant to State law, including without limitation the Uniform Trade Secrets Act.

14.0. RESTRICTIONS ON EMPLOYEE'S RIGHT TO COMPETE.

14.01 Covenant Not to Compete. The parties acknowledge Employee as a professional staff member who in the course of Employee's duties to Employer will assist executive personnel of Employer. Employee further acknowledges that Employer would not enter into this Agreement and pay to Employee the Employee Compensation unless Employee agrees to enter into and be bound by the terms and conditions of this Covenant not to Compete for a specific period of time after termination. Employee agrees that for a period of two (2) years following the expiration or termination of this Agreement for any reason by either party, Employee shall not directly or indirectly enter into or engage in the practice of general or specialty dentistry, which treats Medicaid patients, whether as a sole proprietor, partner, shareholder, officer, director, employee or independent contractor of any corporation, limited liability company, partnership or any other entity, or in any manner become associated with, affiliated with or financially interested in any business or enterprise engaged in the practice of dentistry (general or special) that provides dental services for Medicaid patients within a ten (10) mile aerial radius of the Practice Location, or Employer's practice location on the date of termination if Employer has moved its location, or the location of any of the Employer's related practices. The above Covenant and restriction applies only to Employee engaging in the practice of dentistry relating to clinics that see more than 51% Medicaid patients and does not restrict Employee from practicing dentistry in any other capacity at any location after termination of this Agreement. If after termination of this Agreement the Employee becomes associated with a chain of dental clinics, the above Covenant and restriction applies only to the location of the clinic where the Employee works and not the other locations within the chain of dental clinics.

14.02 Employer's Remedies and Damages. In the event of Employee's actual or threatened breach of the above Covenant, Employer shall have the right to obtain injunctive relief, specific performance, money damages or to seek any other remedy available to Employer. Employee waives any requirement for Employer to post bond in the event Employer seeks injunctive relief against Employee. In addition, in any action to enforce the above Covenant, the prevailing party shall be entitled to collect reasonable costs and expenses, including attorney's fee, and accountant's fees from the other party.

14.03 Reasonableness and Independence of Restrictions. Employee agrees that the above Covenant is reasonable with respect to its duration, geographical area and proscription and has had the opportunity to review this Agreement with legal counsel. Employee acknowledges that the above Covenant will not prohibit Employee from practicing dentistry on non-Medicaid patients at any location or from otherwise earning a living. Employee further agrees that all the covenants Employee has made above shall be construed as an agreement independent of any other provision of this Agreement. All covenants shall survive the termination of this Agreement. The existence of any claim or cause of action of Employee against Employer, whether or not predicated upon the terms of this Agreement, shall not constitute a defense to the enforcement by Employer of these covenants. If any provision of this Agreement becomes or is found to be illegal or unenforceable, it must first be modified to the extent necessary to make it legal and enforceable and then, if necessary, severed from the Agreement to allow the remainder of the Agreement to remain in full force and effect.

15.0 TERMINATION. This Agreement shall be terminated as follows:

15.01 Termination Without Cause.

(a) This Agreement may be terminated without cause by either Employer or Employee within the first seven (7) days after completion of the Orientation Period, immediately upon written notice to the other party. Employer shall be obligated to pay Employee any state licensing and credentialing fees incurred by Employee through the date of termination in contemplation of entering into this Agreement, as well as any previously agreed upon Orientation Period compensation, fees and travel expenses incurred by Employee through the date of termination..

(b) After the fifteenth day, this Agreement may be terminated at any time without cause by either Employer or Employee giving ninety (90) days calendar notice, in writing, to the other party (such 90-day period referred to as the "Notice Period"). Employee acknowledges that the Notice Period is required to employ a replacement Dentist, provide him/her with the necessary orientation and receive the proper credentials to provide services to patients of the Practice. This Agreement shall terminate effective as of 12:00.01 AM on the ninety first (91st) calendar day after the date of the written notice stated above.

(i) In the event that either party serves the other party with written notice of its intention to terminate the Agreement without cause as provided for in Subsection 15.01(b) above, Employer shall have the right to immediately relieve Employee of Employee's duties as of the date that such notice is received by the other party. However, Employer shall be obligated to pay Employee his/her normal compensation, based on Employee's then in-effect Employee Compensation for the balance of the Notice Period.

(ii) In the event Employee terminates this Agreement without cause and does not provide Employer the full ninety (90) calendar day written notice required in Subsection 15.01(a), Employee will be required to pay Five Hundred Dollars ($500.00) per each business day from the date of the termination notice to (i) the date of Employee's termination, or (ii) the date that Employer has hired and employed a replacement associate dentist, whichever comes first. Employee acknowledges that Five Hundred Dollars ($500) per business day is a reasonable estimate of the cost that would be incurred by Employer having to engage an independent contractor in order to fulfill at least a portion of the service that Employee would otherwise have provided.

(iii) During the term of notice given by either party pursuant to Subsection 15.01(b), the remaining terms of this Agreement shall remain in full force and effect including but not limited to Section 15.04.

15.02 Death of Employee. This Agreement shall be immediately terminated upon Employee's death.

15.03 Inability to Perform Duties. This Agreement may be terminated by Employer if Employee is unable to perform the duties of his/her position for a period of thirty (30) consecutive days, subject to all state and federal laws and regulations and all Employer policies concerning disability and maternity leave. Nothing herein shall prohibit Employer in its sole discretion from extending such period of time as it may determine reasonable and appropriate.

15.04 Termination for Cause. Employer shall have the right to immediately terminate this Agreement for cause. Cause shall include, without limitation, the following: (i) material breach of this Agreement by Employee, (ii) willful neglect of Employee's duties; (iii) repeated failure by Employee to conform and comply with Employer's policies and procedures; (iv) the determination of Employer in good faith that Employee is not providing adequate patient care or that the health, safety or welfare of patients is jeopardized by continuing the engagement of Employee, whether such determination is made in accordance with the Quality Criteria or otherwise; (v) suspension, revocation, cancellation or imposition of any restrictions or limitations on Employee's right to practice dentistry or right to dispense or prescribe drugs; (vi) adjudication by any professional organization having jurisdiction over Employee that Employee is guilty of professional misconduct; (vii) sanction or exclusion of Employee from participation in Medicaid or any other state or federal healthcare program for program related violations; (viii) termination for cause of Employee's participation in any other insurance plans or programs served by Employer; (ix) inability of Employer to obtain malpractice insurance on Employee; (x) if any of the representations of Employee contained herein are false or incorrect or if any warranty of Employee is breached; or (xi) the indictment or conviction of Employee of any crime punishable as a felony involving moral turpitude, immoral conduct or professional misconduct or negligence, including but not limited to fraud against federal or state government.

16.0 MUTUAL INDEMNITY. Each party (the "Indemnifying Party") agrees to indemnify and hold the other party (the "Indemnitee") harmless from and agrees to defend the Indemnitee against any and all claims, losses, damages, injuries and liabilities (collectively, "Loss") arising from or on account of the breach of this Agreement by such party or the acts taken or failed to be taken by the Indemnifying Party or by any person under the direct supervision of the Indemnifying Party. Notwithstanding any other provisions of this paragraph, the amount of indemnification owed by the Indemnifying Party to the Indemnitee under any circumstances shall be reduced by the amount of any insurance proceeds recovered or recoverable from any third party in connection with such Loss. If the Indemnitee receives a payment (an "Indemnity Payment") required by this Agreement from the Indemnifying Party in respect of any Loss and the Indemnitee subsequently receives any insurance proceeds in respect of such Loss, then the Indemnitee shall, without demand, reimburse the Indemnifying Party the amount, if any, by which such Loss would have been reduced had the Indemnity Payment been received prior to the payment by the Indemnifying Party.

17.0 TERMINATION OF PRIOR AGREEMENTS. This Agreement shall terminate any and all prior agreements, whether written or oral, for the employment of Employee by Employer. This Agreement contains the entire agreement between the parties and may not be changed orally, but only by an agreement in writing signed by both parties.

18.0 ASSIGNMENT. Employer shall have the right to assign this Agreement to a subsidiary or affiliate, successor in interest, or, in the event of a sale of the company or its assets, to the purchaser of same. Neither party shall have the right to assign their rights under this Agreement, in whole or in part, nor delegate their duties, without the written consent of the other party.

19.0 STATE LAW. This Agreement shall be governed by the laws of the State of

Massachusetts.

20.0 **NOTICES.** All notices required or permitted by this Agreement shall be in writing and shall be given by personal delivery or sent to the address of the party set forth below by registered or certified mail, postage prepaid, return receipt request, or by reputable overnight courier, prepaid receipt acknowledged. Notices shall be deemed received on the earlier date of actual receipt or, in the case of notice by mail or overnight courier, the date of receipt marked on the acknowledgment of receipt. Rejection or refusal to accept or the inability to deliver because of change of address of which no notice was given shall be deemed to be received as of the date such notice was deposited in the mail or delivered to the courier.

If to Employer:
Small Smiles Dental Center of [redacted] LLC
c/o FORBA Holdings, LLC
618 Church Street, Suite 520
Nashville, TN 37219
Attention: Legal Department
Fax: (615) 750-0303

If to Employee:
[redacted], DDS
[redacted]
[redacted] MA [redacted]

(or such other addresses as may be furnished by the parties.)

21.0 **RESOLUTION OF DISPUTES.** The parties agree that any and all differences, controversy or claims arising out of or relating to this Agreement, or the breach of this Agreement and any related documents that are unable to be resolved by the parties acting and negotiating in good faith, prior to the commencement of arbitration or litigation, shall be submitted to mediation. In the event the parties are unable to agree on the selection of a mediator or in the event the mediation does not resolve the dispute, the parties agree that any and all differences, controversies or claims arising out of or relating to this agreement, or the breach of this agreement and any related documents, shall be submitted to and settled by binding arbitration in Massachusetts. However, notwithstanding the above, the parties agree that any claim for injunctive relief shall be decided by a court of competent jurisdiction without any requirement that the issue first be submitted to mediation or arbitration. In the event the parties are unable to mutually agree as to the selection of an arbitrator, each party shall select an arbitrator and the two arbitrators shall select a third arbitrator who shall arbitrate the dispute. Any arbitration determination shall be binding upon the parties, final and absolute. Judgment upon the arbitration award shall be entered in any court having jurisdiction.

22.0 **SEVERABILITY.** If any provision of the Agreement becomes or is found to be illegal or unenforceable for any reason, such clause or provision must first be modified to the extent necessary to make this Agreement legal and enforceable and then if necessary, severed from the remainder of the Agreement to allow the remainder of the Agreement to remain in full force and effect.

23.0 **SURVIVAL.** The parties agree that the representations, warranties, covenants and other agreements between the parties shall survive execution and termination of the Agreement. This Agreement shall bind and benefit Employee and Employer and their successors and assigns.

24.0 **RELATIONSHIP OF PARTIES.** The relationship of the parties created by this Agreement is solely that of an employer and employee.

This Agreement is signed by the parties on the date stated above.

EMPLOYER:
Small Smiles Dental Center of [redacted] LLC

By _____
[redacted] **DMD**
Vice President

EMPLOYEE:

_____
[redacted] **DDS**

EXHIBIT A

DISCLOSURE SCHEDULE

(This schedule must be completed by the Dentist)

Please list any and all disciplinary actions on your dental licenses (including pending) or malpractice settlements (including pending) and sign and date at the bottom. If there are none to disclose, please write none and sign and date at the bottom.

Dentist's Signature: _____

Dr. [redacted], DDS

Date: _____, 2010

EXHIBIT B

EXAMPLE EMPLOYEE COMPENSATION CALCULATION

GENERAL EXAMPLE (LEAD DENTIST)

EMPLOYEE BASE COMPENSATION		PRACTICE LOCATION COMPENSATION	
Ancillary Service Billings (employee)	10,000		
- 1.5% collection adjustments	(150)		
Estimated Ancillary Service Collections (100%)	*9,850*		
x State Percentage Amount	*18%*		
Employee Base Comp (Ancillary) - part 1	**1,773**		
Employee's Gross Billings	105,000	Practice Location Gross Billings	315,000
- Ancillary Service Billings (employee)	(10,000)	- Ancillary Service Billings (practice)	(30,000)
- 1.5% collection adjustments	(1,425)	Practice Location Gross Production	285,000
Estimated Collections	*93,575*	- 1.5% collection adjustments	(4,275)
x 80% for Individual compensation	*80%*	*Est Practice Location Collections*	*280,725*
Subtotal	74,860	*x 20% for Practice Location comp*	*20%*
x State Percentage Amount	*18%*	Subtotal	56,145
Employee Base Comp - part 2	**13,475**	*x State Percentage Amount*	*18%*
		Allocable to Dentists	10,106
		*x Employee Working Days Calculation**	33.3%
		Employee Portion of Practice Location Comp for Month	**3,369**

Employee Base Comp (Ancillary) - part 1	**1,773**
+ Employee Base Comp - part 2	**13,475**
+ Practice Location Comp	**3,369**
+ Lead Dentist Compensation (1.10%)	**3,088**
= Total Employee Compensation for Month	**$21,704**

* Employee Working Days Calculation

EMPLOYEE days worked in center for Month	20.00	A
/ TOTAL DENTISTS days worked for Month	60.00	B
EMPLOYEE % of Practice Location	33.3%	A/B

NOTE: Lead dentists receive an additional 1.10% of Total Center Estimated Practice Location Collections or $3,034 ($275,800 x 1.10%) in the example of EMPLOYEE above

EXHIBIT 13

Exit Interview – CHURCH STREET HEALTH MANAGEMENT
Associated Dental Centers

Employee Name: [redacted]	Dental Center: FLORENCE
Home Phone: [redacted]	Mobile Phone: [redacted]
Resignation/Term Date: 7/1/2011	Job Title: Lead Dentist

This form may be returned directly to Human Resources by the employee completing the form and will be kept confidential.

[redacted] **fax**
[redacted] **fax**

CHURCH STREET HEALTH MANAGEMENT
Attn: Human Resources
[redacted]
Nashville, TN. 37219

Exit Interview Questions:

1. Were your initial objectives for joining the Dental Center achieved? **Circle One: Yes or No**
Please Explain: To provide quality compassionate care to children with Medicaid or SCHIP.

2. What aspects of your job were most satisfying? Providing a service that these children otherwise would not be able to receive. Restoring a smile to a child in pain or need.

3. What aspects of your job were most dissatisfying? Only after the doctors were converted to production based compensation. This conversion caused distractions and realignment of priorities. Inability to concentrate only on dentistry and patient needs.

4. Which of the following was the MOST significant reason for you leaving the Dental Center?

___ I was satisfied with the Dental Center.
Reason for leaving: * See #14

___ I was dissatisfied with the Dental Center.
Reason for leaving: _____

___ I was concerned about potential violations of the Code of Ethics and Business Conduct or the Compliance Program.
Please explain: _____

5. What is your opinion about the following areas as it pertains to supporting your personal development:

A. Training and Education programs: Satisfactory

B. Facilities: Good

C. Equipment and supplies: Good

6. What recommendations would you suggest which would benefit:

A. Your Dental Center:

B. Employees: Return to salary for the doctors even if it is significantly reduced. This would benefit employees and patients.

C. Patients:

7. Is there a point of uncertainty or disagreement about your employment that you have been unable to settle satisfactorily that you would like to share?

8. The following question relates to the following areas of the Dental Center's Employee Benefit Plan:

A. Did the Benefit options meet your needs sufficiently? **Circle One: Yes or (No)**
If no, please explain: No paid days off, vacation, sick or holidays for the doctors. No stability.

B. What, if anything, would you change about the compensation plan? Return to salary even if it is cut. This would return stability to a professional position

C. Did you receive regular performance reviews? **Circle One: Yes or (No)**
Were you satisfied with the process? **Circle One: Yes or (No)**
If no, please explain: Haven't had one in 3 years.

9. Would you recommend the Dental Center to others? **Circle One: (Yes) or No**
Why or why not? Because it provides services to children in need

10. Are you aware of any violations of law or the principals contained in the Dental Center's Code of Ethics and Business Conduct or Compliance Plan? **Circle one: Yes or (No)**
If yes, please explain:

11. Are you aware of any quality of care issues within the Dental Center or concerns that a patient did not receive care that met professionally recognized standards of health care? **Circle one: Yes or No**
If yes, please explain? _____

12. Are you aware of any instances of patient harm within the Dental Center? **Circle one: Yes or No**
If yes, please explain? _____

13. Were you aware of the Ethics and Compliance Hotline? **Circle one: Yes or No**
If yes, did you feel free to utilize it? **Circle one: Yes or No**
Comments: _____

14. Are there any additional comments or questions you would like to make that we did not cover?
After > 7 years service, I was heartbroken to have to make the decision to leave. I loved my job, I loved my working family at the center. This job was very rewarding and stressful at the same time. At this point of my career I have to have stability and ability to take care of myself. With no salary, no vacation days, no holidays, no sick days, too much time was spent worrying about who was coming thru the door, whether significant treatment would be accomplished, etc. I often found myself spending more time worrying about chart documentation than about patient treatment. Was also very disappointed that my immediate supervisor did not bother to communicate with me when I announced I was leaving. He had at least 30 days to call but I guess I was not important or significant enough. But I am leaving proud of my service.

If you have any additional concerns regarding HR and would like to speak to someone, please contact:

[redacted], **Director of Human Resources at** [redacted]

If you have any unresolved compliance or quality of care issues that you would like to discuss, please contact:

[redacted], **Chief Compliance Officer at** [redacted]

Thank you for helping us with this important survey. We wish you the best as you continue your career aspirations.

EXHIBIT 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

OCT - 4 2012

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Committee on the Judiciary
United States Senate
Washington, DC 20510

RE: Corporate Integrity Agreement With CSHM

Dear Chairman Baucus and Senator Grassley:

Pursuant to the September 21, 2012, request from Senator Grassley's staff, I am providing you an overview of the Office of Inspector General's (OIG's) monitoring of the Corporate Integrity Agreement (CIA) with CSHM (f/k/a FORBA Holdings, LLC, f/k/a Church Street Health Management, collectively CSHM) that was executed on January 15, 2010. We appreciate this opportunity to discuss certain aspects of OIG's monitoring of this CIA.

If you have any questions regarding this letter or CSHM's obligations under its CIA, please contact me, or your staff may contact [redacted], Director of Congressional and Regulatory Affairs, at [redacted] or [redacted].

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Inspector General

Enclosure

Office of Inspector General's Monitoring of Corporate Integrity Agreement With CSHM

On January 15, 2010, the Department of Justice, the Office of Inspector General (OIG), and CSHM (f/k/a FORBA Holdings, LLC, f/k/a Church Street Health Management, collectively CSHM) entered into a settlement agreement to resolve CSHM's liability for violations of the False Claims Act. In addition to paying $24 million to settle the case, CSHM entered into a 5-year quality of-care corporate integrity agreement (CIA) with OIG. In all health care fraud cases, OIG weighs many factors when determining whether to enter into a CIA in lieu of pursuing an administrative exclusion of the provider from participation in the Federal health care programs (FHCP). This analysis is particularly important in cases in which the provider is a primary point of access for or major source of health care items or services for FHCP beneficiaries. The purpose of a CIA is to require a company to implement the basic functions of a compliance program so that potential violations of civil, criminal, or administrative law and/or potential failure to meet FHCP requirements can be prevented, identified, and corrected.

CIAs require companies to implement policies and systems that are fundamental to the establishment of an effective compliance program. OIG generally requires a provider to commit to a 5-year term under the CIA because of the time and effort required to establish effective systems and processes and to create a lasting culture of compliance within an organization. OIG seeks to promote providers' compliance with CIAs through feedback and, where appropriate, penalties or exclusion for breach. Because our goal is to promote compliance with the CIA, providers are given an opportunity to cure any breach before OIG imposes exclusion for a CIA breach. The presence of a CIA does not, nor is it intended to, guarantee that the provider is in compliance with FHCP requirements. However, OIG has found that the compliance program elements required under our CIAs are powerful tools to identify and address noncompliance with FHCP requirements.

OIG's Monitoring of the CSHM CIA

Currently, CSHM operates 61 dental facilities in 19 States and has represented that it treats more than 500,000 patients annually. It remains a major point of access for and source of much-needed dental services for our youngest Medicaid beneficiaries. OIG has undertaken a comprehensive approach to monitoring the CIA, through which we have carefully balanced both our authority to enforce the obligations of the CIA and our concerns about access to dental care for children covered by Medicaid.[1] These concerns range from ensuring that adequate numbers

[1] *See, generally, Dental Crisis in America: The Need to Expand Access,* Subcommittee on Primary Health and Aging, U.S. Senate Committee on Health, Education, Labor, & Pensions, (112th Cong.) (February 29, 2012), available at http://www.help.senate.gov/hearings/hearing/?id=a4b31ccd-5056-9502-5d8c-93b8b9da5d60; *see also Children and Oral Health: Assessing Needs, Coverage, and Access*, Kaiser Commission on Medicaid and the Uninsured (June 2012); *A Costly Dental Destination: Hospital Care Means States Pay Dearly*, The PEW Center on the State, February 2012, available at http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/A%20Costly%20Dental%20Destination(1).pdf.

of dentists are available to treat Medicaid beneficiaries to ensuring that the care as provided to those patients meets all FHCP requirements and professionally recognized standards of care.

The CIA includes financial and quality-of-care compliance obligations. Under the CIA, CSHM is required to have systems in place to evaluate its compliance with FHCP requirements and professionally recognized standards of pediatric dental care. Specifically, the CIA requires CHSM to engage an Independent Quality Monitor (Monitor) to assess the quality of care that is rendered in CSHM's dental facilities and to determine whether CSHM's policies, practices, and systems conform to all professionally recognized standards of care. The CIA provides the Monitor with unfettered access to enter CSHM facilities, review records, and observe patient care. The CIA also contains Board-level obligations, which require a level of engagement and accountability by the individuals responsible for overall leadership of the company.

Our CIA-monitoring efforts have revealed quality and compliance issues at a number of CSHM facilities, which have been corrected through a variety of actions. We have exercised our authority under the Breach and Default provisions of the CIA to address those areas of noncompliance, most notably through the assessing of the largest Stipulated Penalty ever imposed against a provider under a CIA and through a forced divestiture of a CSHM dental facility. Because the Monitor has found that the quality of care varies greatly between CSHM's dental facilities, we have been in close communication with the Monitor to address issues specific to the problematic facilities. During the time that we have monitored CSHM under this agreement, the company has experienced a significant ownership change and multiple turnovers in key management personnel. As of June 2012, CSHM emerged from bankruptcy and is operating under a new owner; a new Board of Directors; and a new senior management team, including a new Chief Executive Officer, new Chief Compliance Officer, new Chief Dental Officer, and new General Counsel. OIG believes that its monitoring of the CIA, and the actions it has taken under that agreement, have benefited the FHCPs and Medicaid beneficiaries.

OIG's Enforcement of CIA Provisions

Beginning in August 2010, OIG and the Monitor identified lapses in CSHM's compliance efforts and communicated concerns about these lapses to CSHM. OIG and the Monitor have performed numerous unannounced site visits to CSHM's corporate headquarters and its dental facilities to determine the extent to which CSHM has complied with its obligations under the CIA. On May 13, 2011, OIG imposed a Stipulated Penalty of $230,000 against CSHM for its failure to implement training, develop and distribute policies and procedures, submit an Independent Review Organization report, and provide notice of Government investigations and its submission of false certifications from CSHM's Compliance Officer and Chief Dental Officer. As a result of OIG's action, CSHM paid the penalty, took corrective action, and forced the resignation of its Chief Compliance Officer and demotion of its Chief Dental Officer.

After imposing Stipulated Penalties, OIG continued to closely monitor CSHM. On March 8, 2012, OIG issued CSHM a Notice of Material Breach and Intent To Exclude (March 2012 Notice). This action was based on findings by OIG and the Monitor at CSHM's Small Smiles Dental Center of Manassas (Manassas Center), a facility with which OIG and the Monitor had particular quality-of-care concerns. The March 2012 Notice addressed issues at Manassas

Center, including CSHM's submission of a false certification; its continued failure to comply with the policies and procedures requirements of the CIA at that facility; and its continued failure to report quality-of-care lapses at that facility to OIG, the States, and other applicable agencies. Pursuant to the terms of the CIA, the company was afforded 30 days to respond to OIG's March 2012 Notice and to cure the material breach as cited by OIG.

In March 2012, CSHM agreed to divest Manassas Center and to implement additional compliance obligations at its dental centers nationwide. This resolution of the March 2012 Notice resulted in a controlled transfer of existing Manassas Center patients to a new dental provider in that community, continued access to dental care for CSHM's patients nationwide, and heightened quality and compliance standards under which CSHM facilities are now required to operate. This is the first instance in which OIG has forced the divestiture of a company's affiliate and required expanded compliance obligations to cure the material breach of CIA obligations.

On the basis of the representations of CSHM and our consultations with others within the Government, if OIG had not worked with CSHM to resolve the March 2012 Notice in this expedited fashion, we believe that an uncontrolled shutdown of CSHM would likely have occurred. Our FHCP Government partners informed us that about half a million children would have lost access to care if CSHM had been excluded. OIG's proposed exclusion would also have denied our State partners the opportunity to transition patients to other facilities for continuing and future dental care.

As a result of the Monitor's findings from its onsite visit to Small Smiles Dental Centers of Oxon Hill (Oxon Hill Center) in May 2012, OIG required CSHM to agree to more expansive and stringent CIA requirements. Under a letter agreement, OIG required CSHM to focus its corrective action on specific deficiencies and obtained a new contractual right to demand that CSHM temporarily suspend services at any CSHM facility for training or other purposes on the basis of the Monitor's findings as detailed in the Monitor's reports.

OIG has worked closely with CSHM's new senior management team to ensure that all pending issues and OIG concerns are being addressed. On June 22, 2012, OIG issued to CSHM a Notice of Material Breach and Intent To Exclude (June 2012 Notice) for CSHM's failure to implement policies and procedures and to implement the Monitor's recommendations at CSHM's Small Smiles Dental Center of Youngstown (Youngstown Center). The June 2012 Notice also included an assessment of a $100,000 Stipulated Penalty for the breach of the CIA. OIG considered CSHM's recent and substantial ownership and management changes in determining the appropriate remedies for conduct that occurred prior to the changes. Pursuant to its obligations under the CIA, CSHM timely paid the Stipulated Penalties and responded to OIG's June 2012 Notice. OIG considered CSHM's response to be sufficient to cure the material breach cited in the June 2012 Notice and notified the company that it would not proceed with an exclusion action against Youngstown Center.

OIG will continue to monitor the CIA to respond to issues reported by the Monitor and the company. We remain focused on identifying and appropriately addressing concerns at problematic facilities while being cognizant of the needs of Medicaid beneficiaries to have

access to quality dental care. OIG has directed the Monitor to revisit certain facilities to assess the company's implementation of the Monitor's recommendations for improvements to quality and compliance. Furthermore, OIG will continue to refer cases to State licensing boards and Medicaid Fraud Control Units and to open investigations of individual dentists who may be providing substandard care.

The Monitor has informed OIG that the quality and compliance environment at CSHM has progressively improved under the CIA. The Monitor has further indicated to OIG that the onsite visits to CSHM's facilities under the new ownership structure have all been positive. We believe the CIA-imposed quality monitoring obligations have been a major catalyst for the changes that OIG is observing with respect to CSHM's current quality and compliance initiatives.

EXHIBIT 15

STATE SETTLEMENT AGREEMENT

I. PARTIES

This Settlement Agreement ("Agreement") is entered into between the State of New York and FORBA Holdings, LLC, ("FORBA") through their authorized representatives, hereinafter collectively referred to as "the Parties."

II. PREAMBLE

As a preamble to this Agreement, the Parties agree to the following:

A. FORBA provides (or has provided) business management services to dental centers as set forth in Exhibit A hereto, located in Alabama, Arizona, Colorado, Connecticut, the District of Columbia, Georgia, Idaho, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Nebraska, Nevada, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, and Virginia that provide services primarily to Medicaid-eligible patients (collectively, the "Centers").

B. [redacted] is an individual resident of Maryland. On December 21, 2007, [redacted] filed a qui tam action in the United States District Court for the District of Maryland captioned United States ex rel. [redacted] v. Small Smiles of Langley Park, PC, et al., No. 07-3416 (D. Md.) (hereinafter, "the Maryland Civil Action").

C. [redacted] is an individual resident of Virginia. On June 12, 2008, [redacted] filed a qui tam action in the United States District Court for the Western District of Virginia captioned United States of America and Commonwealth of Virginia ex rel. [redacted] v. Small Smiles of Roanoke LLC, [redacted], D.D.S., [redacted],

D.D.S., [redacted], D.D.S., and [redacted], D.D.S., Case No. 7:08-cv-00370 (hereinafter "the Virginia Civil Action").

D. [redacted] is an individual resident of South Carolina. On July 16, 2008, [redacted] filed a qui tam action in the United States District Court for District of South Carolina captioned [redacted] o/b/o the United States of America v. Children's Medicaid Dental of Columbia, LLC d/b/a "Small Smiles", Case No. 3:08-CV-2562-CMC (hereinafter "the South Carolina Civil Action"). (The South Carolina Action, the Virginia Civil Action, and the Maryland Civil Action will collectively be known as "the Civil Actions.") (The individuals listed in Paragraphs B, C, and D will collectively be referred to as "the Relators.")

E. FORBA has entered into or will be entering into a separate settlement agreement (the "Federal Settlement Agreement") with the United States (as that term is defined in the Federal Settlement Agreement).

F. The State of New York contends that FORBA caused to be submitted claims for services provided by the Centers for payment to the Medicaid Program ("Medicaid"), 42 U.S.C. §§ 1396–1396v and the State Children's Health Insurance Program ("SCHIP").

G. The State of New York contends that it has certain civil and administrative causes of action against FORBA for engaging in the following conduct (hereinafter referred to as the "Covered Conduct") in connection with services and items that the Centers provided to children who were Medicaid and SCHIP beneficiaries during the period from September 2006 through the Effective Date of this Agreement: (1) causing claims to be submitted by the Centers for reimbursement for performing pulpotomies that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care; (2) causing claims to be submitted by the Centers for reimbursement for placing crowns that were not

medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care; (3) causing claims to be submitted by the Centers for reimbursement for the administration of anesthesia (including, without limitation, nitrous oxide) that was not medically necessary, that was performed in a manner that did not meet professionally-recognized standards of care, and/or was administered by an unlicensed, non-certified, or otherwise unauthorized individual; (4) causing claims to be submitted by the Centers for reimbursement for extractions that were not medically necessary and/or were performed in a manner that did not meet professionally recognized standards of care; (5) causing the Centers to fail to obtain informed consent for certain dental procedures and services; (6) causing claims to be submitted by the Centers for reimbursement for fillings that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care; (7) causing claims to be submitted by the Centers for reimbursement for sealants that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care; (8) causing claims to be submitted by the Centers for reimbursement for radiographs (i.e., x-rays) that were not medically necessary, were taken in a manner that did not meet professionally-recognized standards of care, and/or were taken by an unlicensed, non-certified, or otherwise unauthorized individual; and (9) causing claims to be submitted by the Centers for reimbursement for behavior management techniques, including without limitation those techniques involving a papoose board, that were not medically necessary and/or were performed in a manner that did not meet professionally-recognized standards of care.

H. This Agreement is neither an admission of liability by FORBA nor a concession by the State of New York that its claims are not well founded.

I. To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, the Parties reach a full and final settlement pursuant to the Terms and Conditions below.

III. TERMS AND CONDITIONS

1. FORBA shall pay to the United States and the states listed in Exhibit B hereto (hereinafter referred to as the "Medicaid Participating States"), collectively, the sum of twenty-four million dollars ($24,000,000), plus any interest that has accrued between June 15, 2009, and the Effective Date of the Federal Settlement Agreement at a rate of 2.75% per annum ("Settlement Amount"). On the Effective Date of this Agreement, as defined in Paragraph 29 herein ("Effective Date"), this sum shall constitute a debt due and immediately owing to the United States and the Medicaid Participating States. FORBA shall discharge its debt to the United States and the Medicaid Participating States under the following terms and conditions:

a. FORBA shall pay to the United States the principal sum of $14,285,644.75 (the "Federal Settlement Amount"). FORBA shall pay the Federal Settlement Amount, plus interest accrued thereon at the rate of 2.75% per annum pursuant to the terms of the Federal Settlement Agreement.

b. FORBA shall pay to the Medicaid Participating States the sum of $9,714,355.25 ("State Settlement Amount"). FORBA shall pay the State of New York's share of the State Settlement Amount, plus interest accrued thereon at the rate of 2.75% per annum, in accordance with the Payment Schedule found at Exhibit C. Within 10 days after the Effective Date of the Federal Settlement Agreement, FORBA shall set aside $404,764.78, plus any interest that may have accrued between June 15, 2009, and the Effective Date of the Federal Settlement Agreement, into an interest-bearing account of its own choosing as agreed upon between

FORBA and the National Association of Medicaid Fraud Control Units Settlement Team ("NAMFCU Team"). . FORBA shall thereafter make fixed pro rata payments according to the schedule in Exhibit C and as directed by the State of New York. The entire principal balance of the Medicaid State Settlement Amount or any portion thereof, plus any interest accrued on the principal as of the date of any prepayment, may be prepaid without penalty.

c The total portion of the Settlement Amount paid by FORBA in settlement for the Covered Conduct for the State of New York is $1,151,668.69, consisting of a portion paid to the State of New York under this Agreement and another portion paid to the Federal Government as part of the Federal Settlement Agreement. The individual portion of the State Settlement Amount allocated to the State of New York under this Agreement is the sum of $575,111.35, plus applicable interest.

2. Contingent upon receipt of their appropriate portion of the State Settlement Amount, the Medicaid Participating States agree to pay, as soon as feasible after such receipt, agreed-upon amounts that have been addressed via side letters to the Relators in the Civil Actions not previously dismissed by Relators, in which the states are parties.

3. Subject to the exceptions in Paragraph 4 (concerning excluded claims), below, in consideration of the obligations of FORBA in this Agreement, and subject to Paragraph 15, below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the State of New York agrees to grant a temporary covenant not to sue FORBA, its parent (Small Smiles Holding Company, LLC), its current and former direct and indirect subsidiaries (EEHC, Inc., FORBA Services, Inc., Sanus Services, Inc., FORBA NY, LLC, and Sanus NY, LLC), the Centers, and the successors and assigns of any of them, and all current officers and directors of FORBA and its parent or

direct and indirect subsidiaries (collectively, the "FORBA Released Parties"), for any civil or administrative monetary causes of action that the State of New York has for any claims submitted or caused to be submitted to its Medicaid and SCHIP Programs for the Covered Conduct, ("Temporary Covenant Not to Sue"). Conditioned upon full payment by FORBA of the Settlement Amount, the State of New York agrees to retract the Temporary Covenant Not to Sue and agrees to release the FORBA Released Parties for any civil or administrative monetary cause of action that the State of New York has or may have for any claims submitted or caused to be submitted to its Medicaid and SCHIP Programs for the Covered Conduct. Other than as expressly referred to herein, no individuals are released by this Agreement, nor are any of the entities listed in Exhibit D hereto.

4. Notwithstanding any term of this Agreement, the State of New York specifically does not release any person or entity from any of the following liabilities:

a. Any civil, criminal, or administrative liability arising under state revenue codes;

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusion from the State of New York's Medicaid Program;

d. Any civil liability that FORBA or the FORBA Released Entities have or may have under any state statute, regulation, or rule not covered by this agreement;

e. Any liability to the State of New York for any conduct other than the Covered Conduct;

f. Any liability which may be asserted, directly or indirectly, by private payors or insurers, including those that are paid by the State of New York's Medicaid Program on a fully capitated basis;

g. Any liability based upon such obligations as are created by this Agreement;

h. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;

i. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct;

j. Any liability for failure to deliver goods or services due; or

k. Except as expressly provided for in Paragraph 3, any liability of individuals, including employees of the Centers.

5. In consideration of the obligations of FORBA in this Agreement and the Corporate Integrity Agreement ("CIA"), entered into between OIG-HHS and FORBA, conditioned upon FORBA's full payment of the Settlement Amount, and subject to Paragraph 15, below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the State of New York, except as reserved in Paragraph 4 above, subject to Paragraph 15 below, and as reserved in this paragraph agrees to release and refrain from instituting, directing, or maintaining any administrative action seeking the exclusion of the FORBA Released Parties from the State's Medicaid or SCHIP Programs for the Covered Conduct. Nothing in this Agreement precludes the State of New York from taking action against any FORBA Released Party if that Released Party is excluded by the federal government, or for conduct and practices other than the Covered

Conduct. Notwithstanding the foregoing, in the event of Default as defined in Paragraph 16, below, the State of New York may exclude FORBA from participating in its Medicaid and SCHIP Programs until FORBA pays the Settlement Amount and reasonable costs as set forth in Paragraph 1, above. The State of New York will provide written notice of any such exclusion to FORBA. FORBA waives any further notice of the exclusion and agrees not to contest such exclusion either administratively or in any state or federal court. Reinstatement to program participation is not automatic. If at the end of the period of exclusion FORBA wishes to apply for reinstatement, FORBA must submit a written request for reinstatement to the State of New York's Medicaid Program. FORBA will not be reinstated unless and until the State of New York approves such request for reinstatement.

6. FORBA has provided various financial materials to the United States including certain audited financial statements ("Financial Statements"). The State of New York has relied on the completeness and reliability of those financial materials in reaching this Agreement. FORBA warrants that the Financial Statements are complete, accurate, were prepared in accordance with Generally Accepted Accounting Principles ("GAAP"). If the State of New York learns of any asset(s) in which FORBA had an interest that were not disclosed in the Financial Statements, or if the State of New York learns of any misrepresentation by FORBA on, or in connection with, the Financial Statements, and if such nondisclosure or misrepresentation changes the estimated net worth of FORBA set forth in the Financial Statements by 1.2 million dollars ($1,200,000.00) or more, the State of New York may at its option: (a) rescind this Agreement and file suit based on the Covered Conduct; or (b) let the Agreement stand and collect the full Settlement Amount plus one hundred percent (100%) of the value of the net worth of FORBA previously undisclosed. FORBA agrees not to contest any collection action

undertaken by the State of New York pursuant to this provision, and immediately to pay the State of New York all reasonable costs incurred in such an action, including attorney's fees and expenses.

7. In the event that the State of New York, pursuant to Paragraph 6 (concerning disclosure of assets), above, opts to rescind this Agreement, FORBA agrees not to plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any civil or administrative claims that (a) are filed by the State of New York within ninety (90) calendar days of written notification to FORBA that this Agreement has been rescinded, and (b) relate to the Covered Conduct, except to the extent these defenses were available on the Effective Date of this Agreement.

8. FORBA waives and shall not assert any defenses FORBA may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action.

9. FORBA fully and finally releases the State of New York, its agencies, employees, and agents from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that FORBA has asserted, could have asserted, or may assert in the future against the State of New York, its agencies, employees, and agents, related to the Covered Conduct and the State of New York's investigation and prosecution thereof.

10. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by the State of New York's Medicaid Program

related to the Covered Conduct; and FORBA agrees not to cause the Centers to resubmit to the State of New York's Medicaid Program any previously-denied claims related to the Covered Conduct, and agrees not to appeal any such denials of claims. Nothing in this Paragraph 10 shall restrict FORBA's or the Centers' right to contest any denials, withholdings, or claims by any private payors or insurers, including those paid by the State of New York's Medicaid Program on a capitated basis.

11. FORBA agrees to cooperate fully and truthfully with the State of New York's investigation of individuals and entities not released in this Agreement. Upon reasonable notice, FORBA shall encourage, and agrees not to impair, the cooperation of its agents, directors, officers, and employees, and shall use its best efforts to make available, and encourage the cooperation of former agents, directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals. FORBA agrees to furnish to the State of New York, upon request, complete and unredacted copies of all non-privileged documents, reports, memoranda of interviews, and records in its possession, custody, or control concerning any investigation of the Covered Conduct that it has undertaken, or that has been performed by its counsel or other agent.

12. This Agreement is intended to be for the benefit of the Parties and the FORBA Released Parties only. The Parties do not release any claims against any other person or entity, other than the FORBA Released Parties, except to the extent provided for in Paragraph 13 (waiver for recipients paragraph), below.

13. FORBA agrees that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents,

sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

14. FORBA warrants that it has reviewed its financial situation and that following the restructuring outlined in Exhibit E hereto (the "Restructuring"), it will be solvent within the meaning of 11 U.S.C. §§ 547(b)(3) and 548(a)(1)(B)(ii)(I), and shall remain solvent subject to the projections provided to the United States on February 10, 2009 (the "Projections"), following payment to the State of New York of its portion of the State Settlement Amount. Further, the Parties warrant that, in evaluating whether to execute this Agreement, they (a) have intended that the mutual promises, covenants, and obligations set forth constitute a contemporaneous exchange for new value given to FORBA, within the meaning of 11 U.S.C. § 547(c)(1); and (b) conclude that these mutual promises, covenants, and obligations do, in fact, constitute such a contemporaneous exchange. Further, the Parties warrant that the mutual promises, covenants, and obligations set forth herein are intended to and do, in fact, represent a reasonably equivalent exchange of value that is not intended to hinder, delay, or defraud any entity to which FORBA was or became indebted to on or after the date of this transfer, within the meaning of 11 U.S.C. § 548(a)(1).

15. If within ninety-one (91) days of the Effective Date of this Agreement or of any payment made under this Agreement, FORBA commences, or a third party commences, any case, proceeding, or other action under any law relating to bankruptcy, insolvency, reorganization, or relief of debtors (1) seeking to have any order for relief of FORBA's debts, or seeking to adjudicate FORBA as bankrupt or insolvent; or (2) seeking appointment of a receiver, trustee, custodian, or other similar official for FORBA or for all or any substantial part of FORBA's assets, FORBA agrees as follows:

a. FORBA's obligations under this Agreement may not be avoided pursuant to 11 U.S.C. § 547, and FORBA shall not argue or otherwise take the position in any such case, proceeding, or action that: (i) FORBA's obligations under this Agreement may be avoided under 11 U.S.C. § 547; (ii) FORBA was insolvent at the time this Agreement was entered into, or became insolvent as a result of the payment made to the State of New York; or (iii) the mutual promises, covenants, and obligations set forth in this Agreement do not constitute a contemporaneous exchange for new value given to FORBA.

b. If FORBA's obligations under this Agreement are avoided for any reason, including, but not limited to, through the exercise of a trustee's avoidance powers under the Bankruptcy Code, the State of New York, at its sole option, may rescind the releases in this Agreement and bring any civil and/or administrative claim, action, or proceeding against FORBA for the claims that would otherwise be covered by the releases provided in Paragraphs 3-5, above. FORBA agrees that (i) any such claims, actions, or proceedings brought by the State of New York (including any proceedings to exclude FORBA from participation in the State's Medicaid Program) are not subject to an "automatic stay" pursuant to 11 U.S.C. § 362(a) as a result of the action, case, or proceedings described in the first clause of this Paragraph, and FORBA shall not argue or otherwise contend that the State of New York's claims, actions, or proceedings are subject to an automatic stay; (ii) FORBA shall not plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claims, actions, or proceeding that are brought by the State of New York within ninety (90) calendar days of written notification to FORBA that the releases have been rescinded pursuant to this Paragraph, except to the extent such defenses were available on the Effective Date; and (iii) the United States and the states listed in Exhibit B have

a valid claim against FORBA in the amount of forty-five million dollars ($45,000,000.00), plus civil penalties to be determined by the Court, and the State of New York may pursue its claim in the case, action, or proceeding referenced in the first clause of this paragraph, as well as in any other case, action, or proceeding.

c. FORBA acknowledges that its agreements in this Paragraph are provided in exchange for valuable consideration provided in this Agreement.

16. a. If, for any reason, FORBA fails to pay any and all of the payments owed pursuant to this Agreement within fifteen (15) calendar days of the due date, the State of New York will provide written notice of the non-payment to the persons identified in Paragraph 16.b, below, and FORBA shall have an opportunity to pay the unpaid balance within fifteen (15) calendar days from the date of receipt of the written notice. If FORBA fails to pay the remaining unpaid balance of its payment obligations under this Agreement within fifteen (15) calendar days of receiving the notice of non-payment ("Default"), any dismissals as to FORBA shall, at the State of New York's option, be null and void, and the Settlement Amount referenced in Paragraph 1 above, less any payments already made, shall become immediately due and payable and shall bear interest at the Medicare interest rate (per 42 C.F.R. part 405.378) as of the date of Default until payment of the Settlement Amount is made in full. Furthermore:

In the event of Default as described above, the State of New York may at its option: (1) rescind its releases; (2) offset the remaining unpaid balance of the Settlement Amount from any amounts due and owing to FORBA by any department, agency, or agent of the State of New York at the time of Default; (3) institute an action or actions against FORBA in the courts of the State of New York; and (4) FORBA agrees not to contest any draw, offset, or collection action

undertaken by the State of New York pursuant to this Paragraph, either administratively or in any court.

In the event of a Default as described above, FORBA agrees to pay the State of New York all reasonable costs of collection and enforcement of this Agreement, including attorney's fees and expenses. In the event the State of New York opts to rescind this Agreement pursuant a Default, FORBA agrees that: (i) FORBA shall not plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claims, actions, or proceeding that are brought by the State of New York within ninety (90) calendar days of written notification to FORBA that the releases have been rescinded pursuant to this Paragraph, except to the extent such defenses were available on the Effective Date; and (ii) the United States and the states listed in Exhibit B have a valid claim against FORBA in the amount of forty-five million dollars ($45,000,000.00) and the State of New York may pursue its claim in the case, action, or proceeding referenced in the first clause of this Paragraph, as well as in any other case, action, or proceeding.

b. The State of New York will provide notice, as required under Paragraph 16.a, above, by courier or registered mail, to [redacted], FORBA Holdings, LLC [redacted], and [redacted], King & Spalding LLP, [redacted].

17. In the event of a Default as defined in Paragraph 16, above, the State of New York may exclude FORBA from participating in its Medicaid Program until FORBA pays the Settlement Amount and reasonable costs as set forth in Paragraphs 1 and 16 above. The State of New York's Medicaid Program shall not pay anyone for items or services, including administrative and management services, furnished, ordered, or prescribed by FORBA in any

capacity while FORBA is excluded. This payment prohibition applies to FORBA and all other individuals and entities (including, for example, anyone who employs or contracts with FORBA, and any hospital or other provider where FORBA provides services). The exclusion applies regardless of who submits the claim or other request for payment. FORBA shall not submit or cause to be submitted to the State of New York's Medicaid Program any claim or request for payment for items or services, including administrative and management services, furnished, ordered, or prescribed by FORBA during the exclusion. Violation of the conditions of the exclusion may result in criminal prosecution, the imposition of civil monetary penalties and assessments, and an additional period of exclusion. FORBA further agrees to hold the State of New York's Medicaid Program and all of its recipients harmless from any financial responsibility for items or services furnished, ordered, or prescribed to such recipients after the effective date of the exclusion. FORBA waives any further notice of the exclusion and agrees not to contest such exclusion either administratively or in any state or federal court. Reinstatement to program participation is not automatic. If at the end of the period of exclusion FORBA wishes to apply for reinstatement, FORBA must submit a written request for reinstatement to the State of New York's Medicaid Program. FORBA will not be reinstated unless and until the State of New York approves such request for reinstatement.

18. If after the Effective Date, and before FORBA has made all payments required pursuant to Paragraph 1 of this Agreement, FORBA's actual annual revenues for any fiscal year exceed the projected revenues for that fiscal year as reflected in the Projections by fifteen percent (15%) or more, then an additional payment of $1,000,000.00 shall be made for that applicable year (with a 40.48% pro rata share of the payment allocated to the Medicaid Participating States and the remaining 59.52% pro rata share allocated to the United States).

Payments under this provision shall reduce the outstanding principal balance and shall be applied against principal payments due in the settlement payment schedule (Exhibit C) in reverse order, in order to shorten the total payment period. FORBA agrees to provide its financial statements no later than one-hundred and twenty (120) days following the end of each calendar year along with any payment required under this clause for that year. This will be measured annually.

If after the Effective Date, and before FORBA has made all payments required pursuant to Paragraph 1 of this Agreement, FORBA enters into management agreements with new clinics that are over and above the number of new clinics that were included in the Projections as of that year, then an additional payment of $500,000.00 shall be made for each year in which the total number of clinics exceed the total number of clinics in the Projections as of that year (with a 40.48% pro rata share of the additional payment allocated to the Medicaid Participating States and the remaining 59.52% pro rata share allocated to the United States). Payments under this provision shall reduce the outstanding principal balance and shall be applied against principal payments due in the Payment Schedule in reverse payment order, in order to shorten the total payment period. FORBA shall provide an annual statement with a certification from a company officer that states the total number of new clinics that FORBA entered into management agreements with in that year no later than one-hundred and twenty (120) days following the end of each calendar year along with any payment required under this clause for that year.

If after the Effective Date, and before FORBA has made all payments required pursuant to Paragraph 1 of this Agreement, in the event of a "Company Change of Control," all principal and interest remaining outstanding and unpaid pursuant to this Settlement Agreement shall accelerate and become immediately due and payable, and such principal and accrued and unpaid interest shall be paid upon the consummation of such Company Change of Control. A

"Company Change of Control" shall not include the Restructuring or transfers to existing equity owners in accordance with the Restructuring, and shall mean the sale of all or substantially all of the assets of FORBA, or the sale or transfer of more than fifty percent (50%) of the equity ownership of FORBA to any person not an equity owner of FORBA or otherwise an affiliate of FORBA on the Effective Date.

Amounts that are due under these paragraphs and not paid when due will be considered amounts in Default. Default amounts are subject to the Default provisions contained in this Settlement Agreement as specified in Paragraph 16, including the Default rate of interest at the Medicare interest rate (per 42 C.F.R. part 405.378) beginning as of the date of Default until payment of the Settlement Amount is made in full.

19. Except as expressly provided to the contrary in this Agreement, each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

20. In addition to all other payments and responsibilities under this agreement, FORBA agrees to pay all reasonable travel costs and expenses of the NAMFCU Team. FORBA will pay this amount by separate check made payable to the National Association of Medicaid Fraud Control Units, after the Medicaid Participating States execute their respective Agreements, or as otherwise agreed by the Parties.

21. FORBA represents that this Agreement is freely and voluntarily entered into without duress or compulsion.

22. This Agreement is governed by the laws of the State of New York.

23. For purposes of construction, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

24. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

25. The individuals signing this Agreement on behalf of FORBA represent and warrant that they are authorized by FORBA to execute this Agreement. The signatories of the State of New York represent that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement.

26. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

27. This Agreement is binding on FORBA's successors, transferees, heirs, and assigns.

28. All parties consent to the State of New York's disclosure of this Agreement to the public.

29. This Agreement is effective on the later of the date of the last signatory to the Agreement and the Effective Date of the Federal Settlement Agreement ("Effective Date of this Agreement"). Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE STATE OF NEW YORK

DATED: 1/15/10

BY: [redacted]

Title Special Deputy Attorney General
Office of the Attorney General

DATED: _____

BY: _____
Name
Title
Medicaid Program

THE STATE OF NEW YORK

DATED:_____ BY: _____
Name
Title
Office of the Attorney General

DATED: 1-15-2010 BY: [redacted]
Title ASSISTANT MEDICAID INSPECTOR GENERAL
Medicaid Program

FOR [redacted]
MEDICAID INSPECTOR GENERAL

FORBA - DEFENDANT

DATED: 1/15/10 BY: [redacted]
Chief Executive Officer of FORBA

DATED: _____ BY: _____
[redacted]
Counsel for FORBA

FORBA - DEFENDANT

DATED: _____ BY: [redacted]
Chief Executive Officer of FORBA

DATED: 1/20/10 BY: [redacted]
Counsel for FORBA

EXHIBIT A

Small Smiles Dental Centers

Name of Center	City, State
Small Smiles of Dothan, P.C.	Dothan, Alabama
Small Smiles of Montgomery, P.C. (formerly known as [redacted], D.D.S., P.C.)	Montgomery, Alabama
Children's Medicaid Dental Clinic, P.C.	Phoenix, Arizona
Children's Dental Clinic of Tucson, LLC	Tucson, Arizona
6th Street of Denver Dental Clinic, P.C.	Aurora, Colorado
Small Smiles Dentistry for Children, P.C.	Colorado Springs, Colorado
Smile High Dentistry for Children, P.C. (formerly known as Smile High Dentistry for Children, Inc.)	Denver, Colorado
Small Smiles of Greeley, P.C.	Greeley, Colorado
DeRose Children's Dental Clinic, P.C. (formerly known as [redacted], D.D.S., P.C.; [redacted], P.C.)	Pueblo, Colorado
Children's Dental Clinic of Thornton, P.C.	Thornton, Colorado
Small Smiles Dental Center of Hartford, P.C.	Hartford, Connecticut
Small Smiles of Washington D.C., P.C.	Washington, D.C.
Small Smiles of Atlanta, P.C. (formerly known as Small Smiles of Atlanta, Inc.)	Atlanta, Georgia
Small Smiles of Augusta, P.C. (formerly known as Small Smiles of Augusta, Inc.)	Augusta, Georgia
Small Smiles of Macon, P.C. (formerly known as Small Smiles of Macon, Inc.)	Macon, Georgia
Small Smiles of Savannah, P.C. (formerly known as Small Smiles of Savannah, Inc.)	Savannah, Georgia
Small Smiles Dental Clinic of Boise, PLLC	Boise, Idaho
Small Smiles of Fort Wayne, LLC	Fort Wayne, Indiana
Children's Dental Clinic of Gary, LLC	Gary, Indiana
The Children's Dental Clinic of Indianapolis, LLC	Indianapolis, Indiana
Dental Clinic of Indianapolis at Eagledale Plaza, LLC	Indianapolis, Indiana
Small Smiles of South Bend, LLC	South Bend, Indiana
The Indian Springs Dental Clinic, LLC	Kansas City, Kansas
Topeka Dental Clinic, LLC	Topeka, Kansas
Small Smiles of Wichita, LLC	Wichita, Kansas
Small Smiles of Louisville, P.S.C.	Louisville, Kentucky
Small Smiles of Baltimore, P.C.	Baltimore, Maryland
Small Smiles of Langley Park, P.C.	Langley Park, Maryland
Small Smiles of North Baltimore, P.C.	Baltimore, Maryland
Small Smiles of Oxon Hill, P.C.	Oxon Hill, Maryland
Small Smiles Dental Center Brockton, LLC (formerly known as Small Smiles Dental Center of Brockton, LLC)	Brockton, Massachusetts

Name of Center	City, State
Small Smiles Dental Center of Holyoke, LLC	Holyoke, Massachusetts
Small Smiles of Lawrence, LLC	Lawrence, Massachusetts
Small Smiles of Lynn, LLC	Lynn, Massachusetts
Small Smiles of Mattapan, LLC	Mattapan, Massachusetts
Small Smiles of Springfield, LLC	Springfield, Massachusetts
Small Smiles of Worcester, LLC	Worcester, Massachusetts
Small Smiles of Omaha, P.C.	Omaha, Nebraska
Small Smiles of Reno, LLC	Reno, Nevada
Small Smiles Dental Center of Manchester, PLLC	Manchester, New Hampshire
Small Smiles Dentistry for Children, Albuquerque, P.C.	Albuquerque, New Mexico
Small Smiles of East Albuquerque, P.C.	Albuquerque, New Mexico
Small Smiles Dentistry for Children, Santa Fe, P.C.	Santa Fe, New Mexico
Albany Access Dentistry, PLLC	Albany, New York
Small Smiles Dentistry of Albany, LLC	Albany, New York
Small Smiles Dentistry of Newburgh, LLC	Newburgh, New York
Small Smiles Dentistry of Rochester, LLC	Rochester, New York
Small Smiles Dentistry of Syracuse, LLC	Syracuse, New York
Small Smiles of Akron, LLC - [redacted], DDS and [redacted], DDS (formerly known as Small Smiles of Akron, LLC- [redacted], DDS and [redacted], DDS)	Akron, Ohio
Small Smiles of Cincinnati, LLC- [redacted], DDS and [redacted], DDS (formerly known as Small Smiles Dental Clinic of Cincinnati; Small Smiles of Cincinnati LLC; Small Smiles of Cincinnati LLC – [redacted], DDS and [redacted], DDS; Small Smiles of Cincinnati, LLC)	Cincinnati, Ohio
Small Smiles of Columbus, LLC - [redacted], DDS and [redacted], DDS (formerly known as Small Smiles of Columbus, LLC; Small Smiles of Columbus, LLC- [redacted], DDS and [redacted], DDS)	Columbus, Ohio
Small Smiles of Dayton, LLC - [redacted], DDS and [redacted], DDS (formerly known as Small Smiles of Dayton, LLC; Small Smiles of Dayton, LLC- [redacted], DDS and [redacted], DDS)	Dayton, Ohio
Small Smiles of Roselawn, LLC - [redacted], DDS and [redacted], DDS (formerly known as Small Smiles of Roselawn, LLC; Small Smiles of Roselawn, LLC- [redacted], DDS and [redacted], DDS)	Roselawn, Ohio
Small Smiles of Toledo, LLC - [redacted], DDS and [redacted], DDS (formerly known as Small Smiles of Toledo, LLC; Small Smiles of Toledo, LLC- [redacted], DDS and [redacted], DDS)	Toledo, Ohio
Small Smiles Dental Center of Youngstown, LLC- [redacted], DDS and [redacted], DDS (formerly known as Small Smiles of Youngstown, LLC- [redacted], DDS	Youngstown, Ohio

Name of Center	City, State
and [redacted], DDS)	
Children's Dental Clinic of Oklahoma City, PLLC	Oklahoma City, Oklahoma
Children's Dental Clinic of Oklahoma City at Portland Plaza, PLLC	Oklahoma City, Oklahoma
Children's Dental Clinic of Tulsa, PLLC	Tulsa, Oklahoma
Small Smiles Dental Center of East Liberty, LLC	Pittsburgh, Pennsylvania
Children's Dental Clinic of Charleston, LLC (formerly known as Children's Medicaid Dental of Charleston, LLC)	Charleston, South Carolina
Small Smiles Dental Centers of Columbia, LLC (formerly known as Children's Medicaid Dental of Columbia, LLC)	Columbia, South Carolina
Children's Dental Clinic of Florence, LLC (formerly known as Florence Children's Dental Clinic, LLC)	Florence, South Carolina
Small Smiles Dental Centers of Greenville, LLC (formerly known as Children's Medicaid Dental of Greenville, LLC)	Greenville, South Carolina
Small Smiles of Myrtle Beach, LLC	Myrtle Beach, South Carolina
Small Smiles of Spartanburg, LLC	Spartanburg, South Carolina
Texas Smiles Dental Center of Austin, PLLC (formerly known as Small Smiles of Austin, PLLC)	Austin, Texas
Texas Smiles Dental Center of Beaumont, PLLC (formerly known as Small Smiles of Beaumont, PLLC)	Beaumont, Texas
Wild Smiles Dental Center of Houston, PLLC (formerly known as Small Smiles Dental Center of South Houston, PLLC; Texas Smiles Dental Center of South Houston, PLLC)	Houston, Texas
Small Smiles of Manassas, LLC	Manassas, Virginia
Small Smiles of Richmond, LLC	Richmond, Virginia
Small Smiles of Roanoke, LLC	Roanoke, Virginia

EXHIBIT B
Medicaid Participating States

Alabama

Arizona

Colorado

Connecticut

District of Columbia

Georgia

Idaho

Indiana

Kansas

Kentucky

Maryland

Massachusetts

Nebraska

Nevada

New Hampshire

New Mexico

New York

Ohio

Oklahoma

Pennsylvania

South Carolina

Texas

Virginia

EXHIBIT C

FORBA, INC
State of New York

TOTAL MEDICAID SETTLEMENT (STATE/FEDERAL) $1,151,668.69

1.	State Share of Medicaid Restitution	$575,111.35
2.	Interest	$51,771.26 *
3.	Total State Settlement Amount	$626,882.61 **

*This amount does not include interest accrued and payable with Payment 1
**These are state monies only; do not send or credit any amount to the federal government

Payment Schedule
State of New York

Payment	Principal	Interest	Total Restitution
Payment 1	$23,962.97	Plus Applicable Interest	$23,962.97 +Int
Payment 2	$23,962.97	$3,789.15	$27,752.12
Payment 3	$23,962.97	$3,624.40	$27,587.37
Payment 4	$14,976.86	$3,459.65	$18,436.51
Payment 5	$14,976.86	$3,356.69	$18,333.55
Payment 6	$14,976.86	$3,253.72	$18,230.58
Payment 7	$14,976.86	$3,150.76	$18,127.61
Payment 8	$11,981.48	$3,047.79	$15,029.27
Payment 9	$11,981.48	$2,965.42	$14,946.90
Payment 10	$11,981.48	$2,883.05	$14,864.53
Payment 11	$11,981.48	$2,800.67	$14,782.16
Payment 12	$11,981.48	$2,718.30	$14,699.78
Payment 13	$11,981.48	$2,635.93	$14,617.41
Payment 14	$11,981.49	$2,553.55	$14,535.04
Payment 15	$11,981.49	$2,471.18	$14,452.67
Payment 16	$11,981.49	$2,388.81	$14,370.29
Payment 17	$11,981.48	$2,306.44	$14,287.92
Payment 18	$11,981.48	$2,224.06	$14,205.55
Payment 19	$311,518.68	$2,141.69	$313,660.37
Payment Totals	$575,111.35	$51,771.26	$626,882.61

The first payment due date, pursuant to the Settlement Agreement, is within ten (10) days after the Effective Date of the Federal Settlement Agreement. The second payment will be due at the end of the following quarter (i.e. if the first payment is made before December 31, 2009, the second payment will be due on March 31, 2010; if the first payment is made between January 1, 2010 and March 31, 2010, the second payment would be due on June 30, 2010), with each payment to follow at the end of every subsequent quarter (i.e. the payment dates will be 12/31, 3/31, 6/30 and 9/30), until all payments have been made. This is subject to the provisions for accelerated and delinquent payments as addressed in the Settlement Agreement.

EXHIBIT D

"Old FORBA" Entities Not Released:

- LICSAC, LLC (formerly known as FORBA LLC)
- DD Marketing, Inc. (formerly known as D.D. Marketing & Consulting, Inc.)
- DeRose Management, LLC
- LICSAC NY, LLC (formerly known as FORBA NY, LLC)

EXHIBIT E

S&S COMMENTS
01/30/2009

For Settlement Discussion Purposes Only, Subject to FRE 408

FORBA: Consensual (Out of Court) Term Sheet

Summary of Terms

Consensual Restructuring Agreement:	Pending final agreement on the terms of an acceptable consensual restructuring and following the date on which this Term Sheet is verbally accepted by the requisite parties, the Company, the Senior Lenders, Arcapita (the "Equity Sponsor"), Carlyle, ACAS, and any other necessary parties will negotiate in good faith to enter into a limited forbearance agreement and a restructuring and lock up agreement (the "Lock Up Agreement"), which will condition the closing of any consensual restructuring of the Company (the date on which such restructuring consummates, the "Closing") on resolution with the US Department of Justice (DOJ) and Office of the Inspector General (OIG) of the pending investigation of the Company by an outside date to be determined (the "Outside Closing Date"); provided, however, that the parties shall use their reasonable best efforts to effectuate the Closing no later than April 30, 2009.
Existing Senior Debt Conversion:	At Closing, the principal amount of the existing senior debt (the "Existing Senior Debt") will be reduced by the sum of: (1) the amount of the Existing Senior Debt Pay Down referred to below; and (2) the amount of the Existing Senior Debt converted to New Second Lien Senior Debt referred to below.
Existing Senior Debt Pay Down:	At Closing, the Company will pay down a portion of the principal of the Existing Senior Debt with $25 million of the proceeds of the issuance of New OpCo PIK Notes (described below).
Existing Senior Debt Interest Until Closing	Interest through and including December 31, 2008 on the Existing Senior Debt will have accrued at the default rate under the Existing Senior Debt documents and will be paid as provided below. From and after January 1, 2009 until the Closing, interest will accrue on the Existing Senior Debt at LIBOR + 3.50% per annum and will be paid monthly commencing January 31, 2009 and on the last day of each month thereafter until the Closing and on the Closing; provided, that if after giving effect to any monthly interest payment the Company has less than $3

	million in cash on its consolidated balance sheet then it shall be required to make such monthly interest payment in an amount so that its cash position is not less than $3 million after giving effect to such payment, with the balance of such interest payment due the immediately following month (and in no event later than the Closing) in addition to any other interest payments due on such payment date but to be paid prior to the payment of such interest due on such payment date (with any portion of such interest not so paid carrying forward to subsequent months (but no later than the Closing) until paid; provided, further, that if Closing does not occur by the Outside Closing Date, then the Company shall owe the Senior Lenders an additional 1.50% per annum on the outstanding principal amount of the Existing Senior Debt from January 1, 2009 through and including the Outside Closing Date.
Payment of Principal of Existing Senior Debt Amounts Due December 31, 2008 and of Accrued Interest:	On the date that the Lock Up Agreement is executed and on the last day of each month thereafter, the Company shall apply all "excess cash flow" (as defined in the Lock Up Agreement but to be computed after giving effect to the payment of current interest referred to above) to pay first, the principal due on December 31, 2008, and then, the unpaid interest at the default rate accrued through December 31, 2008; provided, that after giving effect to any such payment, the Company's projected cash balance (as set forth in the Company's cash flow forecast delivered to the Senior Lenders, in form and substance reasonably satisfactory to the Senior Lenders, immediately prior to the proposed date of such payment) during the period from the date of such payment through the then expected Closing date shall at all times be greater than or equal to $3 million; provided, further, that all such principal and accrued interest shall be paid not later than the earlier of (x) the Closing and (y) the Outside Closing Date.
Senior Revolver:	Commitments terminate at Closing.
Senior Debt Restructuring Fee:	At Closing, the Senior Lenders shall have earned a restructuring fee (the "Restructuring Fee") payable by the Company on the earlier of the payment in full of the First Lien Senior Debt (as defined below) and the New Second Lien Senior Debt described below (together with the First Lien Senior Debt, the "Senior Debt") and the maturity date in an amount equal to 1.0% of the

aggregate principal amount of the Senior Debt (exclusive of the $25 million pay down described above) outstanding at Closing; provided, that, such fee shall be reduced to (x) 0.25% of such aggregate principal amount if the Company has repaid all of the outstanding principal amount of the Senior Debt, together with all accrued interest thereon, on or before the 2nd anniversary of the Closing and (y) 0.50% of such aggregate principal amount if the Company has repaid all of the outstanding principal amount of the Senior Debt, together with all accrued interest thereon, after the 2nd anniversary of the Closing and on or before the 3rd anniversary of the Closing.

Exchange of Sub Notes: At Closing, all accrued and unpaid cash and PIK interest on the Sub Notes (including cash and PIK interest accrued through Closing) shall be added to the balance of the Sub Notes, and the Sub Notes (including accrued interest) will be exchanged in their entirety for the specified amounts and/or portions of New OpCo PIK Notes, New Preferred Equity, and New Common Equity as described below.

Exchange of PIK Notes: At Closing, all accrued and the unpaid PIK interest on the PIK Holdco Notes (including PIK interest accrued through Closing) shall be added to the balance of the PIK Holdco Notes, and the PIK HoldCo Notes (including accrued interest) will be exchanged in their entirety for the consideration described below.

Current Equity: At Closing, the current equity of Holdco will be exchanged for the consideration described below.

New Investment: At Closing, the Equity Sponsor will make a new money investment of $30 million in the Company in exchange for New OpCo PIK Notes and New Common Equity, as described below. The proceeds of the new investment, together with cash on hand at the Company, will be used: (a) to repay $25 million of the Existing Senior Debt and satisfy the Company's other restructuring-related obligations under this Term Sheet; (b) to pay accrued interest and restructuring-related costs and expenses of the Senior Lenders; (c) to pay restructuring-related costs and expenses of ACAS and Carlyle, and the Company; and (d) to pay any initial payment required to be made to the DOJ, provided that the Company shall have a minimum of $3 million cash on its balance sheet at

Closing. The Equity Sponsor shall fund the fees and expenses of Navigant due and owing from the date hereof through the Closing (as well as reimbursing the Company for any fees and expenses of Navigant paid by the Company), provided that the Equity Sponsor shall be entitled to reimbursement from Holdings of fees and expenses of Navigant accrued through the Closing on behalf of the Company and actually paid by Equity Sponsor. Such reimbursement shall occur only after satisfaction in full of the First Lien Senior Debt, the New Second Lien Senior Debt, the New OpCo PIK Notes and the liquidation preference of the New Preferred Equity, but prior to any distribution on account of the New Common Equity. This reimbursement right will be evidenced by a series of junior preferred equity that will be non-voting and not accrue any coupon. The Equity Sponsor shall pay any fees and expenses of Navigant accrued after the Closing.

Additionally, at Closing, ACAS shall pay to the Equity Sponsor its share of amounts funded to collateralize the "Special 2008 Revolving Advance" (as defined in and pursuant to the April 3, 2008 forbearance agreements and related security documents among the parties), in the amount of $549,010.00.

New Second Lien Senior Debt: At Closing, the Company will issue to the Senior Lenders New Second Lien Senior Debt in an amount of $25 million. The New Second Lien Senior Debt will accrue interest until the first anniversary of the Closing at 2% per annum PIK and LIBOR + 1% per annum cash pay and thereafter at 0.50% per annum PIK and LIBOR + 2.50% per annum cash pay; provided, that in no event shall such combined interest rate be less than 4%. Interest will be payable quarterly. The New Second Lien Senior Debt will mature on the maturity date of the First Lien Senior Debt, with no amortization prior thereto (but subject to mandatory prepayments, including from "excess cash flow" (to be defined as agreed upon in definitive loan documentation)), and will have a second lien in the collateral securing the First Lien Senior Debt.

New Common Equity: At Closing, Holdco will issue: (a) 35% of the New Common Equity to Carlyle and ACAS, in partial satisfaction for the exchange of the Sub Notes, the PIK Notes, and the current equity of Holdco; and (b) 65% of the New Common Equity to the Equity Sponsor, each of

which shares shall be subject to *pro rata* dilution for distribution of New Common Equity to certain management shareholders and certain other non-management holders of the current equity other than Equity Sponsor, Carlyle and ACAS, in each case in full satisfaction for the exchange of the current equity of Holdco. After Closing, any issuance of any equity or equity security of Holdco (other than equities or equity securities issued in connection with a management incentive program), including subsequent issuances of New Common Stock, will be subject to anti-dilution protection in favor of the holders of the New Common Equity, including the rights of such parties (i.e. Carlyle, ACAS and the Equity Sponsor) to participate in such issuance on a basis pro-rata with their respective holdings of New Common Equity immediately after the Closing.

New OpCo PIK Notes: At Closing, OpCo will issue: (a) $31 million of new, paid-in-kind unsecured notes (the "New OpCo PIK Notes") to Carlyle and ACAS in partial satisfaction for the exchange of the Sub Notes and the PIK Notes; and (b) $30 million of New OpCo PIK Notes to the Equity Sponsor on account of the New Investment referred to above. The New OpCo PIK Notes issued to Carlyle and ACAS, on one hand, and to the Equity Sponsor, on the other hand, shall be *pari passu* in priority with each other.

Terms of New OpCo PIK Notes: New OpCo PIK Notes shall: (a) have an aggregate face value of $61 million; (b) accrue non-cash interest at a rate of 11% per annum, payable-in-kind; (c) mature on the earlier of a change in control or the 7th anniversary of the Closing; (d) be subordinate and junior in right of payment only to the Senior Debt; (e) have covenants no more restrictive than the covenants under the Senior Debt, with a cushion to the Senior Debt of 15%; and (f) be subject to an intercreditor agreement with the Senior Debt on same terms as existing subordination agreement. Equity Sponsor shall have no voting rights in the New OpCo PIK Notes, except that any reduction in the interest rate of such notes, any write-off of the principal amount or accrued principal owed on such notes, and any extension of the maturity date of such notes shall require the affirmative vote of 100% of the holders of the New OpCo PIK Notes (which shall be reflected in definitive documentation providing for the terms of the New OpCo

PIK Notes).

Change of Control:	Under (a) the credit facilities for the First Lien Senior Debt and the New Second Lien Senior Debt and (b) the New OpCo PIK Notes, any future transaction, event or circumstance that results in (i) ACAS and/or Carlyle or their respective affiliates holding a majority of the voting equity securities of Holdco and/or OpCo or (ii) the employees of the Equity Sponsor no longer holding a majority of the seats on the Holdco or OpCo Boards of Directors under circumstances in which employees of the Company, ACAS, Carlyle and/or the Equity Sponsor comprise a majority of the members of the boards of directors of Holdco or OpCo will not be a "Change in Control" or otherwise result in a mandatory prepayment or default of the First Lien Senior Debt, the New Second Lien Senior Debt or the New OpCo PIK Notes.
New Preferred Equity:	At Closing, Holdco will issue 100% of the New Preferred Equity to Carlyle and ACAS, in partial satisfaction for the exchange of the Sub Notes, the PIK Notes, and the current equity of Holdco.
Terms of New Preferred Equity:	New Preferred Equity shall: (a) have a liquidation preference of $60.4 million; (b) have no coupon; (c) be nonvoting; and (d) be redeemable solely upon a change of control. On account of their New Preferred Equity interests, ACAS shall have the right to appoint a total of two members of the Board of Directors of the Company, and Carlyle shall have the right to appoint one member to the Board of Directors of the Company (collectively, the "Preferred Directors") (which shall not have more than nine members unless otherwise agreed to by ACAS and Carlyle), which right may not be assigned to any transferee of any New Preferred Equity shares without the prior written consent of the Board of Directors of the Company. For so long as any of the New Preferred remains outstanding, the consent of the holders of the New Preferred Equity shall be required for the following matters: (i) any transaction by or among the Company and Equity Sponsor or any affiliate of Equity Sponsor; (ii) any merger, combination, reclassification or other structural change in the equity of Holdco that (a) reduces the liquidation preference or eliminates the priority of the New Preferred relative to more junior classes of equity or (b) results in issuance of securities to Equity Sponsor, members of management or any of their respective

affiliates that are senior to or on parity with the New Preferred; (iii) dividends or other distributions to holders of Common Stock (other than dividends payable in shares of Common Stock and customary "tax distributions"); or (iv) any other changes to the organizational documents of Holdco that would adversely affect the relative priorities or other rights of the New Preferred Equity.

Notwithstanding the foregoing consent rights, no consent of the holders of the New Preferred Equity will be required for (i) any new debt or equity issuance to a third party not affiliated with Equity Sponsor or management (an "Independent") undertaken on an arms' length basis; (ii) the issuance of up to $5 million of additional OpCo PIK Notes pursuant to the definitive documentation for and on the same terms as the OpCo PIK Notes (the "Add-On Notes") to Equity Sponsor or any of its affiliates, provided that (A) the Add-On Notes shall be subject to the same voting restrictions as the New OpCo PIK Notes issued to the Equity Sponsor, and shall be offered to the holders of the New Preferred Equity in the same proportion as their share of the New OpCo PIK Notes (without regard to any Add-On Notes) (and any such new debt issuance to holders of the New Preferred Equity shall not be subject to any voting restrictions), and (B) the holders of the New Preferred Equity shall have the option ("Call Option"), exercisable at any time, with closing to occur within 5 business days of such exercise, to purchase from Equity Sponsor or any of its affiliates an amount of the Add-On Notes that would result in such holder having the same percentage ownership of the Add-On Notes as its percentage ownership of the New OpCo PIK Notes (without regard to any Add-On Notes) for a purchase price equal to the then outstanding principal and interest of such Add-On Notes; (iii) the issuance of equity that is junior in priority to the New Preferred Equity to Equity Sponsor or any of its affiliates provided, however, that such issuance shall be offered to holders of the New Preferred Equity in the same proportion that their share of the New Common Equity relates to the New Common Equity held by Equity Sponsor; or (iv) a sale of all or substantially all of the Company to an Independent undertaken on an arms' length basis (whether by way of asset purchase, stock purchase, merger or otherwise), subject however to the

New Preferred Purchase Option.

In the event that the Company or Equity Sponsor receives a bona fide offer for a sale of all or substantially all of the Company from an Independent that the Company or Equity Sponsor desires to accept (a "Bona Fide Offer"), but that if consummated would result in the holders of the New Preferred Equity receiving cash or other proceeds less than the then outstanding liquidation preference on the New Preferred Equity, the holders of the New Preferred Equity will have the right (the "New Preferred Purchase Option") to purchase the OpCo PIK Notes held by Equity Sponsor and 100% of the equity ownership of the Company held by the Equity Sponsor for a cash amount equal to the lesser of (i) the principal and interest then outstanding on the OpCo PIK Notes issued to Equity Sponsor (which New Preferred Purchase Option shall be exercisable only in full and not on a partial basis) or (ii) the value of the net proceeds Equity Sponsor would have received had the Bona Fide Offer been consummated. Any non-cash consideration shall be valued at the then present fair value as determined by agreement of the Company and the holders of the New Preferred Equity or by appraisal by a jointly selected appraiser of national reputation. The New Preferred Purchase Option shall be exercisable within five (5) business days after written notice by the Company to the holders of the New Preferred Equity of a Bona Fide Offer (the "Offer Notice"), which shall be delivered to the holders of the New Preferred Equity promptly following Board approval of such a Bona Fide Offer as provided below, and shall include reasonable detail concerning the Independent and the Bona Fide Offer and be accompanied by the documentation received by the Company, Equity Sponsor or any of their respective advisors for the Bona Fide Offer. Consummation of the New Preferred Purchase Option will occur within thirty (30) calendar days of exercise unless, in the case the Bona Fide Offer includes non-cash consideration, the value of such consideration is not then determined, in which event the consummation will occur within five (5) business days of such determination. The closing of the New Preferred Purchase Option shall be tolled pending receipt of any required regulatory approvals relating to the New Preferred Purchase Option; provided that the holders of the New Preferred Equity are using diligent efforts to obtain such approvals. In the event that the

New Preferred Purchase Option is not exercised in full as provided herein, approval of the sale to the Independent and on the terms and conditions set forth in the Bona Fide Offer identified in the Offer Notice shall not require the consent of the holders of the New Preferred Equity or the Preferred Directors (but shall otherwise be subject to authorization in accordance with the selling entities' organizational documents); provided that a definitive purchase and sale, merger agreement or like agreement providing for such sale is executed and delivered by the parties thereto within 90 calendar days of the receipt of the Offer Notice and that such sale is consummated within the earlier of the time period contemplated in such definitive agreement or 365 calendar days of receipt of the Offer Notice. In the event that the Bona Fide Offer is not timely consummated with the Independent, on the terms and conditions of the Bona Fide Offer identified in the Offer Notice, any such sale of the Company may not be consummated without first re-complying with the terms of this paragraph. The definitive documentation concerning the New Preferred Purchase Option will include covenants on the part of Equity Sponsor, the holders of the New Preferred Equity and the Company to provide each other prompt notice of and, if provided in writing, copies in whatever form received or prepared of all material third-party contacts and all other material information that pertains to, contemplates or is otherwise expected to result in a Bona Fide Offer, including any banker pitch books, indications of interest, written requests for information, valuations, confidential information memoranda, management presentations, letters of intent and all other transaction proposals relating to a sale of the Company; provided, however, that the foregoing shall not include memos, valuations, spreadsheets, models or other documents prepared by Equity Sponsor or the holders of the New Preferred Equity exclusively for their own internal purposes. In addition, the Equity Sponsor and the holders of New Preferred Equity shall have reasonable access to the written due diligence information made available to potential purchasers and to any sell-side banker or financial advisor retained in connection with a proposed sale. No offer received by Equity Sponsor or the Company will be a Bona Fide Offer unless the foregoing covenants have been satisfied with respect to the offer, and the Board of the Company has met to discuss,

consider and approve the offer.

Board Compliance Committee: The Board of Directors shall designate a committee tasked to independently review and oversee the medical regulatory and corporate compliance function of the Company. The Company's SVP of Compliance shall independently report to the committee. Such committee shall be comprised of one ACAS representative, the Carlyle representative, one Arcapita representative, and Mike Lindley. The committee shall be chaired by the ACAS representative and appropriated necessary funds to engage outside advisors at its reasonable discretion.

Senior Management Preferred Participation: At Closing, the Company and certain members of its Senior Management will enter into an agreement that provides for the issuance to Senior Management of stock appreciation rights in an aggregate amount and enterprise value floor to be determined and acceptable to the holders of the existing Sub Notes.

Terms of First Lien Senior Debt: At Closing, the principal amount of the Existing Senior Debt, less (x) the amount of the Senior Debt Pay Down and (y) the amount of the New Second Lien Senior Debt, shall be converted into first lien Senior Debt (the "First Lien Senior Debt"). Interest on the First Lien Senior Debt shall be at (A) LIBOR + 3.50% per annum for the first three years after Closing, (B) LIBOR + 3.75% per annum for the fourth year after Closing and (C) LIBOR + 4.00% thereafter, and will be paid monthly. For purposes of the First Lien Senior Debt, consistent with the documentation of the Existing Senior Debt, the Company shall have the right to interest accrual based on the 30-day LIBOR index. The maturity of the First Lien Senior Debt shall be the 5-year anniversary of the Closing. After the Closing, the First Lien Senior Debt shall amortize, with payment in arrears: (a) for years 1, 2 and 3, at the rate of $425,000 each fiscal quarter; (b) for year 4, at the rate of $750,000 each fiscal quarter; and (c) for year 5, at the rate of $1 million each fiscal quarter. The First Lien Lenders and any First Lien Lender which provides a hedge agreement in respect of the First Lien Senior Debt shall have a pari passu first lien secured interest in the assets now securing the Existing Senior Debt. The Company's management shall meet quarterly with the Senior Lenders to provide operational and financial updates. Financial covenant definitions shall remain as in the Existing Senior Debt documents, subject

to appropriate amendments mutually acceptable to the parties, and covenant levels will be determined to reflect a cushion of 10 to 20% from Company's base case financial projections that are satisfactory to Company, the holders of the current equity of the Company, and the Senior Lenders. All other terms and conditions of the Senior Debt shall be subject to the approval of the Senior Lenders and will include a negative covenant on the payment of management fees to the Equity Sponsor or any of its affiliates; provided, that such fees can be accrued as a subordinated obligation of Holdings that will be payable and paid only after payment in full of the liquidation preference on the New Preferred Equity. As one of the Closing conditions, prior to the execution of the definitive lock-up and restructuring agreement as contemplated herein, the Company shall deliver a capital expenditures budget satisfactory to the Senior Lenders in their reasonable discretion. The capital expenditure budget will be designed to provide the Company with flexibility to reasonably increase capital expenditures in the event that the Company is outperforming the base case forecast. The Company may carry forward unspent capital expenditures from prior periods on conditions to be agreed upon by the parties.

Amended and Restated Company Organizational Documents:

The organizational documents of the Company shall be amended and restated to reflect the transactions contemplated in this term sheet and, among other things, include (a) "drag-along" rights on a basis to be determined to compel all shareholders of the Company to sell their New Common Equity in connection with a sale transaction approved by the Company's Board of Directors (subject to compliance with the New Preferred Purchase Option, if applicable), and in the event the "drag-along" rights are not triggered, customary "tag-along" rights other than for customary permitted transfers, (b) liquidation preferences, if applicable, and (c) such other terms and conditions as are customary for transactions of this type, including without limitation preemptive and registration rights and a negative covenant on the payment of management fees to the Equity Sponsor or any of its affiliates; provided, that such fees can be accrued as a subordinated obligation of Holdings that will be payable and paid only after payment in full of the liquidation preference on the New Preferred Equity.

Releases:	At Closing, the Company, the Equity Sponsor, and subsidiaries and affiliates of the Company, on one hand, and Carlyle, ACAS, and the Senior Lenders, on the other hand, shall provide each other with releases of all claims relating to the Company that existed prior to the Closing. These releases shall not release any party from its obligations or any other claims arising out of the definitive documentation for the transactions contemplated by this term sheet or from and after the Closing.
DOJ/OIG Claim, Forbearance and Lock-Up:	Amount and treatment of claim to be determined. The Company is currently in negotiations with the DOJ and the OIG. Upon and following the date on which this Term Sheet is verbally accepted by the requisite parties, the parties will negotiate in good faith to enter into a forbearance agreement establishing a forbearance period through close of business on February 13, 2009, during which time the parties will negotiate in good faith and enter into a lock-up and restructuring agreement that, among other things, provides for a "stand-still" pending conclusion of negotiations with the DOJ and OIG, with the Closing to occur immediately after the effective date of the agreement between the Company and the DOJ and OIG.
Shari'ah Compliance:	The New Common Equity, the New Preferred Equity, the New OpCo PIK Notes, the New Second Lien Senior Debt and all other instruments issued by the Company at or in connection with the Closing will be structured to comply with the requirements mandated by the Equity Sponsor's *Shari'ah* supervisory board.
Structure:	The New Common Equity, the New OpCo PIK Notes and the New Preferred Equity and all other instruments issued to ACAS and Carlyle will be structured to optimize the Company's, the Equity Sponsor's, ACAS's and Carlyle's tax and accounting requirements, subject to no adverse effect on the Senior Lenders.

THE FOREGOING TERM SHEET IS NOT AN OFFER FROM ANY PARTY TO ANY PARTY, IS FOR SETTLEMENT DISCUSSION PURPOSES ONLY, AND IS SUBJECT TO FEDERAL RULE OF EVIDENCE 408. NO LEGALLY BINDING OBLIGATION OF ANY PARTY WILL BE ESTABLISHED UNLESS AND UNTIL DEFINITIVE DOCUMENTS CONTAINING TERMS ACCEPTABLE TO ALL PARTIES ARE APPROVED BY THE COMPANY AND EACH OTHER PARTY TO SUCH DOCUMENTS, EXECUTED AND DELIVERED, AND ALL NECESSARY APPROVALS/CONSENTS ARE OBTAINED.

EXHIBIT 16

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
Church Street Health Management, LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Clinic Report
Oxon Hill, MD

Deliverable #1-55

April 20, 2012

Executive Summary

Introduction

The Office of Inspector General (OIG) and Church Street Health Management, LLC (CSHM) (f/k/a FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Oxon Hill, 30A Audrey Lane, Oxon Hill, MD 20745 (Clinic).

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were provided but they were not organized and not all materials were provided while on-site.

Overall Summary of Critical Findings and Observations

The critical findings and observations from the Monitor's visit are as follows:

Regarding quarterly chart audits from January 2010 through January 2012, the Monitor could not confirm the billing errors were corrected because, despite a specific request, the Monitor was not provided documentation to show Medicaid remittance or recoupment.

While reviewing CSHM's January 2012 chart audit, the Monitor found comments from the CDO for questions #6 and #7 that stated: "Caries is not documented on the upper odontogram, not visible on the x-ray so medical necessity is not documented"; however, question #10 addresses lack of documentation of medical necessity and results in automatic failure if answered in the negative. Question #10 received a positive score and the dentist passed the audit with a score of 96 percent. Considering the CDO's comments regarding questions #6 and #7, there did not appear to be support for the medical necessity for the treatment provided. Additionally, for this same dentist, questions #21 through #73 were not answered for another patient; however, there was no explanation how a passing score could occur with 52 questions left unanswered.

The oral surgeon was involved in an adverse event on , involving injury to soft tissue. The patient was anesthetized and the oral surgeon began the procedure by incising soft tissue in preparation for the planned exaction prior to determining the teeth had already been extracted despite clear markings on the Tooth Chart that the teeth had previously been extracted. The patient's Health History, which was completed after this adverse event, included a statement that she had problems with memory; however, this was not recorded on the previous six Health History forms completed.

The notebook containing the *Center Adverse Event Log* and signature sheet also contained the investigative reports and patient records, which would be available for review by individuals not authorized to see such materials. This was present in the Clinic even though CSHM's on-site visit identified the same issue.

A random sample of 30 visits representing 30 separate patients and records was identified for the record review process. Upon review of the 30 operative visits, the Monitor determined an expanded review of specific patient records was necessary to identify trends related to quality of care. As a result, additional operatory visits for patients #019, #020, #022, and #027 were reviewed. Operative visits for these patients are labeled with the patient's identification number followed by the letter "a," "b," or "c" to differentiate between the audited dates of service.

Documentation of decay and existing conditions on the Tooth Chart was inconsistent. Decay was not documented on the upper odontogram in 12 records, and 12 records did not document existing conditions on the upper odontogram of the Tooth Chart.

X-rays were stored inconsistently in the record. Some X-rays were stored in a plastic sleeve while others were loose in the patient's record. Several records contained X-rays that had fallen out of the X-ray holder. There were also X-rays that could not be located or were found in the patient's record without a label. In addition, several of the duplicate X-rays provided to the Monitor were incorrectly labeled right and left and appeared flipped, making it difficult to determine medical necessity for treatment provided.

Six records showed a Snap-A-Ray film-holding device was used to expose bitewing X-rays, limiting the ability to evaluate the furcation areas. The Monitor's pediatric dentist determined periapical X-rays were indicated in order to evaluate the vitality of the teeth and determine appropriate treatment; however, periapical X-rays were not taken. Two additional records showed no X-rays or photographs were taken to support the medical necessity for treatment provided.

Three records contained non-diagnostic X-rays or photographs. Another five records did not document rationale for X-rays taken outside of *Food and Drug Administration (FDA)/American Dental Association (ADA) Guidelines* and three records did not document interpretation of X-rays.

Attachment A provides an overview of the patient management techniques overutilized or underutilized with respect to protective stabilization and pain management. The following is a summary of the critical findings highlighted in Attachment A.

- Within the 30 records, the Monitor found 7 patient visits where neither local anesthesia nor nitrous oxide analgesia were administered for fillings performed on children who were younger than 7 years old. In addition, six of the seven patient visits documented use of active or passive stabilization for non-emergent treatment that was performed without local anesthesia on children who were five years old or younger.
- Five additional patient visits did not contain documentation to show all teeth that received treatment had been properly anesthetized. In addition, all five of these

visits documented some form of protective stabilization was utilized. Of the five patient visits, two showed mandibular infiltration was used to provide pulpal anesthesia to mandibular second molars that received pulpotomies. The other three records had insufficient information to determine how the local anesthesia was administered.

- Within the 30 records reviewed, 20 patient visits were identified in which some form of protective stabilization was utilized. Of these 20 patient visits, 16 were for non-emergent treatment.
- Passive stabilization with the use of a papoose, also referred to as a patient stabilization device (PSD), was documented in 11 patient visits within the 30 records reviewed. Documentation in the records for all 11 patient visits indicated the child was resistant and uncooperative prior to treatment, with only two patient visits recording changes in behavior scores to indicate behavior improvement after the patients were placed in a PSD. In addition, the Monitor's pediatric dentist determined that non-emergent treatment was performed in 7 of the 11 patient visits that recorded use of a PSD. According to the CDO's Best Practice Memo dated January 19, 2012, the use of a PSD is for emergent and/or limited treatment. The Monitor is especially concerned about the use of the PSD on a patient to restore teeth without the use of local anesthesia.
- Active stabilization was documented in 9 patient visits contained within the 30 records reviewed. The comments recorded in many of these records indicated parents were used to physically restrain an uncooperative child in order to provide dental treatment. These findings further support the Monitor's pediatric dentist's observations regarding parents being used to physically restrain uncooperative children instead of using a PSD. In addition, there were two records that had no documentation to show that consent for protective stabilization was obtained for the use of active stabilization.

Nitrous oxide analgesia was administered in 12 of the 30 reviewed records. All 12 records documented both the initial and working concentrations of nitrous oxide were administered at 30 percent to 40 percent with no time recorded for the initial concentration. Therefore, the documentation did not show nitrous oxide was titrated in 10 percent increments as described in the *American Academy of Pediatric Dentistry (AAPD) Guidelines for the use of Nitrous Oxide for Pediatric Dental Patients*.

Within the 30 records reviewed, nine patient visits did not provide any documentation or radiographic evidence to support the medical necessity for the treatment provided. Six of the nine patient visits showed pulpotomies were performed without medical necessity.

Six records showed evidence of the same teeth treated multiple times, some with the progression of treatment evolving from a filling to multi-surface filling to pulpotomy and SSC and/or loss of tooth altogether.

The X-rays in three records showed fillings, pulpotomies, and/or SSCs were performed below professionally recognized standards of care.

A form of active restraint was used were parents are asked to lie on top of their children to restrain their movements.

Treatment was provided to restrained children who were fighting, crying, and basically hysterical, using large mouth props that overextended their mouths, compromising their ability to swallow and protect their airways. Water spray from hand pieces, cotton pellets used for pulpotomies, and stainless steel crowns (SSCs) that are fitted and removed all presented potential risk to these children's airways.

Preparedness and anticipation was lacking on the part of the dental assistants during procedures on uncooperative young children.

Overall Summary of Recommendations

Set forth below is a summary of the report's recommendations:

- Ensure all requested documents are provided to the Monitor in a timely manner.
- Ensure *Code of Conducts* are signed by all employees and provided to the Monitor as requested.
- Ensure the Office Manager/Compliance Liaison is able to determine the intranet location of updated forms, including the required upgrade or mandatory replacement information.
- Ensure Attestation Letters are correctly completed and signed for each quarterly chart audit.
- Because CSHM had difficulty supplying the Monitor with billing error corrections, evaluate whether systems are adequate to monitor necessary remittances or recoupment.
- Ensure all dentists, including oral surgeons, are included in quarterly chart audits.
- Ensure documentation of completion of CAPs for all failed quarterly chart audits.
- Provide clarification as to why question #10 in the January 2012 chart audit was given a positive score and why the dentist did not receive an automatic failure considering the CDO's comments on questions #6 and #7.
- Ensure auditors accurately and completely answer all questions on the chart audit tool.
- Ensure on-site procedures are sufficient to evaluate the quality of care in the facility.
- Perform a root cause analysis as to why a consent form was created for a treatment that was already performed.
- Ensure training needs identified in the Compliance Liaison quarterly reports are addressed related to clinical training for dental assistants and patient management training.

- Ensure staff members are verifying correct completion of and signature on the Authorization of Persons to Consent for Treatment form.
- Ensure staff members are properly reviewing the patient's Health History form for completeness of patient information and documenting findings related to missing information or explanations to "yes" responses.
- Ensure staff members are correctly documenting existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure staff members store X-rays in the records securely, and ensure they are labeled with the date of exposure and patient identification.
- Ensure staff members provide diagnostic X-rays and duplicated X-rays are mounted and labeled correctly.
- Ensure staff members take appropriate diagnostic X-rays or photographs when indicated.
- Ensure staff members document rationale for X-rays taken outside of *FDA/ADA Guidelines*.
- Ensure staff members document the interpretation of all X-rays taken.
- Ensure dentists are administering local anesthesia when indicated and performing an assessment to determine effectiveness of local anesthesia.
- Ensure the appropriate method of delivery of local anesthesia is used when performing procedures that require pulpal anesthesia.
- Ensure use of protective stabilization, whether active or passive, is in compliance with *AAPD Guidelines* and CSHM policy on protective stabilization and consent for protection stabilization has been obtained.
- Ensure dentists are following the *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* with respect to stabilization and when to refer a patient to a specialist.
- Ensure dentists administer nitrous oxide/oxygen analgesia in accordance with *AAPD Guidelines,* including documentation of proper titration.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure staff members provide documentation to support the rationale for placement of multi-surface fillings instead of SSCs.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of restorative procedures.
- Ensure staff members properly document and bill re-treatment of teeth as re-do fillings instead of new restorations.
- Ensure the Account History Report and the patient's record reflect the correct date of service and all procedures performed.

- Ensure the maximum dose of local anesthetic is calculated prior to administration of local anesthetic.
- Ensure gauze shields are consistently used to protect the airways of patients when appropriate.
- Ensure clinics are aware of the CSHM policy about the unacceptability of parents lying on children to restrain them during treatment.
- Ensure the dentists use mouth props appropriately and there is a variety of mouth prop sizes for dentists to use on young patients without overextending their mouths and compromising their ability to swallow.
- Ensure dental assistants understand the necessity of being prepared and responding rapidly during treatment of anxious young children and are trained to respond accordingly.
- Ensure dentists understand how to manage acute dental infections and the proper use of delayed treatment and antibiotics in their management.
- Ensure the Clinic's culture supports dentists who provide treatment using restraints only in accordance with the revised CSHM guidelines. The culture also should support dentists when they make the clinical judgment to abort treatment when it is not safe to continue, no matter what the child's presenting condition may be. While treatment of patient #037 using the PSD fit the new PSD policy in that tooth #B had severe enough decay that an emergency was pending, the dentist should feel supported in the judgment to abort treatment when it was not safe to continue.
- Ensure dentists know the necessary data to be gathered for proper documentation of dental trauma.
- Ensure those who provide fluoride treatments to patients with dental varnish use the products according to manufacturer's directions and modify the amount used to make it appropriate for the patient's age and weight.

Clinic On-site Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management, LLC (CSHM) (f/k/a FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Oxon Hill, 30A Audrey Lane, Oxon Hill, MD 20745 (Clinic).

Implementation

The OIG approved an unannounced on-site visit to be conducted from March 7-10, 2012, at the Clinic. The Monitor notified [redacted], Compliance Officer, on March 7, 2012, prior to arriving on-site. Representatives from the Senate Judiciary Committee were also on-site during the afternoon on March 7, 2012 and participated in interviews.

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were provided but they were not organized and not all materials were provided while on-site.

Entrance Conference

An entrance conference was held on March 7, 2012, at approximately 8:30 a.m. The Monitor Team of [redacted], CDA, RDH, [redacted] RDH, MS, and [redacted] DDS, MSD, attended. Clinic staff members [redacted], DDS, Lead Dentist, and Office Manager and Compliance Liaison [redacted], CDA, EFDA, also attended. An overview of the process was discussed, including the point of contact information, the intent to conduct treatment observations, and the need to interview individuals employed by the Clinic.

General

The testing attributes in this section are designed to ensure the required personnel and notifications are present in the Clinic as required by the CIA and CSHM policies and procedures. The relevant findings are as follows:

- The Clinic has a designated Compliance Liaison, as required by the CIA, Section III.A.3.
- Two posters are displayed in the waiting room titled *The Small Smiles Pledge to Children, Families & Communities* (one in English and one in Spanish). The posters contained content as required in the CIA, Section III.A.4, to reflect "CSHM's commitment to ensuring that all dental services and items provided

meet professionally recognized standards of care." As required by the CIA, Section III.B.2.m, both posters included contact information for filing or registering a complaint with the parent compliance hotline, the appropriate State Dental Board, and the OIG.

- A sign in the waiting room, written in English and Spanish, indicates that parents have a right to accompany their child in the treatment area.
- Current licenses are displayed for all dentists and dental hygienists.
- An *Ethics and Compliance Hotline* poster, with a toll-free phone number, is displayed in the employee break room. The poster indicates callers may choose to remain anonymous when calling and there will be no retribution toward anyone who reports a suspected violation in good faith, as required by the CIA, Section III.F. It also includes the phone number for the appropriate State Dental Board.
- A current *Quality of Care Dashboard* was posted in the break room.
- A list of current compliance committee members was in the break room, as required by CSHM's *Code of Ethics and Business Conduct (Code of Ethics)*.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) signs and forms are written in English and Spanish.
- Documentation was supplied to support the List of Excluded Individuals and Entities (LEIE) and Excluded Parties List System (EPLS) databases were checked prior to date of hire for five individuals the Monitor chose from the list of employees.

Review of Quality Control System

The testing attributes in this section are designed to determine whether the clinical policies and procedures are up-to-date and distributed; whether the *Code of Ethics* has been signed by each employee; whether required training has been conducted; whether internal audits were performed; whether the Clinic provided a timely and appropriate response to any internal audit findings; and how complaints were handled at the Clinic-level.

Policies and Procedures

The CIA, Section III.B, requires a code of conduct and specific policies and procedures be developed and implemented. Recently, CSHM changed its process to an electronic format for the most recent policies, procedures, and forms. The relevant findings are as follows:

- Using the list of employees supplied by CSHM, the Monitor reviewed acknowledgments and certifications related to CSHM's *Code of Ethics*. For 2010, it was determined that one employee signed the *Code of Ethics* on January 20, 2010, which was after her termination date of May 13, 2008. Additionally, there was no signed *Code of Ethics* provided for another employee. For 2011, it was determined one employee signed the *Code of Ethics* after his termination date; one employee did not sign within 30 days of being hired; and there was no

signed *Code of Ethics* for another employee hired in 2011. For 2012, there was no *Code of Ethics* provided for 14 of the 20 employees.

- The following paper manuals were maintained in the Clinic and all contained the required notification that printed policies and procedures should not be relied on unless it is first verified on the CSHM intranet site.
  - *Office Manager's Manual*
  - *Infection Control Manual*
  - *Clinical Coordinator's Manual*
  - *Policy and Procedures for FORBA Associated Dental Centers*
- The Compliance Liaison was familiar with the *Policy and Procedure Development* policy issued on March 1, 2011. He evidenced good knowledge of new policies. In the morning huddle attended by the Monitor, he asked the staff to name the most current policy change and reviewed it with them.
- The Compliance Liaison was questioned about revised policies and how he determines how they have been changed. He stated changes made to an existing policy, procedure, or forms are communicated to him by e-mail and reviewed in the monthly compliance liaison meetings.
- The staff members reported new or revised policies or procedures are discussed during the morning huddles held on Tuesday and Thursday each week.
- Staff members interviewed generally evidenced good knowledge of the policies and procedures they use in their daily work however, the Clinical Coordinator was not current with CSHM policies and procedures.
- Staff members were able to articulate that updates are found on the intranet.
- The Compliance Liaison was able to identify recent form changes; however, he was unable to locate the section on the intranet that identifies current forms and whether they require upgrade or mandatory replacement. He stated he relies on the e-Cat section of the intranet where forms are ordered to determine current forms to use. He later stated he called the regional director and was told the e-Cat inventory section of the intranet was the correct location of the most up-to-date information for forms. He printed a page for the Monitor from the e-Cat inventory that contained a comment column with information on current forms; however, the information in the comment column did not contain the dates of the most current forms. All forms used in the Clinic are up-to-date.

Training

CSHM recently incorporated the use of a Continuing Education (CE) Tracking System to ensure all employee training requirements have been met. In the past, training documentation has been unorganized and signature sheets were used for training verification. This new system provides a more organized and reliable approach to tracking employee training. As a result of this change, the Monitor reviewed the training

signature sheets and the CE Tracking System data for five active clinical employees to verify all training requirements were completed.

The CIA, Section III.C.1, requires two hours of general training related to the CIA requirements and CSHM's Compliance Program. This training must be performed within 90 days of the effective date or 90 days after becoming a "covered person," whichever is later. Three hours of "Clinic Quality Training" are required for each "Clinical Quality Covered Person." This training must be delivered within 10 days after the start of employment or within 90 days after the effective date, whichever is later, and an additional 2 hours each year, thereafter. In addition, periodic training is required on an as-needed basis but at least semi-annually and for a minimum of two hours annually.

Initial Training and 2010 Periodic Training requirements were verified while on-site in the Clinic by reviewing training signature sheets. The 2011 training requirements were verified by reviewing the CSHM CE Tracking System data. After review of the Clinic signature sheets and the CSHM CE Tracking System data, the Monitor determined all training requirements had been met within the required time frame for the five randomly selected employees.

Internal Audits

The CIA, Section III.B.2, requires CSHM to install measures designed "to promote the delivery of patient items or services at CSHM and CSHM facilities that meet professionally recognized standards of health care, including but not limited to appropriate documentation of dental records, including radiographs or digital photos consistent with professional recognized standards of health care." One of the required policies is a periodic audit of clinical quality. CSHM has developed a *Chart Audit Policy* that governs the process for chart audits by CSHM. The relevant findings are as follows:

- CSHM policy requires each Associated Dental Center to receive four quarterly chart reviews consisting of five patient records per dentist. The Monitor requested all chart audits from January 15, 2010, to present. The Clinic underwent an audit in January, April, July, and October 2010. According to correspondence received from CSHM, "the Oxon Hill Center was scheduled to have quarterly chart audits conducted in January, April, July and October [2011.] The Center failed its January 2011 audit, then failed its March re-audit. The re-audit for March's failed audit did not occur until June (rather than May), which was another failure. The former executive management team verbally requested a delay in the third quarter re-audit to allow retraining and remediation. After this request and retraining (which took place in August – when the re-audit from the June failure should have occurred), the Center was again re-audited in September and passed. The Center was then audited, on schedule, in October 2011." Additionally, the Clinic underwent an audit in January 2012.
- The *Attestation Letter for Chart Review (Attestation Letter)* was provided for all audits; however, there were two *Attestation Letters* provided with dates in October 2011. One dated October 12, 2011, was signed and dated by the Office Manager but not the Lead Dentist. The other was signed and dated by the Lead

Dentist; however, the center name was not filled in and there was no date or signature for the Office Manager.

- The Clinic received an overall score of 90 percent or higher for each of the audits completed in 2010; therefore, no Corrective Action Plan (CAP) was required for the Clinic.
- All dentists passed each quarterly chart audit for 2010. Billing errors were identified in the 2010 audits; however, the Monitor could not confirm the billing errors were corrected because, despite a specific request, the Monitor was not provided documentation to support Medicaid remittance or recoupment.
- The Clinic received an overall score of 80 percent for the January 2011 chart audit. Three of the five dentists failed the audit with one dentist, an oral surgeon, receiving an automatic failure. One of the dentists and the oral surgeon filed appeals. The Appeals Determination e-mail dated March 4, 2011, revised the Clinic score to 84 percent while one dentist's score remained the same. The oral surgeon's score was removed altogether with the following explanation in the Appeals Determination: "We are going to hold off on auditing the oral surgeons until we finish developing an oral surgery template and provide the necessary training." Documentation showed the oral surgeon was not audited again in 2011. A CAP was issued; however, the Monitor was provided with no documentation of completion of the CAP for the January 2011 failed audit. In addition, the Monitor could not confirm the billing errors were corrected because, despite a specific request, the Monitor was not provided documentation to show Medicaid remittance or recoupment.
- The Clinic received an overall score of 89 percent for the March 2011 re-audit. One dentist failed the re-audit. A CAP was issued requiring the Chief Dental Officer (CDO) to review audit results and areas of concern with the failing dentist and the Lead Dentist. Additionally, the Regional Director was required to review proper chart documentation with the Clinic. The CAP was completed, according to e-mails from the CDO and Regional Director to the Audit Manager. The Monitor could not confirm the billing errors were corrected because, despite a specific request, the Monitor was not provided documentation to show Medicaid remittance or recoupment.
- The Clinic received an overall score of 83 percent for the June 2011 re-audit. Three dentists failed the re-audit, with one receiving an automatic failure. A CAP was issued, and two of the dentists filed appeals. The Appeals Determination documented that the dentist's automatic failure was changed to a passing score of 92 percent. The other dentist's score was changed from 84 percent to 87 percent, while the Clinic's score changed from 83 percent to 84 percent. Documentation of the completion of the CAP was provided.
- The Clinic received an overall score of 94 percent for the September 2011 re-audit. All dentists received a passing score for the re-audit. Therefore, no CAP was issued.

- The Clinic received an overall score of 99 percent for the October 2011 chart audit. Three dentists passed with scores of 100 percent and one dentist passed with a score of 99 percent. Two billing errors were identified regarding failure to bill for procedures provided.
- The Clinic received an overall score of 93 percent for the January 2012 chart audit. One dentist failed the audit with a score of 89 percent. No documentation of a CAP was provided to the Monitor. Two billing errors were reported to the Clinic in an e-mail dated February 13, 2012. In reviewing the January 2012 chart audit tool, the Monitor found comments regarding questions #6 and #7 from the CDO stating: "Caries is not documented on the upper odontogram, not visible on the x-ray so medical necessity is not documented"; however, question #10 addresses lack of documentation of medical necessity and results in automatic failure if answered in the negative. Question #10 received a positive score and the dentist passed the audit with a score of 96 percent. Considering the comments from questions #6 and #7, there does not appear to be any support for the medical necessity for the treatment provided. The Monitor would like clarification as to why question #10 was given a positive score and why the dentist did not receive an automatic failure considering the CDO's comments. Additionally, for this same dentist, questions #21 through #73 were not answered for another patient; however, there was no explanation how a passing score could occur with 52 questions left unanswered.
- The November 2011 Clinical Risk Assessment Focus Tool (CRAFT) report stated: "The Audit Manager, Clinical Review has obtained from the IT department the ID#s for the exceptions in item #3 that may require immediate attention. The cases below will be pulled and audited by the Director, Clinical Audit Review if they have not been included in the quarterly chart audits. A report was created to determine which centers and doctors completed 10+ crowns and pulpotomy cases in the center YTD through October." Oxon Hill's Lead Dentist was identified as a dentist completing 3 cases of 10 or more crowns and pulpotomies in a single visit.
- CSHM conducted an internal audit on March 31, 2011. The critical findings related to quality of care stated that proposed treatment plans were not consistently signed and the Health History form was not found in one of the 25 records reviewed.
- Staff members reported that CSHM representatives were on-site for two days to observe care and discuss policies and procedures. The on-site visit occurred on February 15-16, 2012. The purpose was to conduct a Joint Compliance and Operations visit and this Clinic was chosen because it was an outlier with respect to adverse events, patient complaints, and chart audit failures. At the time of the Monitor's on-site visit, the report and CAPs had not been finalized; however, the Monitor received the reports on April 10, 2012. The on-site report indicated the purpose was to understand "how the compliance department will conduct visits in the future and determine if there are operational questions that could be worked into the format . . . that are relevant to both departments." CSHM team members

included the Chief Compliance Officer (CCO); the CDO; two Senior Vice-Presidents, Operations; the Executive Vice President, Operations; the Compliance Attorney; and the Regional Director. According to the "Site Visit Summary Report," the team conducted staff interviews; the CDO reviewed charts and observed care; and the CCO and CDO conducted training. In addition, the CCO had discussions with the Compliance Liaison about the new chart audit tool, the job description, the annual certification process, and the compliance binder. The report provided findings and recommendations and CAPs. Some notable aspects of this report include:

- The on-site had several findings that were also findings by the Monitor, including, but not limited to, the lack of knowledge by the Clinical Coordinator of policies and procedures; the adverse event log contained investigative reports, which included protected health information; and the need to document interpretation of X-rays on the Tooth Chart.
- The on-site did not have any findings related to observations of care, and of the 12 dental records reviewed; there were only minor charting errors and one instance of missing "evidence like x-rays or photos for medical necessity."
- The Clinical Coordinator was terminated.
- The CDO is still re-evaluating the incident and CAP related to the soft tissue injury by the oral surgeon discussed below in the complaint section.

Complaints

The CIA, Section III.B.2.g, requires that "compliance issues are promptly and appropriately investigated" and, if substantiated, that CSHM implement "effective and timely corrective action plans" and monitor compliance with such plans. In addition, the CIA, Section III.D, requires the establishment of a disclosure program that includes a mechanism to enable individuals to disclose any issues in an anonymous manner. Finally, the CIA, Section III.A.4, requires the creation of a parent compliance hotline. Two CSHM policies address these complaints: Disclosure Program and Policy and Patient Advocate Policy and Procedure. The relevant findings are as follows:

- Staff members interviewed indicated if they received a complaint from a parent, they would report it to the Compliance Liaison. The Compliance Liaison reported he would report it to the Patient Advocate.
- Staff members were able to identify some adverse events, although typically it was about a cut or swallowed tooth. A few staff members identified chart documentation errors as an adverse event.
- Complaints are received from parents using a variety of mechanisms. They are in response to follow-up calls to the "Net Promoter Score System (NPS) Survey," from center comment cards, e-mails from the website, and feedback during a Clinic visit. Several of the parent comment cards were complimentary, indicating satisfaction with the visit and complimenting the dentists and staff on being friendly.

- There have been seven adverse events with respect to this Clinic. Two were related to treatment performed without proper written consent, a third related to a cut to the month, a fourth related to a chemical burn to the cheek, a fifth involved a splash of irrigation solution in the eye, even though protective eyewear was used, and a sixth related to a patient swallowing a polishing disk. The most recent adverse even occurred on , and involved injury to soft tissue. The patient came to the Clinic for an evaluation of the sublingual salivary duct. The oral surgeon began the procedure by incising soft tissue in preparation for the planned exaction prior to determining the teeth had already been extracted, including the administration of six carpules of local anesthesia, but the teeth had been previously extracted by this oral surgeon in May 2011. The patient signed a "Surgical Informed Consent" for the extractions and nitrous oxide and local anesthesia were administered. The Health History forms completed and did not indicate any health issues. On a Health History form was completed and a "yes" answer was provided to the question: "Does the patient have any other health problems." An explanation was requested and the documents state "problems with memory." The progress note dated stated the patient "disclosed she has severe memory problems & clearly didn't recall/remember me previously removing her wisdom teeth. I had her update her medical records." The odontograms dated and , indicate the six teeth were already extracted.
- CAPs were instituted with respect to all substantiated adverse events.
- Feedback came from a variety of sources, including the parent comment cards, the Parent Hotline, and the website. Twenty-four individuals provided feedback, of which six were positive and the remainder negative. For every complaint, there was documentation of follow-up and, where appropriate, staff counseling.

Recommendations

- Ensure all requested documents are provided to the Monitor in a timely manner.
- Ensure *Code of Conducts* are signed by all employees and provided to the Monitor as requested.
- Ensure the Office Manager/Compliance Liaison is able to determine the intranet location of updated forms, including the required upgrade or mandatory replacement information.
- Ensure Attestation Letters are correctly completed and signed for each quarterly chart audit.
- Because CSHM had difficulty supplying the Monitor with billing error corrections, evaluate whether systems are adequate to monitor necessary remittances or recoupment.
- Ensure all dentists, including oral surgeons, are included in quarterly chart audits.
- Ensure documentation of completion of CAPs for all failed quarterly chart audits.

- Provide clarification as to why question #10 in the January 2012 chart audit was given a positive score and why the dentist did not receive an automatic failure considering the CDO's comments on questions #6 and #7.
- Ensure auditors accurately and completely answer all questions on the chart audit tool.
- Ensure on-site procedures are sufficient to evaluate the quality of care in the facility.
- Perform a root cause analysis as to why a consent form was created for a treatment that was already performed.

Review of Communication System

The testing attributes related to the communication system were designed to determine whether the communication system is effective. The CIA, Section III.E.I, states the Monitor shall determine whether the "communication system is effective, allowing for accurate information, decisions, and results of decisions to be transmitted to the proper individuals in a timely fashion." The relevant findings are as follows:

- The Compliance Liaison submitted compliance reports quarterly as required by the CIA, Section III.A.2. The report dated October 14, 2011, asked the Compliance Liaison to answer three questions regarding documentation of medical necessity. He was supposed to ask different staff members each question. Three staff members were asked "how to document the medical necessity of a crown." Each answered the question incorrectly. Three different staff members were asked "how to document the medical necessity of a pulpotomy." Each answered the question incorrectly. Three additional staff members were asked "to show you on the intranet exactly where to find written guidance on documenting medical necessity." None of the three staff members could tell the Compliance Liaison where to find the information. Additionally, the Compliance Liaison was asked: "Did all the people you interviewed regarding medical necessity give you the correct answers? How do you know? If they did not tell you the correct answer, what did you do?" In response, the Compliance Liaison stated: "All six people that were asked a medical necessity did answer correctly. The reason I know is because I have 18 yeas (sic) of DA experience and I have ready (sic) over Dr. [redacted] white papers and I confirmed the answers with Dr. [redacted]." An additional question asked: "What training needs, suggestions or questions do you or your center have as it relates to compliance or quality of care?" In response, among other items listed, the Compliance Liaison stated "hands on clinical training for DA" and "more Patient management training for all staff." The Monitor was provided no documentation of follow-up to that response by CSHM. In the Compliance Liaison Quarterly Report dated January 20, 2012, question IV stated: "CSHM was surprised at the Q3 Compliance Liaison reports as to how many people provided incorrect answers as it related to documenting medical necessity. Ask 3 different people how to document medical necessity.

List their names and the answers that they give in the space provided." All three staff members answered the question correctly.

- The Monitor asked the Compliance Liaison to describe his role and responsibilities. He reported his role is to update policies and procedures; report adverse events, illegal activity, or mishaps; report overpayments; and be a role model.
  - The Compliance Liaison reported the quality of care at this facility was "great"; however, he also reported that during his tenure as Compliance Liaison at the Small Smiles Dental Centers of Manassas, he was not aware of any quality of care issues.
- Staff members interviewed articulated the existence of the employee hotline and that complaints can be made anonymously.
- Staff members participate in "morning huddles" on Tuesdays and Thursdays, which include discussions of new or revised policies and procedures and announcements of upcoming webinars.

The CIA, Section III.B.2.m, requires CSHM to design measures to collect reports relating to patient care incidents, injuries, abuse, neglect, and to inform patients when a substantiated incident of patient harm occurs at the facility. The CIA, Section III.B.2.10, requires a policy related to parental accompaniment. CSHM policies allow patients, parents, and guardians to provide feedback using the NPS Survey completed at the end of the visit. The survey asks the person completing it whether he or she can be contacted. In addition, communication between the Clinic and patients, parents, and guardians is facilitated by preprinted Parent Comment Cards, a parent hotline, e-mails, and the option to report issues to a staff member. CSHM's *Parent Notification and Adverse Events* policy is designed to inform patients, parents, and legal guardians of substantiated incidents of patient harm. In addition, CSHM's *Parent Absence/Presence Policy* is designed to ensure parents and guardians have a right to accompany children into treatment. The relevant findings are as follows:

- The NPS Survey is available at the checkout desk. The response rate as of February 29, 2011, indicated the Clinic had a year-to-date response rate of 86 percent, with 89 percent participation rate.
- Preprinted Parent Comment Cards, written in English and Spanish, were available to the parents at the checkout desks.
- A sign informs parents of their right to accompany the child into the treatment rooms. The January 2012 *Smile Factor Snapshot*, which records the results based on Clinic-level criteria from the "NPS parent survey," indicates 100 percent of the respondents were aware they could accompany their child during treatment and 63.6 percent chose to accompany their child during treatment.
- The *Smile Factor Snapshot* also rates the Clinic on other factors, such as ease of scheduling, cleanliness, staff demeanor, wait time, and explanation of paperwork and procedures. The November 2011 *Smile Factor Snapshot* showed the Clinic scored below company average for ease of scheduling and reasonable wait time.

The December 2011 *Smile Factor Snapshot* showed the Clinic scored above company average in all areas. The January 2012 *Smile Factor Snapshot* showed scores were below the company average for ease of scheduling.

- The Clinic has a *Center Adverse Event Log* that documented seven adverse events reported at this Clinic. This is consistent with the Patient Advocate Tracking Report. Notification of the log's existence is located on the Health History form. The *Adverse Event Disclosure Log* indicates nine individuals have asked to review the *Center Adverse Event Log;* however, only one of the individuals signed the log. The notebook containing the *Center Adverse Event Log* and signature sheet also contained the investigative reports and patient records, which would be available for review by individuals not authorized to see such materials. This was identified as an issue during the CSHM on-site in February 2012. The week after the Monitor's on-site visit, the Regional Manager visited and confirmed the investigative reports and patient records were removed.
- Staff members interviewed were aware of the translation service. It was mentioned during the huddle the morning before the Monitor asked any questions about the service. There are also staff members who are fluent in Spanish, French, and Korean.

The CIA, Section III.B.2.11, requires a policy on informed consent. Treatment plans are the basis for obtaining informed consent. As noted in the CSHM policy on *Informed Consent*, part of informed consent includes understanding the alternatives to the proposed treatment. CSHM has indicated its policy does not require dentists to present treatment plans. The CDO's "Protective Stabilization and Treatment Planning" white paper, dated March 2009, sets forth concerns about allowing dental assistants to present treatment plans. It cites "complaints that parents generate regarding misunderstandings over their child's care, or over what they perceive to be a lack of communication with the dentists who planned and provided the treatment." The CDO quotes from an article published in *Pediatric Dentistry*, the peer-reviewed, official journal of the American Academy of Pediatric Dentistry (AAPD), in which an attorney states: "The task of obtaining informed consent should not be delegated to an auxiliary, but should be that of the pediatric dentist." (Pediatr Dent 1995; 17:0-97). The CDO then states: "It is incumbent on the Small Smiles dentist to be part of the treatment plan presentation, to answer the parent's questions, and provide explanations that the dental assistant may have difficulty doing." Furthermore, in the training prepared by the CDO titled "Treatment Planning for Small Smiles Patients," he states that staff "[m]ay give *preliminary* presentation of treatment plan," but "[s]taff cannot obtain consent- must be done by doctor" [emphasis in original]. Recent CDO training indicates that treatment plans may be done by dentists or "[T]rained staff." The presentation is considered "preliminary" until the "dentist stops by to ensure that any questions the parent may have are answered" and the parent should not sign the treatment plan until this opportunity is presented. In addition, the training indicates it is best, but not essential, that the dentist be present when the parent signs the treatment plan.

- Staff members were able to articulate the correct policy for when consent is required.
- Staff members interviewed reported that dental assistants usually present the treatment plan to the parent and obtain consent; however, sometimes the dentist performs this function.

Recommendations

- Ensure training needs identified in the Compliance Liaison quarterly reports are addressed related to clinical training for dental assistants and patient management training.

Quality Improvements

The Monitor requested the CDO be present during the exit interview due to the critical nature of some of the Monitor's findings related to treatment observations. During a subsequent meeting on April 12, 2012, the CCO and CDO provided an update of corrective actions taken as a result of the preliminary findings mentioned in the exit interview conducted on March 9, 2012, which was followed with a written report that stated the following actions were taken:

- On Sunday, March 11, the Executive Vice President, Operations, discussed with the Lead Dentist the preliminary findings and directed:
  - The Lead Dentist to cease immediately the practice of parents lying on children in order to accomplish treatment; review this directive in morning huddle; and review the CDO's White Paper dated March 2009 titled *Protective Stabilization and Treatment Planning*.
  - The Lead Dentist to retrain staff members about the proper sizing of mouth props.
- On Monday, March 12, the Lead Dentist confirmed these measures were taken.
- On Tuesday and Wednesday, March 13-14, the Regional Director conducted an on-site visit and completed the following tasks:
  - Conducted a "lunch and learn" regarding documentation of medical necessity;
  - Confirmed the adverse event log had been separated from investigative reports;
  - Informed the Clinical Coordinator of additional training required;
  - Observed treatments and confirmed none involved the practice of lying on top of patients; and
  - Confirmed the Lead Dentist had addressed with all staff members the inappropriateness of lying on top of patients during treatment.

Review of Dental Record Documentation

The testing attributes related to the dental record documentation were designed to determine whether the documentation was complete and accurate, including HIPAA-related forms, medical necessity, and consent forms. A random sample of 30 visits

representing 30 separate patients and records was identified from the patient listing provided by CSHM, based on all Medicaid patients seen for operative visits from December 8, 2011, through March 2, 2012. Of the 30 operatory visits selected, one was for operative services provided in the Operating Room (OR). Upon review of the 30 operative visits, the Monitor determined an expanded review of specific patient records was necessary to identify trends related to quality of care. Therefore, several patient records had two or three operatory visits that were included in the dental record review process. Findings related to additional operative visits are labeled as "a," "b," or "c" next to the patient's identification number. The Monitor's pediatric dentist provided consultation on 25 of the 30 patient records reviewed. In addition, the Monitor's pediatric dentist had findings related to documentation as a result of her observations of patient care. Findings related to patients #031 and above are a result of these observations, with the exception of patient #50, which is related to an adverse event. The relevant findings from the review of the 30 visit records and treatment observations are as follows:

The Monitor did not receive all requested documents for the record review prior to departure and left instructions for the Clinic to supply the missing documentation; however, copies for one complete record and additional documentation were not received, resulting in another request to CSHM for the missing documentation.

Authorization Form

Patient #016's Authorization of Persons to Consent for Treatment form dated was not completed correctly and was not signed or dated by the mother and a witness.

Health History

The Health History form was not completed correctly in 6 of the 30 (patients #003, #012, #013, #015, #018, and #023) reviewed records. The majority of the findings were related to unanswered questions or follow-up questions regarding a positive history of asthma/breathing problems.

The table below provides a summary of each finding.

Health History		
Patient	**Date**	**Finding**
#003		The Health History form did not document an answer for "Is the patient taking any medications at this time?" Additionally, it did not document an explanation for the "yes" response to "Does the patient have any dental problems/concerns at this time?"

Health History		
Patient	**Date**	**Finding**
#012		The Health History form did not document adequate information for asthma/breathing problems and for allergies. There was no indication of medications taken for seasonal allergies or when the last medication was taken. Additionally, there was no information given regarding frequency of asthma attacks, when the last attack occurred, and whether the patient uses an inhaler.
#013		The Health History form did not document an answer for "Does the patient have any other health problems?"
#015		The Health History form did not document the date of birth for the patient.
#018		The Health History form did not document adequate follow-up information to the "yes" response to "asthma/breathing problems." While notations state "Albuterol as needed q 2 weeks out of a month," it did not address when the last attack happened or whether the patient had an inhaler with them to use if needed.
#023		The Health History form did not document additional information for the "yes" response to "Has the patient had surgery?"

Tooth Chart

Twelve records (patients #001, #003, #005, #007, #010, #012, #014, #016, #023, #026, #033, and #034) did not document decay on the upper odontogram of the Tooth Chart. Therefore, the Tooth Chart did not support the documentation of medical necessity for treatment provided.

Twelve records (patients #001, #003, #008, #010, #014, #015, #016, #019, #021, #024, #026, and #028) did not document existing conditions on the upper odontogram of the Tooth Chart.

In five records (patients #001, #002, #006, #016, and #023), the lower odontogram did not document completed treatment.

The tables below contain a summary of the findings related to the Tooth Chart.

Decay on the Upper Odontogram		
Patient	**Date**	**Finding**
#001		There was no decay documented on the Tooth Chart for teeth #E and #F or on the occlusal of tooth #J.

[redacted] Small Smiles Dental Centers of Oxon Hill

Decay on the Upper Odontogram		
Patient	**Date**	**Finding**
#003		There was no decay documented on the Tooth Chart for teeth #D, #E, #F,#G, #O, #P, #S, and #T.
#005		There was no decay documented on the Tooth Chart for teeth #D, #E, #F, and #G.
#007		There was no decay documented on the Tooth Chart for teeth #S and #T.
#010		There was no decay documented on the Tooth Chart for teeth #A and #B.
#012		There was no decay documented on the Tooth Chart for tooth #T.
#014		There was no decay documented on the Tooth Chart for tooth #I.
#016		There was no decay documented on the Tooth Chart for teeth #A and #B.
#023		There was no decay documented on the Tooth Chart for teeth #K and #L.
#026		There was no decay documented on the Tooth Chart for teeth #T and #30.
#033		There was no decay documented on the Tooth Chart for teeth #A, #B, #I, #J, and #T.
#034		There was no decay documented on the Tooth Chart for teeth #A, #B, #C, #D, #E, #F, #G, #J, and #T.

Existing Conditions on the Upper Odontogram		
Patient	**Date**	**Finding**
#001		The abscess of tooth #E was not recorded on the Tooth Chart.
#003		The radiographic abscesses of teeth #F and #L were not recorded on the Tooth Chart.
#008		The radiographically demonstrable furcation radiolucency of tooth #I and the existing stainless steel crown (SSC) on tooth #S were not recorded on the Tooth Chart.
#010		The existing restorations on teeth #S and #T were not recorded on the Tooth Chart. Additionally, the Tooth Chart did not document the incomplete removal of pulpal tissue in tooth #S, which received a pulpotomy on .
#014		The teeth present were not circled on the upper odontogram of the Tooth Chart.

Existing Conditions on the Upper Odontogram		
Patient	**Date**	**Finding**
#015		The Tooth Chart did not document the existing occlusal filling on tooth #S.
#016		The upper odontogram of the Tooth Chart documented existing fillings on teeth #A, #B, #S, and #T instead of decay. The X-rays dated did not show evidence of existing fillings; however, there was evidence of decay.
#019		The upper odontogram of the Tooth Chart did not document the existing fillings on teeth #A and #B.
#021		The upper odontogram of the Tooth Chart did not document the existing filling on tooth #K or the "defective" restorations on teeth #M and #R.
#024		The Tooth Chart did not document the radiographically demonstrable furcation radiolucency evident on teeth #K and #L.
#026		The Tooth Chart did not document the radiographically demonstrable furcation radiolucency of tooth #L or the decay and abnormal resorption of the distal root of tooth #J.
#028		The Tooth Chart did not document the existing pulpotomies on teeth #L and #T. Additionally, there was no documentation of the incomplete removal of pulpal tissue on teeth #L and #T.

Completed treatment on the Lower Odontogram		
Patient	**Date**	**Finding**
#001		The lower odontogram did not document the occlusal filling performed on tooth #J or the pulpotomy performed on tooth #F.
#002		The lower odontogram did not document the filling performed on tooth #S or the pulpotomy and SSC performed on tooth #T.
#006		The lower odontogram did not document completed treatment for teeth #D, #E, #F, and #G.
#016		The lower odontogram did not document the completed SSC on tooth #B.
#023		The lower odontogram did not document the filling placed on the occlusal surface of tooth #K.

X-rays and Photographs

X-rays were stored inconsistently in the record. Some X-rays were stored in a plastic sleeve while others were still loose in the patient's record. Several records contained X-rays that had fallen out of the X-ray holder. In addition, several of the duplicate X-rays provided to the Monitor were incorrectly labeled right and left and appeared flipped, making it difficult to determine medical necessity for treatment provided.

One record (patient #026) contained an original and duplicate panoramic X-ray stored in the patient's record; however, they were not labeled with patient identification or the date of exposure. Another record (patient #001) did not contain the maxillary occlusal X-ray taken on , and the Clinic was unable to locate the missing X-ray.

Six records (patients #003, #016, #020, #022, #028, and #030) showed a Snap-A-Ray film-holding device was used to expose bitewing X-rays, limiting the ability to evaluate the furcation areas. The Monitor's pediatric dentist determined periapical X-rays were indicated in order to evaluate the vitality of the teeth and determine appropriate treatment; however, periapical X-rays were not taken. Two additional records (patients #009 and #027), showed no X-rays or photographs were taken to support the medical necessity for treatment provided.

Three records (patients #007, #008, and #018) contained non-diagnostic X-rays or photographs. Another five records (patients #011, #012, #015, #016, and #028) did not document rationale for X-rays taken outside of *Food and Drug Administration (FDA)/American Dental Association (ADA)* (*FDA/ADA Guidelines*) and three records (patients #014, #026, and #026) did not document interpretation of X-rays.

The tables below provide a summary of each finding regarding X-rays.

Diagnostic X-rays or Photographs Not Taken		
Patient	**Date**	**Finding**
#003		A Snap-A-Ray device was used to take bitewing X-rays. The Monitor's pediatric dentist found extensive radiographically demonstrable decay on teeth #S and #T but was unable to see the furcation areas on the bitewing X-ray; therefore, a periapical X-ray was needed to evaluate the vitality of the teeth and to determine appropriate treatment. However, no periapical X-ray was taken.
#009		There were no X-rays or photographs taken to support treatment provided to teeth #C, #D, #E, #S, and #T. The Hygiene Procedures form dated , and the Op Sheet dated did not document a reason why X-rays or photographs were not attempted.

Diagnostic X-rays or Photographs Not Taken		
Patient	**Date**	**Finding**
#016		The bitewing X-ray showed distal decay extending beyond the cementoenamel junction (CEJ) of tooth #S. A Snap-A-Ray device was used to expose the bitewing X-rays; therefore, the furcation of teeth #S and #L was not visible. Because of the extent of the decay and the inability to visualize the furcation, a periapical X-ray was indicated to rule out pulp necrosis or pathology that would determine appropriate treatment.
#020		The duplicate bitewing X-rays provided to the Monitor appeared to be mounted incorrectly. A Snap-A-Ray device was used to take bitewing X-rays, limiting the ability to evaluate the furcation area of tooth #T. A periapical X-ray was indicated; however, no periapical X-ray was taken.
#022		A Snap-A-Ray device was used to expose the bitewing X-rays, limiting the ability to evaluate the furcation areas of teeth #I, #J, #S, and #T. Periapical X-rays were indicated to evaluate the furcation areas; however, none were taken.
#027		The Hygiene Procedures form documented X-rays were not taken because of "child moving"; however, there was no explanation why photographs were not taken to support the medical necessity for the one surface filling placed on tooth #S and the two surface fillings placed on teeth #A and #T.
#028		Review of X-rays revealed the bitewing X-rays dated used to diagnose the pulpotomy and SSC, showed a Snap-A-Ray device was used limiting the visibility of the furcation of tooth #L. A periapical X-ray was indicated; however, no periapical X-ray was taken.
#030		A Snap-A-Ray device was used to expose the bitewing X-rays, limiting the ability to evaluate the furcation areas of teeth #K, #L, #S, and #T. Because of the extent of the decay and the inability to visualize the furcation, periapical X-rays were indicated to rule out pulp necrosis or pathology that would determine appropriate treatment.

Non-diagnostic X-rays or Photographs		
Patient	**Date**	**Finding**
#007		The photographs were not of diagnostic quality to assess the size of the decay on tooth #A, which received a pulpotomy and an SSC.
#008		The right bitewing X-ray was not diagnostic because of blurring, which is indicative of movement during exposure.
#018		The right bitewing X-ray was overlapped on teeth #S and #T, rendering it non-diagnostic.

No Rationale for X-rays		
Patient	**Date**	**Finding**
#011		Maxillary and mandibular occlusal X-rays were taken outside the *FDA/ADA Guidelines* on , and .
#012		Maxillary and mandibular occlusal X-rays were taken outside the *FDA/ADA Guidelines* on and
#015		Maxillary and mandibular occlusal X-rays were taken outside the *FDA/ADA Guidelines* on and .
#016		Maxillary and mandibular occlusal X-rays were taken on An additional maxillary occlusal X-ray was taken during the hygiene appointment without documentation of medical necessity.
#028		Maxillary and mandibular occlusal X-rays were taken outside the *FDA/ADA Guidelines* on , and .

No Interpretation of X-rays		
Patient	**Date**	**Finding**
#014		There was no documentation of interpretation of the panoramic X-ray.
#016		There was no documentation of interpretation of the maxillary occlusal X-ray.
#026		There was no documentation of interpretation for the panoramic X-ray.

Patient Management

Attachment A provides an overview of the patient management techniques overutilized or underutilized with respect to protective stabilization and pain management. Below is a summary of the Monitor's findings:

Local Anesthesia

Within the 30 records, the Monitor found 7 patient visits (patients #009, #012, #018, #020c, #22a, #027a, and #027b) where neither local anesthesia nor nitrous oxide analgesia were administered for fillings performed on primary teeth in children who were younger than 7 years old. In addition, six of the seven patient visits (patients #009, #018, #020c, #022a, #027a, and #027b) documented use of active or passive stabilization for non-emergent treatment that was performed without local anesthesia on children who were five years old or younger.

The CDO's Best Practice Memo dated November 22, 2011, addressed a variety of issues related to local anesthesia and notes: "I have used **bold** font to emphasize key points." The Memo states: "**Non-use of local anesthesia is acceptable in limited instances.**" The CDO continues with "non-use of local anesthesia is most appropriate for an older patient who has experienced local anesthetic injections and who understands that the discomfort to be expected during treatment is no greater than that of receiving one or more injections for the procedure. A good example is an 8-year-old who has received previous care under local anesthetic and who requires buccal pit restorations on #19 and #30 in which you anticipate that the caries extends just beyond the DEJ. Further, to lessen the minor discomfort of preparing small pits without local anesthetic, **consider placing the patient on nitrous oxide for its analgesic effects**."

Five additional patient visits (patients #002, #003, #007, #020c, and #022b) did not contain documentation to show all teeth that received treatment had been properly anesthetized. In addition, all five of these visits documented some form of protective stabilization was utilized. Of the five patient visits, two (patients #002 and #020c) showed mandibular infiltration was used to provide pulpal anesthesia to mandibular second molars that received pulpotomies. The documentation in the records for the remaining three patient visits (patients #003, #007, and #022b) did not show anesthesia was administered to all or some of the teeth that received treatment, one of which included pulpotomies and SSCs. The CDO's Best Practice Memo mentioned above addresses the ineffectiveness of mandibular infiltration for pulpal anesthesia in primary mandibular second molars and recommends use of a mandibular block to ensure pulpal anesthesia in these teeth.

The following table provides a summary of this additional information.

Additional Local Anesthesia Findings		
Patient	**Date of Service**	**Finding**
#002		The Operative Procedures form (Op Sheet) documented mandibular infiltration as the method used to deliver local anesthesia in order to achieve

Additional Local Anesthesia Findings		
Patient	**Date of Service**	**Finding**
		pulpal anesthesia for the pulpotomy and SSC performed on a primary mandibular second molar, tooth #T.
#003		There was no documentation of local anesthesia delivered to the left side of the mouth. Therefore, there was no documentation of local anesthesia provided to teeth #F and #G, which were extracted, and tooth #O, which received a multiple surface filling.
#007		There was no documentation on the Op Sheet of local anesthesia provided to the left side of the mouth, which would include tooth #J, which was treated with an occlusal lingual restoration.
#020c		The Op Sheet records mandibular infiltration was used as the method to administer local anesthesia to achieve pulpal anesthesia for the pulpotomy performed on a primary mandibular second molar, tooth #T.
#022b		The Op Sheet had Lidocaine marked, the dose calculated for patient's weight (DCPW) recorded, and "R" circled; however, the method and dose were not noted. Therefore, the Monitor was unable to determine whether local anesthesia was administered for the pulpotomy and SSC performed on teeth #A and #B because of the missing information.

Protective Stabilization

Within the 30 records reviewed, 20 patient visits (patients #001, #002, #004, #005, #006, #007, #009, #011, #017, #018, #019b, #020a, #020b, #020c, #022a, #022b, #025, #027a, #027b, and #027c) were identified in which some form of protective stabilization was utilized. Of these 20 patient visits, 16 (patients #002, #004, #005, #006, #007, #009, #011, #018, #019b, #020b, #020c, #022a, #025, #027a, #027b, and #027c) were for non-emergent treatment. The following provides a summary related to passive and active stabilization use in the Clinic.

Passive stabilization with the use of a papoose, also referred to as a patient stabilization device (PSD), was documented in 11 patient visits within the 30 records reviewed (patients #002, #004, #005, #007, #017, #018, #020c, #022a, #022b, #025, and #027a). Documentation in the records for all 11 patient visits indicated the child was resistant and uncooperative prior to treatment, with only two patient visits (#002 and #020c) recording changes in behavior scores to indicate behavior improvement after the patients were placed in a PSD. In addition, the Monitor's pediatric dentist determined

that non-emergent treatment was performed in 7 of the 11 patient visits (patients #005, #007, #018, #020c, #022a, #025, and #027a) that recorded use of a PSD. According to the CDO's Best Practice Memo dated January 19, 2012, the use of a PSD is for emergent and/or limited treatment. The Monitor is especially concerned about the use of the PSD on a patient to restore teeth without the use of local anesthesia.

Active stabilization was documented in 9 patient visits contained within the 30 records reviewed (patients #001, #006, #009, #011, #019b, #020a, #020b, #027b, and #027c). The comments recorded in many of these records indicated parents were used to physically restrain an uncooperative child in order to provide dental treatment. These findings further support the Monitor's pediatric dentist's observations regarding parents being used to physically restrain uncooperative children instead of using a PSD. In addition, there were two records (patients #001 and #020a) that had no documentation to show that consent for protective stabilization was obtained for the use of active stabilization.

Nitrous Oxide

Nitrous oxide analgesia was administered in 12 of the 30 reviewed records (patients #001, #003, #006, #008, #011, #013, #017, #024, #025, #027, #029, and #030). All 12 records documented both the initial and working concentrations of nitrous were administered at 30 percent to 40 percent with no time recorded for the initial concentration. Therefore, the documentation did not show nitrous oxide was titrated in 10 percent increments as described in the *AAPD Guidelines for the use of Nitrous Oxide for Pediatric Dental Patients*.

Medical Necessity

Within the 30 records reviewed, 9 patient visits (patients #004, #007, #012, #013, #019, #020b, #026, #028, and #030) did not provide any documentation or radiographic evidence to support the medical necessity for the treatment provided. Six of the nine patient visits (patients #007, #013, #019, #020b, #028, and #030) showed pulpotomies were performed without medical necessity. The Monitor's pediatric dentist reviewed each of these records.

The following table provides details related to each finding:

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
#004		The record did not contain evidence to support the extraction of teeth #D and #G. While the Tooth Chart documented decay for teeth #D and #G, the X-rays dated [redacted] indicated fully rooted teeth with intact, though cariously involved, clinical crowns and without evidence of abscess. It was unclear why these teeth were extracted.

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
#007		There was no documentation of decay on the Tooth Chart for tooth #T and no evidence of decay on the photograph dated . Therefore, there was lack of evidence of medical necessity for the occlusal filling provided to tooth #T. Additionally, the photograph of tooth #A did not show enough of the tooth to document the necessity of a pulpotomy. Without an X-ray, the photograph should have been of adequate quality to document the size of the lesion. Therefore, there was no evidence of medical necessity to support the pulpotomy performed on tooth #A.
#012		There was lack of evidence of medical necessity for the filling placed in tooth #T because there was no decay documented on the upper odontogram of the Tooth Chart dated , and no radiographically evident decay on the X-rays dated
#013		There was lack of radiographic evidence to support the medical necessity for the pulpotomy performed on tooth #L. The X-ray dated , did not show decay half way to the pulp.
#019		The X-rays did not support the medical necessity for the pulpotomy performed on tooth #S. The X-ray dated , did not show decay half way to the pulp. This treatment was not provided on the audited dates of service but was identified during the Monitor's expanded review of the patient's record.
#020b		The documentation in the notes on the Op Sheet and the X-rays dated , do not support the medical necessity for the pulpotomy and SSC performed on teeth #A and #B because the only radiographically demonstrable decay is an etch in the enamel on the mesial of tooth #A.
#026		Tooth #S was restored with an SSC but the X-ray dated showed less than one-third of the root remaining; therefore, the X-ray does not support the medical necessity for the SSC performed on tooth #S.

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
#028		On the X-rays dated , the radiographically demonstrable decay on tooth #J did not appear to reach half way to the pulp. The X-rays were five months old; however, based on the extent of decay visible on those films, there was lack of medical necessity for the pulpotomy performed on tooth #J. An additional review of the X-rays dated showed there was no medical necessity for the pulpotomy and SSC performed on tooth #T on , because there was no radiographically demonstrable decay on tooth #T.
#030		While decay was documented on the Tooth Chart, the X-rays dated , did not demonstrate decay half way to the pulp on tooth #I; therefore, there was a lack of medical necessity to support the pulpotomy on tooth #I.

Multi-surface Fillings

Two records (patients #003 and #020) did not document why teeth were treated with multi-surface fillings instead of SSCs. Regarding patient #003, the Monitor's pediatric dentist determined teeth #O and #P were treated with four surface fillings with no explanation why the teeth did not receive SSCs. Regarding patient #020c, there was lack of documentation to explain why tooth #L received a distal, occlusal, buccal filling instead of an SSC.

Other Quality of Care Issues

Six records (patients #001, #007, #009, #015, #018, and #021) showed evidence of the same teeth being treated multiple times, some with the progression of treatment evolving from a filling to multi-surface filling to pulpotomy and SSC and/or loss of tooth altogether. Two records (patients #007 and #008) documented teeth were re-treated with the same fillings; however, the subsequent fillings were not documented as redo fillings.

The X-rays in three records (patients #010, #019, and #028) showed fillings, pulpotomies, and SSCs were performed below professionally recognized standards of care.

The following tables provide details related to each finding:

Teeth Treated Multiple Times	
Patient	**Finding**
#001	The Account History Report documented teeth #E and #F each received a mesial facial lingual filling on . The Op Sheet dated

Teeth Treated Multiple Times	
Patient	**Finding**
	documented tooth #E was extracted and tooth #F received a pulpotomy and an SSC.
#007	According to the Account History Report, teeth #S and #T were treated with one surface amalgam fillings on the occlusal surfaces on The teeth were treated again on with one surface amalgam fillings on the occlusal surfaces. The fillings were not coded as redo fillings.
#009	According to the Account History Report, teeth #D and #E received facial fillings on , lingual fillings on , and facial fillings on .
#015	Tooth #K received an occlusal buccal filling on , and a redo occlusal filling on . Tooth #J received an occlusal lingual filling on , a mesial composite one surface filling on , and an SSC on .
#018	Tooth #S was treated with an occlusal filling on , and again on .
#021	The patient's record showed facial composite fillings were placed on teeth #R and #M on , and then treatment planned to redo because of "defective" restoration only six months later. The , Op Sheet also showed tooth #I received an SSC, which had to be re-cemented on .

Substandard Care	
Patient	**Finding**
#010	The Monitor's pediatric dentist determined there was almost no removal of pulpal tissue on tooth #S, which received a pulpotomy on On the X-ray dated it appears the pulp chamber was not entered. Furthermore, the bitewing X-ray did not demonstrate the furcation of tooth #S in order to determine the success of the pulpotomy.
#019	Teeth #A and #B received multiple surface fillings on The Op Sheet states: "Pulp not exposed - full coverage not needed" and "A(L) deep - vitrebond placed." At the time of these fillings, the patient was three years old. The X-rays dated show large fillings in teeth #A and #B with a distal overhang on tooth #B.
#028	The Monitor's pediatric dentist determined X-rays dated , revealed incomplete removal of pulpal tissue on tooth #L, which received a pulpotomy and an SSC on and tooth #T, which received a pulpotomy and an SSC on . In addition, the SSCs on teeth #K, #L, #S, and #T are oversized and overextended.

Account History

In one record (patient #001), there were discrepancies regarding the dates on the Op Sheet, Nitrous Oxide Consent form, and the Account History Report. In three records (patients #011, #017, and #018), the Account History Report documented services that were billed in error. The Account History Report in four records (patients #014, #016, #025, and #029) did not document services that were performed.

The following table provides details related to each finding:

Account History		
Patient	**Date**	**Finding**
#001		There were discrepancies on the Account History Report regarding the date of service. The audited date of service as documented on the Account History Report was ; however, the Op Sheet was dated and the Nitrous Oxide form dated . The Op Sheet dated documented treatment to teeth #E, #F, and #J; however, the Account History Report documented treatment to tooth #E on , and treatment to teeth #F and #J on Additionally, the Op Sheet documented an occlusal X-ray was taken of teeth #E and #F. The occlusal X-ray of teeth #E and F was documented on the Account History Report for however, there was no X-ray found in the record.
#011		The Account History Report documented behavior management indicating passive stabilization was used during treatment. There were error corrections made on the Op Sheet that appeared to be confusing. The Op Sheet documented passive stabilization; however, according to the notes on the Op Sheet and the Consent for Protective Stabilization form, active stabilization was utilized instead of passive. Therefore, behavior management should not have been documented on the Account History Report.
#014		The Op Sheet documented a panoramic X-ray was taken on the audited date of service; however, the X-ray was not documented on the Account History Report.
#016		The panoramic X-ray and the maxillary occlusal X-ray dated were not documented on the Account History Report.

Account History		
Patient	**Date**	**Finding**
#017		The Account History Report shows billing for "09220 Deep sedation/Gen. Anesthesia 1st 30 min" when treatment was not provided under general anesthesia for . It appears fees were collected for this billing error.
#018		Tooth #S was treated with an occlusal filling on and again on . The filling was charged out on , instead of being documented on the Account History Report as a redo at no charge.
#025		The Account History Report did not record the use of nitrous oxide for the audited date of service.
#029		The Account History Report did not document the use of local anesthesia for the audited date of service.

Recommendations

- Ensure staff members are verifying correct completion of and signature on the Authorization of Persons to Consent for Treatment form.
- Ensure staff members are properly reviewing the patient's Health History form for completeness of patient information and documenting findings related to missing information or explanations to "yes" responses.
- Ensure staff members are correctly documenting existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure staff members store X-rays in the records securely, and ensure they are labeled with the date of exposure and patient identification.
- Ensure staff members provide diagnostic X-rays and duplicated X-rays are mounted and labeled correctly.
- Ensure staff members take appropriate diagnostic X-rays or photographs when indicated.
- Ensure staff members document rationale for X-rays taken outside of *FDA/ADA Guidelines*.
- Ensure staff members document the interpretation of all X-rays taken.
- Ensure dentists are administering local anesthesia when indicated and performing an assessment to determine effectiveness of local anesthesia.
- Ensure the appropriate method of delivery of local anesthesia is used when performing procedures that require pulpal anesthesia.
- Ensure use of protective stabilization, whether active or passive, is in compliance with *AAPD Guidelines* and CSHM policy on protective stabilization and consent for protection stabilization has been obtained.

- Ensure dentists are following the *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* with respect to stabilization and when to refer a patient to a specialist.
- Ensure dentists administer nitrous oxide/oxygen analgesia in accordance with *AAPD Guidelines*, including documentation of proper titration.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure staff members provide documentation to support the rationale for placement of multi-surface fillings instead of SSCs.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of restorative procedures.
- Ensure staff members properly document and bill re-treatment of teeth as re-do fillings instead of new restorations.
- Ensure the Account History Report and the patient's record reflect the correct date of service and all procedures performed.

Treatment Observations, Findings, and Staff Interviews Related to Care

The treatment observation testing attributes were designed to determine whether care was performed in accordance with CSHM's policies and procedures, the *AAPD Guidelines*, and professionally recognized standards of care.

The on-site review included observations of treatments and interactions with patients, review of workspace, and review of dental records and interviews with dentists and selected staff. Observation of treatment and patient interactions included observation of treatment on 12 patients. Nine of these patients were receiving invasive dental treatment involving local anesthesia. Three of these nine patients were either actively or passively restrained during treatment. One patient did not require local anesthesia and one patient was so uncooperative that treatment was aborted before local anesthesia was administered. One patient was also observed receiving a fluoride varnish application in the hygiene bay. The parent of one patient requested the patient be removed from the list of observed patients because, although he consented to the observation, he objected to the Monitor taking notes. This did not affect the Monitor's report because there were no findings reported for that patient. The review of workspace included observation of activities in the dental hygiene and sterilization areas. Eight individuals were interviewed, including the Lead Dentist, three Staff Dentists, the Compliance Liaison, the Clinical Coordinator, a dental assistant, and a dental hygienist. The CIA, Section III.A.2, specifies the CDO is "responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by CSHM and CSHM facilities meet the professionally recognized standards of health care." Such language directs that possessing knowledge of and following these policies are not at the discretion of the Clinic dentists and staff. The Monitor interviewed the dentists about their familiarity with the recent Best Practice

E-mails and Internal Memoranda that modify, clarify, and add to *Clinical Policies and Guidelines for CSHM Associated Clinics*.

- All dentists demonstrated a good-to-moderate level of familiarity with the CDO's Best Practice E-mails and Internal Memoranda.
- All individuals interviewed were able to accurately demonstrate knowledge of the recent changes in policy for the use of PSDs.

The Monitor also had the following relevant findings:

- The maximum dose of local anesthetic was not calculated for patients treated by the Lead Dentist before she administered local anesthetic. They were calculated and filled in later.
- Nitrous oxide was used appropriately and effectively on young children.
- The Lead Dentist demonstrated good behavior management with young children who were receiving invasive dental treatment, including local anesthesia.
- A form of active restraint was used where parents were asked to lie on top of their children to restrain their movements (patients #035 and #036).
- The Monitor observed three treatments where a mouth prop was used and created an unsafe environment for treatment.
  - A large mouth prop was used in a young patient (patient #034) that stretched her lips so tight the doctor was unable to use distraction to mitigate the pain associated with administering local anesthesia to maxillary anterior teeth. The patient cried during administration of local anesthesia.
  - Patient #036 presented with abscessed teeth #E and #F, which were extracted. The patient was very combative and was held by his father, who basically lay on top of him to try to hold him down. During the extractions, no gauze shield was used to protect the child's airway, which was wide open because the child was screaming the entire time and a largemouth prop was in place. This child's airway was in jeopardy.
  - Patient #037 was treated using a PSD. The treated tooth had large decay approximating the pulp and was treated with a pulpotomy and an SSC. The child screamed and fought the entire time. The patient kept moving her head, making it difficult to keep it secured. She vomited approximately half way through the procedure. The dentist immediately turned the patient on her side and suctioned her mouth and throat. This child's airway was in jeopardy because the mouth prop opened her mouth so wide it restricted her ability to swallow and protect her airway. The patient was screaming and gasping, leaving her airway open and vulnerable. Cotton pellets used during the pulpotomy were placed and removed while SSCs were fitted and removed on a moving, combative, and hysterical child with no methods employed to protect the airway. The quality of this care was not optimal. Following this appointment, this child was referred to have the remaining treatment performed with sedation or general anesthesia.

- During interviews, the Monitor asked the dentist, who had treated the child who had vomited, why she continued to treat the child. The dentist said she had a feeling that if she had to refer patients, it appeared that she didn't try hard enough. She reported parents then complain at the front desk and another dentist treats them. She said this makes her appear as if she is not good enough at managing the child.
- Patient #036 presented with a cellulitis, as evidenced by a swollen upper lip, associated with teeth E and #F. The patient was treated with local anesthesia administered through the infected site. The *AAPD Guidelines* state "a child presenting with a facial swelling secondary to a dental infection should receive immediate dental attention. Depending on clinical findings, treatment may consist of treating or extracting the tooth/teeth in question with antibiotic coverage or prescribing antibiotics for several days to contain the spread of infection and then treating the involved tooth/teeth." (AAPD Reference Manual; Clinical Guidelines on Use of Antibiotic Therapy for Pediatric Dental Patients, Pediatr Dent Special Issue 2011-2012;32:(6):263). No antibiotics were prescribed for this child. When the dentist was asked why she did not place the child on antibiotics and require him to return to the Clinic when the infection had improved, she stated the parent wanted the child treated that day. Injecting through infected tissues can potentially spread the infection. In addition, local anesthesia may not be as effective when administered to infected tissues because the pH differences may interfere with the mechanism of action of the local anesthetic.
- Gauze shields were not consistently used during the fitting and cementing of SSCs or during extractions; one dentist used cotton rolls and gauze to isolate a pulpotomy she was performing on patient #034.
- Preparedness and anticipation was lacking on the part of the dental assistants during procedures on uncooperative young children. Examples include not having the nitrous oxide turned on at the central tank in advance of the appointment and waiting 15 minutes with the doctor and patient in the room for the nitrous oxide to be turned on (patient #034); not being prepared for the procedures planned, such as a pulpotomy; not effectively holding the head of a fighting, combative child, or suctioning effectively; not actively addressing the needs of a child who vomited (patient #037). The doctor pulled the child's head to her side, and retrieved the suction, and suctioned the vomit herself.
- One dentist interviewed indicated the Clinic was short staffed and needed more and better-trained dental assistants. She reported a lack of urgency and preparedness on the dental assistants' parts when they have an anxious child in the chair. The Monitor observed this same behavior during her patient observations.
- A 33-month-old was seen for restorations. He was very frightened and became uncooperative and combative. The dentist referred him to have his treatment performed using sedation or general anesthesia (patient #040).

- One dentist treated a child for an uncomplicated fracture of tooth #E (patient #039). The dentist took an appropriate history from the mother about the fall that caused the fracture; however, there was no evidence in the patient record that an anterior X-ray had been taken for base line information and to rule out root fracture.
- A product, DuraShield®™, was observed being used for fluoride varnish that is a single-use packet containing the varnish and an applicator. The package insert says "DuraShield® is flavored topical varnish containing 5% sodium fluoride for use as a desensitizing agent to relieve hypersensitivity on areas of teeth where dentin or cementum is exposed, and can also be used to line cavity preparations under amalgam restorations." The instructions implied to use as a varnish to exposed tooth surfaces and suggested that "For best results, eliminate any excessive moisture/saliva from area to be treated." There were no guidelines for how the product's use was to be modified for use as a fluoride varnish for in-office fluoride application on very young children for whom excessive fluoride varnish carries risks. The dentist observed applied most of the varnish in the packet to the teeth of a young child (#037). No attempt was made to remove moisture from the teeth.

Recommendations

- Ensure the maximum dose of local anesthetic is calculated prior to administration of local anesthetic.
- Ensure gauze shields are consistently used to protect the airways of patients when appropriate.
- Ensure clinics are aware of the CSHM policy about the unacceptability of parents lying on children to restrain them during treatment.
- Ensure the dentists use mouth props appropriately and there is a variety of mouth prop sizes for dentists to use on young patients without overextending their mouths and compromising their ability to swallow.
- Ensure dental assistants understand the necessity of being prepared and responding rapidly during treatment of anxious young children and are trained to respond accordingly.
- Ensure dentists understand how to manage acute dental infections and the proper use of delayed treatment and antibiotics in their management.
- Ensure the Clinic's culture supports dentists who provide treatment using restraints only in accordance with the revised CSHM guidelines. The culture also should support dentists when they make the clinical judgment to abort treatment when it is not safe to continue, no matter what the child's presenting condition may be. While treatment of patient #037 using the PSD fit the new PSD policy in that tooth #B had severe enough decay that an emergency was pending, the dentist should feel supported in the judgment to abort treatment when it was not safe to continue.

- Ensure dentists know the necessary data to be gathered for proper documentation of dental trauma.
- Ensure those who provide fluoride treatments to patients with dental varnish use the products according to manufacturer's directions and modify the amount used to make it appropriate for the patient's age and weight.

Exit Conference

The exit conference was held on March 9, 2012, at approximately 11:30 a.m. Present at the conference were the Monitor Team of [redacted], [redacted] RDH, MS, [redacted], CDA, RDH, and [redacted], DDS, MDS; [redacted]r, Chief Compliance Officer via telephone; Clinic staff member, [redacted] Office Manager and Compliance Liaison, also attended. The preliminary findings discussed at the exit conference included the following:

- All notices and posters were in place.
- The Adverse Event Log contained patient records and other protected health information that would be made available to unauthorized persons.
- Staff members interviewed were knowledgeable of the translation serve.
- Staff members interviewed were knowledgeable of the existence of the hotline and did not express reluctance in using it.
- There is a concern in reviewing documentation of the most recent adverse event that not all relevant information was provided to CSHM.
- The Monitor observed children whose airways were in jeopardy during treatment. They were treated using restraint and were hysterical, screaming and moving, and had mouth props that opened their mouths to the maximum, limiting their ability to swallow, cough, or protect their airways from their own secretions or the water used to prepare the teeth. One of these children had two maxillary anterior teeth extracted without the use of a gauze shield. One of these children vomited during treatment.
- There was uneven compliance with CSHM policy about how to document medical necessity. The Monitor observed that some charts of patients receiving treatment did not have any charting on the upper odontogram to indicate the presence of disease.
- A form of active restraint was observed where parents were asked to lie on top of their children to restrain their movements. The CDO was asked whether CSHM endorses this type of active restraint. The Monitor was told "No."
- The lead dentist managed several young children well who were receiving invasive dental treatment, including the administration of local anesthesia.
- Two dentists made appropriate referrals for uncooperative patients to be treated with sedation or general anesthesia.
- Interviews indicated mixed levels of familiarity with the Best Practice E-mails and Policies from the CDO by both the dentists and staff.

- All individuals interviewed were able to accurately demonstrate knowledge of the recent changes in the use of PSDs.
- The X-rays were stored inconsistently in the record. Some X-rays were stored in a plastic sleeve while others were loose in the patient's record. Several records contained X-rays that had fallen from the X-ray holder. There were also X-rays found in the patient's record that were not labeled.
- There was inconsistent documentation of decay, pathology, existing conditions, and completed treatment on the Tooth Chart.

Attachment A

On-Site Record Review Assessment of Patient Management

Pt #	Age	DDS	DOS	Protective Stabilization		Behavior		N_2O	LA	Treatment		Summary of Appointment Comments
				Active	PSD	Initial	Final			Performed	Emergent	
001		CA		Yes	No	3	3	Yes	Yes	#F pulp/SSC; #E X-ray; #J (OL) fill; #E extract	Unable to verify because the X-ray was lost	Active stabilization was documented on the Op Sheet and confirmed by the documentation in the Progress Notes, yet there was no Consent for Protective Stabilization form present in the patient's record for the services provided on . The Progress Notes dated , state: "Patient started crying during treatment on anterior. Appears patient was getting restless. Mom held patient's hands and dental assistant held patient's head to help manage patient behavior when it became uncooperative."
002		CA		No	Yes	1	3	No	Yes, but LINE and Inquat used for pulpal anesthesia	#S (O) fill, #T pulp/SSC	No	Progress Notes dated , state: "Patient became combative during administration of anesthesia; kicking and moving head. Mom asked patient to cooperate however patient would not listen. Advised mom patient needs to be stabilized for safety. Patient cried during stabilization but was not mobile."
004		CA		No	Yes	2	2	No	Yes	#D, #G extract; #E, #F pulp/SSC	No for #D, #G. Unable to determine for #E, #F	Op Sheet notes state: "Patient was crying and displaying restrictive movements before treatment. Patient placed in papoose for treatment. Patient cried during treatment."
005		CA		No	Yes	2	2	No	Yes	#K, #L, #S, #T, #J fillings	No	Op Sheet notes state: "Patient combative displaying restrictive movements and unwilling to sit in Op chair. Patient placed in papoose for treatment. Decay detected visually and with explorer tip today. All of patient's treatment completed today."
006		CA		Yes	No	3	2	Yes	Yes	#F pulp/SSC; #D(F), #G(F) fillings; #E extract	No for #D, #G. Yes for #E, #F	Op Sheet notes state: "Patient combative so mom and dental assistant held patient's hands & legs due to patient's combative behavior. Patient cried during treatment."

On-Site Record Review Assessment of Patient Management

Pt #	Age	DDS	DOS	Protective Stabilization		Behavior		N_2O	LA	Treatment		Summary of Appointment Comments
				Active	PSD	Initial	Final			Performed	Emergent	
007		CA		No	Yes	1	1	No	Yes, but no anesthesia noted for left side (#J)	#T(O), #S(O) #J(OL) fillings; #A pulp/SSC	No	Op Sheet notes state: "Patient combative and crying, not a candidate for nitrous, uncooperative." The Op Sheet documented the anesthesia start time at 11:35, treatment start time at 11:40, treatment end time 12:15, PSD start time was documented at 11:30. Behavior indication and response on both the Op Sheet and PSD form were documented as definitely negative: unable or refusing to cooperate. There was no documentation of local anesthesia delivered to the left side of the mouth, which included tooth #J. Tooth #J received a two-surface filling on the audited date of service.
009		GRW		Yes	No	2	2	No	None	#S(OB, #T(OB), #C(F), #D(F), #E(F) fillings	No	Op Sheet notes state: "Patient very difficult active stabilization with mother holding feet, hands and for soft screaming but cooperative." Five teeth in two sextants were treated without the use of local anesthesia or nitrous oxide analgesia. The Monitor is concerned the mother was used to stabilize the child to avoid use of the PSD. There was also no X-rays or photographs to determine whether treatment provided was emergent.
011		GRW		Yes	No	2	3	Yes	Yes	#A, #B SSCs	No	The Op Sheet documented the initial behavior as "negative: patient was reluctant to treatment" and the behavior response as "positive: accepting but anxious." The Nitrous Oxide Consent Form, however, documented the initial behavior as "positive: accepting but anxious" and the behavior response as "negative: patient reluctant to treatment." The Op Sheet notes state: "Mother had to hold patients hands & feet to finish procedure" indicating the patient's behavior deteriorated during treatment. It appeared an error occurred on the Op Sheet regarding the type of stabilization used during treatment because it documented passive stabilization was used; however, notes of the mother holding the patient's hands and feet would demonstrate active stabilization.
012		GRW		No	No	4	4	No	None	#T (OB) Redo filling; #A(OL), #B(O) fillings	N/A; PSD was not used	There was no local anesthesia or nitrous oxide analgesia given for treatment provided to teeth #A, #B, and #T on the audited date of service.

On-Site Record Review Assessment of Patient Management

Pt #	Age	DDS	DOS	Protective Stabilization		Behavior		N_2O	LA	Treatment		Summary of Appointment Comments
				Active	PSD	Initial	Final			Performed	Emergent	
017		JS		No	Yes	2	1	Yes	Yes	#A, #B Pulps/SSCs	Probably for #A, #B	Notes on Op Sheet state: "[Nitrous] calm him a little but moved too much, so had to use papoose. Still struggled but able to get work done." Notes on PSD form state: "At [first nitrous] worked but [patient] moved too much – used papoose. Still cried and moved but able to finish treatment." PSD used prior to administration of anesthesia. Teeth #S and #T received SSCs on with "active stabilization," according to the Op Sheet. The PSD form dated indicates reasons for stabilization as patient was kicking and moving arms and head.
018		JS		No	Yes	2	1	No	None	#I(O), #K(O), #S(O), #T(L) fillings	No	The Op Sheet documented no local anesthesia or nitrous oxide analgesia was administered for occlusal fillings placed in teeth #I and #K, the lingual filling placed on tooth #H, and the redo of defective occlusal filling placed in #S. A PSD was utilized. Notes on the PSD form stated "Patient screamed – cried, (indecipherable) too much. Patient should have been (space) (indecipherable) appt." The PSD form documented initial behavior as negative (patient was reluctant to treatment) and behavior response as definitely negative (unable or refusing to cooperate.)
019a		JS		Cannot detect none	No	2	3	No	Yes	#K,#L Pulps/ SSCs	Probably for #K, #L	Op Sheet notes state: "[Patient] cried and moving during [local anesthesia] application and drilling." The Op Sheet does not document the use of a PSD or active stabilization and it is unclear how the patient's reported movement was managed during treatment.
019b		JS		Yes	No	3	2 and 1	No	Yes	#I SSC; #J Pulp/SSC	No	The Op Sheet notes state: "Had hard time [indecipherable] him cooperate since [patient] didn't like bite block. Keep moving head/body – active stabilization done."
020a		JS		Yes	No	3	2	No	Yes, but no palatal anesthesia	#E extract	X-ray appears mounted backward; #F appears to be abscessed , not #E.	The Op Sheet notes indicate two dental assistants "had to hold him when local anesthesia applied." However, the Op Sheet does not have "Y" circled to indicate active stabilization was used and records the parent was not in the room. In addition, there was no Consent for Protective Stabilization for the extraction performed on . Documentation shows tooth #E was extracted with only infiltration of local anesthesia and no palatal anesthesia was administered.

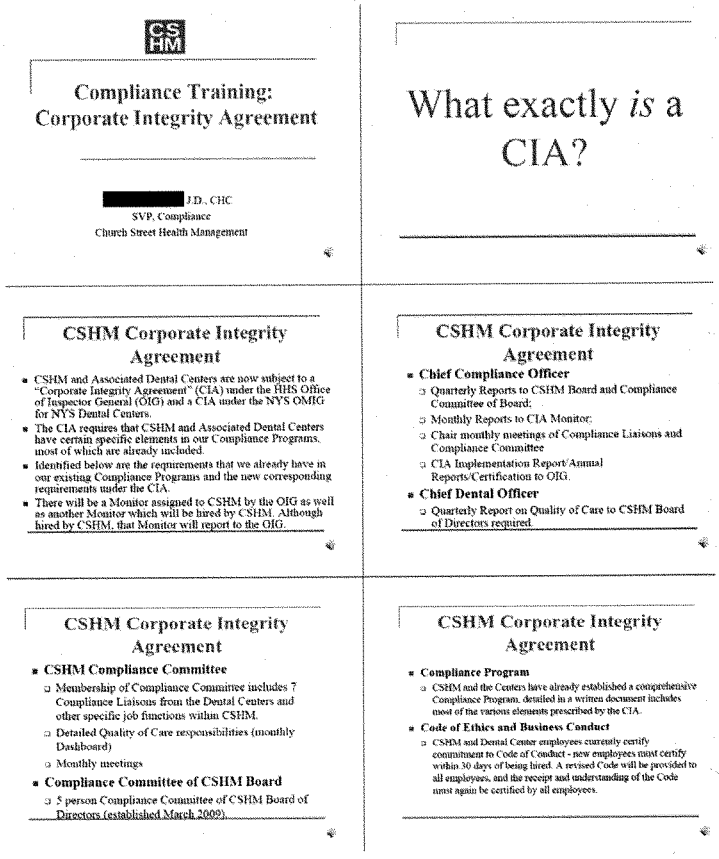
On-Site Record Review Assessment of Patient Management

Pt #	Age	DDS	DOS	Protective Stabilization		Behavior		N_2O	LA	Treatment		Summary of Appointment Comments
				Active	PSD	Initial	Final			Performed	Emergent	
020b		JS		Yes	No	2	1	No	Yes	#A, #B Pulps/SSCs	No	Op Sheet notes state: "Patient non-cooperative active stabilization."
020c		JS		No	Yes	1	3	No	Only LINF for pulpal anesthesia on #T, no LA noted on left side for fillings	#J(OL), #K(MOB), #L(DOB) fillings; #T Pulp/SSC	No	Op Sheet documented no local anesthesia was administered on the left side of the mouth for teeth #J, #K, and #L, which received multi-surface fillings. Documentation also shows infiltration was used as the method to administer local anesthesia to achieve pulpal anesthesia for the pulpotomy performed on a primary mandibular second molar. Op Sheet notes state: "shallow class II [fillings]. Dad wanted to finish treatment and patient did better with papoose so #T (SSC w/ pulp) done as well." The Stabilization form noted: "patient screamed, cried but calm as papoosed, able to finish all his work."
022a		GRW		Yes	Yes	2	2	No	No	#K(OB), #L(O), #S(O), #T(OB) fillings	No	Op Sheet notes state: "Patient very combative. Papoose indicated. Patient kicking screamed during appointment. Mother in op entire visit."
022b		JS		No	Yes	1	2	No	Cannot verify; incomplete LA Section on Op Sheet	#A, #B Pulps/SSCs	Probably	Op Sheet notes state: "Patient wouldn't bite down. Forced to bite down. Patient was crying from walking to operatory, papoose used. Moved/screamed during treatment but finished." Outcome of Stabilization notes state: "Patient cried entire time. Dental Assistant held his head. Patient almost came out of papoose but manage to finish."
025		DTB		No	Yes	1	1	Yes	Yes	#S, #T SSCs	No	Op Sheet notes state: "Child refused to stay in the chair. Mother was told that child would benefit from sedation. She wanted to try protective stabilization first. Teeth #T and #S were restored with crowns. Referral given." Upon review of the X-rays, the Monitor's pediatric dentist found only small enamel etches in the interproximal surfaces and noticed the PSD was used to complete non-emergent treatment.

On-Site Record Review Assessment of Patient Management												
				Protective Stabilization		Behavior				Treatment		
Pt #	Age	DDS	DOS	Active	PSD	Initial	Final	N_2O	LA	Performed	Emergent	Summary of Appointment Comments
027a		DTB		No	Yes	1	1	Yes	None	#A, #S, #T fillings	No	Op Sheet notes state: "Child refused to sit in the chair. Mom requested protective stabilization." There were no X-rays or photographs taken on this patient, and it appears the PSD was used for non-emergent treatment, which was performed without local anesthesia.
027b		JS		Yes	No	1	2	No	None	#I, #J, #K, #L fillings	No	Op Sheet documented no local anesthesia or nitrous oxide analgesia was administered for the filling performed on four teeth. PSD form indicates active stabilization was used and records reason for stabilization as patient was kicking, moving arms and head, and refused to open mouth. Op Sheet notes state: "Mom held the patient while treatment."
027c		CA		Yes	No	1	2	No	Yes	#E, #F two surface fillings, #G strip crown	No	PSD form was not completed correctly and does not document patient's behavior as reported in Op Sheet notes. Op Sheet notes state: "Patient cried during entire treatment. Mom helped manage patient's behavior and mobility by laying on top of her." Ten teeth were treated with no X-rays or photographs to support the medical necessity for services provided.

EXHIBIT 17

COMPLIANCE TRAINING



Compliance Training:
Corporate Integrity Agreement

[redacted], J.D., CHC
SVP, Compliance
Church Street Health Management

What exactly *is* a CIA?

CSHM Corporate Integrity Agreement

- CSHM and Associated Dental Centers are now subject to a "Corporate Integrity Agreement" (CIA) under the HHS Office of Inspector General (OIG) and a CIA under the NYS OMIG for NYS Dental Centers.
- The CIA requires that CSHM and Associated Dental Centers have certain specific elements in our Compliance Programs, most of which are already included.
- Identified below are the requirements that we already have in our existing Compliance Programs and the new corresponding requirements under the CIA.
- There will be a Monitor assigned to CSHM by the OIG as well as another Monitor which will be hired by CSHM. Although hired by CSHM, that Monitor will report to the OIG.

CSHM Corporate Integrity Agreement

- **Chief Compliance Officer**
  - Quarterly Reports to CSHM Board and Compliance Committee of Board;
  - Monthly Reports to CIA Monitor;
  - Chair monthly meetings of Compliance Liaisons and Compliance Committee
  - CIA Implementation Report/Annual Reports/Certification to OIG.
- **Chief Dental Officer**
  - Quarterly Report on Quality of Care to CSHM Board of Directors required.

CSHM Corporate Integrity Agreement

- **CSHM Compliance Committee**
  - Membership of Compliance Committee includes 7 Compliance Liaisons from the Dental Centers and other specific job functions within CSHM.
  - Detailed Quality of Care responsibilities (monthly Dashboard)
  - Monthly meetings
- **Compliance Committee of CSHM Board**
  - 5 person Compliance Committee of CSHM Board of Directors (established March 2009).

CSHM Corporate Integrity Agreement

- **Compliance Program**
  - CSHM and the Centers have already established a comprehensive Compliance Program, detailed in a written document includes most of the various elements prescribed by the CIA.
- ***Code of Ethics and Business Conduct***
  - CSHM and Dental Center employees currently certify commitment to Code of Conduct - new employees must certify within 30 days of being hired. A revised Code will be provided to all employees, and the receipt and understanding of the Code must again be certified by all employees.

CSHM Corporate Integrity Agreement

- **Chart Audits for Dental Centers and Dentists**
  - Chart audits including quality of care reviews are conducted quarterly.
  - Corrective Action Plans (CAPs) and re-audits the following month for failing scores
  - Dentist compensation and Center staff bonuses are tied to quality of care. (CIA requires this – in audit policy.)

CSHM Corporate Integrity Agreement

- **Compliance Training**
  - **General Compliance Training (2 hours)**
    - CIA Training
    - Compliance Program and Code of Conduct Training
  - **Billing/Reimbursement Training (3 hours)**
  - **Clinical/Quality of Care Training (3 hours)**
  - **Additional Specific Training (as needed)**
- **Timeframe for Training**
  - Complete general training within 90 days/begin other training within 90 days
  - Annual training thereafter
  - **New employees must receive training within 30 days of being hired.**

CSHM Corporate Integrity Agreement

- **Required Policies and Procedures**
  - Current polices & procedures revised/expanded; new policies created.
    - Parent Pledge Posters (revised)
    - Parent Notification Policy
      - Adverse Events
      - Center Incident Log (list of events with CAP noted)
  - New *Clinical Guidelines* developed by Chief Dental Officer with Pediatric Dental Advisory Board.**

CSHM Corporate Integrity Agreement

- **OIG and GSA Exclusion Checks**
  - Upon hire
  - Quarterly checks for providers, vendors, and contractors excluded from Medicaid or Medicare
  - OIG & GSA lists (federal) and some state lists

CSHM Corporate Integrity Agreement

- **Patient Advocate**
  - *New addition under CIA*
  - Patient Advocate appointed ([redacted])
    - Also added Patient Advocate Coordinator who is fluent in Spanish
  - Monitors numerous sources of parent/patient feedback/complaints
    - Parent Pledge Poster
    - NPS System
    - Patient Advocate email [redacted]
  - Quarterly Report on Patient Care to CSHM Compliance Committee and CSHM Board Compliance Committee.

CSHM Corporate Integrity Agreement

- **Internal Audit Program**
  - *New addition under CIA*
  - VP, Internal Audit hired ([redacted])
  - Internal Audit serves as another "check" for all CSHM functions, including the function of the Compliance Program and Compliance Department
  - Policies and Procedures
  - Quarterly Reports to Chief Compliance Officer and CSHM Board of Directors.

CSHM Corporate Integrity Agreement

- **Compliance Liaisons**
  - Each Dental Center now has a Compliance Liaison who is responsible for compliance within the Center.
  - Your Center's OM is your Compliance Liaison.
  - Chief Compliance Officer will chair a monthly meeting of the Center Compliance Liaisons.
  - 7 Compliance Liaisons are selected (on a rotating basis) to serve on the CSHM Compliance Committee.

CSHM Corporate Integrity Agreement

- **Quality of Care Dashboard (handout)**
  - Overview of Quality of Care Measures
    - NPS Scores
    - Chart Audit Results
    - Compliance Investigation Information
    - Employee Satisfaction
  - CSHM Compliance Committee is required to oversee the Dashboard and to develop Quality of Care Goals.
  - Dashboard will be updated monthly and be posted in all Associated Dental Centers.

CSHM Corporate Integrity Agreement

- **Independent Quality of Care Monitor**
  - Hired by CSHM, approved by OIG
  - Reports to OIG
  - Ongoing access to monitoring of all CSHM and Dental Center activities.
- **Independent Review Organization (IRO)**
  - The IRO is hired by CSHM to conduct an annual review and report the findings to the OIG
  - The annual review will follow specific criteria set by the OIG.
  - CSHM has selected FTI Healthcare, Inc. as the IRO.

** **ALL employees required to Cooperate with Monitor and IRO**

CSHM Corporate Integrity Agreement

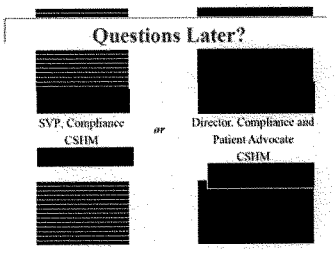
- **Implementation Report**
- **Annual Report and Certifications**
- Certifications affirming compliance with the various provisions of the CIA are required annually by CSHM Senior Management and by certain other employees.

CSHM Corporate Integrity Agreement

Compliance with the CIA is yet another step forward in our efforts to provide the highest quality of care to the patients that we serve and to act in an appropriate and ethical manner in the provision of such care.

YOUR Commitment to Compliance is the KEY!

Any Questions?



Compliance Program and Code of Ethics and Business Conduct

[redacted], J.D., CHC, CHPC
Patient Advocate
CSHM

Goals of Compliance Training

- Each employee should understand that a commitment to compliance is a condition of continued employment.
- Understand the Dental Center's Compliance Program and Code of Ethics and Business Conduct and how it relates to your individual compliance efforts.
- After completing training, you should be able to communicate what role you play in the compliance efforts of your Dental Center.

Code of Ethics and Business Conduct

- Condition of Employment
- **Obey the law**
- **Maintain a legal, ethical and positive work environment**
- Work safely; protect yourself and other employees
- **Keep accurate and complete records**
- Maintain confidentiality of information
- **Record, report and submit financial data properly**

Code of Ethics and Business Conduct

- Steer clear of conflicts of interest
- Avoid illegal or questionable gifts or favors
- Use ethical marketing and advertising practices
- Maintain integrity with outside agents, consultants and vendors
- Follow the law and use common sense in political contributions and activities
- Carefully bid, negotiate and perform contracts

Code of Ethics and Business Conduct

- Protect proprietary information
- Use organization assets wisely
- **Cooperate with government investigations**
- **License and Certifications renewals**
- **Hiring or retention of excluded individuals or entities**
- Compliance with Antitrust laws
- **Report concerns promptly**

Report Suspected Wrongdoing

- Employees should report any conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent or a violation of the Dental Center's compliance Program
- CSHM and Associated Dental Centers' Compliance Programs provide that there will be ***No retribution for reporting such conduct in good faith.***

How should you Report an Issue?

- **Ethics and Compliance Hotline** [redacted]
- Online Submission – https://www.compliance-helpline.com/CSHM.jsp
- Chief Compliance Officer in Nashville [redacted]
- Office Manager/Dental Center Compliance Liaison
- Regional Manager
- Employee Comment Card
- Exit Interview (as a last resort or for continued concerns, BUT REMEMBER –you should report issues *immediately*)

Ethics and Compliance Hotline or Online Submission

- Call the Hotline or report an issue on line for any suspected violation of CSHM's or the Dental Center's Code of Ethics and Business Conduct, Compliance Program, or any law or regulation
- Not intended for non-compliance-related or Human Resource issues (e.g., complaints about co-workers, etc.)
- You may choose to remain *anonymous* when reporting via the Ethics and Compliance Hotline or online submission
  - Keep in mind there may be a point at which an individual's identity may become known or may have to be revealed in certain instances.

Compliance Program

This Compliance Program consists of 7 elements:

1. Designation of Compliance Officer and a Compliance Committee (meets every month)
2. Internal Monitoring and Auditing
3. Operational Guidelines and Policies
4. Ongoing Training and Education
5. Reporting Mechanisms/Open Communication
6. Response to Detected Violations
7. Internal Sanctions and Disciplinary Standards

Compliance Program

1. Compliance Officer
   - Compliance Committee (meets every month)
   - CSHM Board Compliance Committee (meets quarterly)
   - Compliance Liaisons Committee (meets every month)
2. Internal Monitoring and Auditing
   - Compliance Audits (Quarterly Chart Audits)
   - Internal Audit Department
   - Other "Tools" for monitoring 1) Compliance with Regulations and 2) Quality of Care
     - "CRAFT" (Clinical Risk Assessment Focus Tool)
     - Quality of Care Dashboard

Compliance Program

3. Operational Guidelines and Policies
   - Written Standards
   - Code of Ethics and Business Conduct
   - Policies and Procedures
4. Ongoing Training and Education
   - Annual Compliance Training
   - Required Billing and Clinical Training
   - Other Training/CEs
   - Webinars/in-person presentations/"in-services"

Compliance Program

5. Reporting Mechanisms/Open Communication
   - Ethics and Compliance Hotline
   - Other Methods (as described in prior slides)
6. Response to Detected Violations
   - Investigations and Reports
   - Corrective Action Plans
   - Repayment of Overpayments
7. Internal Sanctions and Disciplinary Standards
   - Warnings (DVWs and DWWs)
   - Terminations

Benefits of Compliance Program

- Showing good faith efforts to submit claims appropriately
- Minimizing billing mistakes
- Facilitating speedy payment of claims
- **Avoiding fraud and abuse**
- Reducing chances of future government investigations
- Enforcing an **culture of ETHICS** throughout CSHM and Dental Centers

Fraud and Abuse

- 2 Distinct Terms:
- BOTH Fraud and Abuse are BAD behavior, but Fraud is worse than Abuse
- **Abuse:** Non-criminal behavior. Civil conduct. *Failure to adhere to regulations in a consistent manner*; disregard of whether regulations or laws are being consistently followed.
- **Fraud:** Criminal behavior. *Deceit* or breach of confidence. Lying for profit or to gain some unfair or dishonest advantage.

Medicaid Fraud

- Requires intent
- Submission of a claim for payment under the Medicaid program which:
  - ***Knowingly*** contains materially false information concerning a beneficiary's treatment or bill, or
  - ***Purposely withholds*** information regarding a beneficiary's treatment for the purpose of misleading the Medicaid program

Examples of Fraud and Abuse

- Billing for "phantom patients" who did not really receive services - FRAUD
- Billing for dental services that were not provided - FRAUD
- Other Examples Not as Clear (Fraud OR Abuse?):
- Billing for tests/services that the patient did not need (medically unnecessary services)
- Overcharging for health care services that were provided [upcoding]

Examples of Fraud and/or Abuse

- Double-billing for health care services that were provided
- Providers giving substandard quality of care
- Billing for care by falsely-credentialed providers
- Having an unlicensed person perform services that only a licensed professional should render, then billing as if the licensed professional provided the service

Examples of Fraud and Abuse

- *Knowingly* keeping "Credit Balances" when not otherwise allowed by contract or law
- Paying/Accepting "Kickbacks" in exchange for a referral for dental/medical services or goods (FRAUD) – depends on whether there was an *intent* to influence referrals (not all gifts are inducements or "kickbacks")

Compliance Risk Areas

- **Coding/Billing**
- Proper Licensing & Credentialing
- **Medically Necessary Services**
- **Quality of Care**
- **Documentation [Dental Records]**
- Improper Inducements for Patients [Anti-Kickback]
- False Claims – most of these and other issues regarding submission of claims may fall under this area

Compliance Risk Areas

- **Coding/Billing**
  - Difference between:
    - **Billing errors** (occasional mistakes)
    - Abuse (failure to ensure consistency in billing – NOT intentional)
    - Fraud (intentional conduct)
  - Do not bill for items/services not provided as claimed
  - Do not double bill (results in duplicate payment)
  - Do not bill for non-covered services as if covered
  - Do not knowingly misuse provider identification numbers (e.g., co-signing/counter signing, etc.)
  - Do not upcode (e.g. bill for CDT 7140 instead of CDT 7111 when it is clear that 7140 should not be billed)

Compliance Risk Areas

- **Proper Licensing and Credentialing**
  - Cannot provide treatment when license/credentials have been revoked, suspended or surrendered
- **Medically Necessary Services**
  - Do not administer services not needed
  - Maintain accurate medical records – ***documentation*** should be clear throughout patient chart *(new OP sheets)*
  - Treatment Plan by Dentist should be clearly supported by charts, including x-rays, digital photographs, medical documentation, etc.

Compliance Risk Areas

- **Quality of Care**
  - Quality of care includes, among other things,:
    - Medical Necessity
    - Appropriateness of Care/Treatment
    - Competency of Provider(s)
  - Failure to provide appropriate quality of care to patients is unacceptable.
  - Substandard care will NOT be tolerated by CSHM or Associated Dental Centers
  - In addition to employment sanctions up to, and including, termination, Providers may be excluded from participation in the Medicaid program and sanctioned by Licensing Boards

Compliance Risk Areas

- **Documentation**
  - Should include patient health history, health risk factors, patient's progress, response to changes in treatment, and any change in diagnosis
  - **New Op Sheets and Hygiene Sheets****
  - Must be complete and legible
  - Necessary to determine the appropriate dental treatment for the patient
    - **Rationale for all treatment/ Medical Necessity**
  - Forms basis for coding and billing determinations
    - **CDT Codes used for claims submission must be supported by medical record**
  - Facilitates accurate recording and timely transmission of information

Compliance Risk Areas

- **Improper Inducements [Referrals/Marketing]**
  - Anti-Kickback Statute and Civil Monetary Penalty Statute
  - Cannot solicit, receive, offer or pay anything of value as an inducement to refer, or to fail to refer, any patient whose care is paid in whole or in part by any federal health care program, including Medicaid
  - Gifts and Marketing Policy
    - Gifts to Medicaid Beneficiaries okay - up to $30 value, $50 total per year (not each). NO intent to induce referrals
- **False Claims**
  - *Knowing* submission of claims for payment for services to beneficiaries of federal health care programs (including Medicaid)
  - Know or should have known that claims were false
  - Potential penalties:
    - 3 times amount of claim plus $5500 - $11,000 per claim
    - Exclusion from participation in Medicaid Program

National Response to Medicaid Fraud

- Role of Office of Inspector General (OIG) of US Dept of Health and Human Services (HHS) to identify and eliminate fraud, waste and abuse in the Federal Health Care Programs under HHS
- OIG coordinates a nationwide program of audits, inspections and investigations (for federal healthcare programs only)
- **Exclusion Authority**
  - Criminal (Felony) Conviction = 5 year minimum ban from Federal Programs
  - **Civil sanctions authority includes permissive exclusions**

State Medicaid Program Integrity Efforts

- State Medicaid Fraud Control Units (MFCUs)
- Medicaid Program Integrity as part of the Deficit Reduction Act of 2005 (DRA)
  - Renewable 5 year comprehensive plan to combat fraud, waste, and abuse beginning in 2006
  - Manage DRA Operational Responsibilities
  - Periodic Audits

False Claims Act

- The **federal** Civil False Claims Act provides that a false claim is made:
  - Where any person *knowingly* presents, or causes to be presented, a false or fraudulent claim for payment under a federal healthcare program (including, but not limited to, Medicaid).
  - **NO SPECIFIC INTENT TO BE PAID BY MEDICAID IS REQUIRED.**
  - The terms "knowing" and "knowingly" mean that a person:
    - has actual knowledge of the information;
    - acts in deliberate ignorance of the truth or falsity of the information; or
    - acts in reckless disregard of the truth or falsity of the information.
- The penalty for submitting a false claim is a monetary penalty (fine) of not less than $5,500 and not more than $11,000, plus 3 times the amount of the claim presented. *No proof of specific intent to defraud is required.*

False Claims Act

- In addition to civil monetary penalties, there are administrative remedies for false claims which include, but are not limited to,
  - permissive exclusion from all federal health care programs (including Medicaid), and
  - imposition of a Corporate Integrity Agreement (CIA) to bolster and monitor a provider's compliance program.
- Whistleblower protections are provided under such Acts, with respect to their role in preventing and detecting fraud, waste, and abuse in Federal health care programs.
  - Provisions allowing whistleblowers to bring suit under the civil False Claims Act
  - The government will decide whether or not to intervene in a case brought individually by a whistleblower, but the case may proceed without government participation. In either case, the whistleblower may share in any later recoveries, if there are any.
  - The Act also provides that there will be *no retaliation against employees who act as whistleblowers.*

State False Claims Acts

- A number of states have adopted their own False Claims Acts which apply only to health care claims submitted for payment to their State agencies.
- Such State False Claims Acts have their own civil or criminal penalties for false claims and statements.
- These states include, but are not limited to, Georgia, Indiana, Massachusetts, New Hampshire, New York, Nevada, New Mexico, Oklahoma, Texas, and Virginia.

State False Claims Acts

- Dental Centers in states which have their own State False Claims Acts must comply with their State Acts, as well as the Federal False Claims Act.
  - **A summary of your state's False Claims Act or similar state statute has been provided to your Office Manager for distribution.**
- CSHM complies with State False Claims Acts with respect to Associated Dental Centers in states with such statutes.

Potential Sanctions for Civil Violations of False Claims Acts

- Civil Sanctions (*Non-Criminal*)
  - **Federal False Claims Act (civil): 3 times amount of claim *plus* $5500 - $11,000 for each false claim submitted**
  - **Exclusion from the Medicaid Program**
  - Repayment of overpayments usually multiplied

Potential Sanctions for *Criminal* Violations of False Claims Acts

- **Criminal Behavior**
  - Exclusions
  - Fines
  - Imprisonment
  - **Federal Sentencing Guidelines**
  - Fraud >$500
    - Felony; $10,000 per claim, up to 5-10 years in jail
  - Fraud < $500
    - Misdemeanor; $5,000 per claim, up to 1 year in jail
  - Fraud resulting in patient death/serious bodily injury (SBI)
    - SBI: Up to 20 years
    - Death: $50,000 fine and up to 20 years or more/life

Violation of an OIG Exclusion

- Criminal exclusions: anyone convicted of a felony engaging in fraud/abuse is banned/excluded for minimum of 5 years from Federal Programs [OIG Exclusion]
- Civil exclusions: may excluded for 6 mos. or more from Federal Programs [OIG Exclusion]
- Provision of Services by an Excluded Individual
  - Civil Monetary Penalty of $10,000 for each claim for service submitted or caused to submit
  - Treble damages (3 times) for each claim
  - Criminal Penalties increase fines and jail time

Not Just Medicaid: Other Laws Applicable to Dental Practices

- State Dental Practice Acts
- Other Regulations from State Licensure Boards
- State Public Health Laws
- Other Miscellaneous Laws and Regulations re Confidentiality of Patient Information (HIPAA), Employment (EEOC, Wage & Hour Laws), Environmental Concerns (OSHA), etc.

Responding to Reported Violations

- CSHM will investigate **all** reports of suspected noncompliance
- Reports will be prepared for each such report.
- Corrective Action Plans will be developed to address problems/concerns identified from investigations
- Employees involved in non-compliant behavior or wrongdoing shall be subject to disciplinary action
  - Verbal warnings, written warnings, termination
  - Depending on the circumstances, employees' actions may be reported to State Licensure Boards or other governmental agencies

Final Thoughts

Compliance is NOT a Spectator Sport!

Scenario 1

- Through routine audit procedures CSHM staff discover that Dental Center billed 4 extractions twice – each extraction was billed as both CDT 7111 and CDT 7140.
  - Account history shows that Center was only paid for 4 extractions, not 8. Any compliance concerns? What should be done?
  - Center was paid for 4 extractions as CDT 7140, but no x-rays, digital photos, or narrative indicating that roots were present and extraction was not of coronal remnants only. Any compliance concerns?

Scenario 2

- As part of a routine quarterly chart audit, Dental Center received a chart request from CSHM. The Center has 4 Dentists, so 20 charts were requested. A Front Office Assistant (FOA) noticed that, when gathering the charts and making copies, the following occurred:
  - Dentist X has added notes to the Op sheet for one of his charts, though there were no notes made at the time of the patient's treatment. Dentist X does not indicate the date that he added the notes to the sheet. Is this a compliance concern? Does the amount of time between the treatment and the addition to the notes matter?
  - DA signed a parent's name on a treatment plan in a chart being copied so that it would be "complete." Is this a compliance issue?

Scenario 3

- During treatment at Dental Center, Patient's lip is accidentally cut with a bur. Would this be considered an adverse event? What if the cut required stitches? Does that make a difference?
- What if protective stabilization was used on Patient and no consent was signed by parent/guardian?
- It is discovered that Patient's twin sister received the treatment that was planned for Patient. What should be done?
- What should be done if an adverse event occurs?

Any Questions?

Questions Later?

[redacted]
Chief Compliance Officer
CSHM

or

[redacted]
Patient Advocate
CSHM
[redacted]

Compliance Program for CSHM Dental Management

Purpose

Church Street Health Management (hereinafter, "CSHM") Dental Management has adopted this Compliance Program to reflect its commitment to compliance with legal requirements and ethical standards in the provision of, and billing for, quality dental services to patients.

This Compliance Program is a part of the policies and procedures of Church Street Health Management, d/b/a CSHM Dental Management. All CSHM and CSHM Associated Dental Center employees, independent contractors, and professional personnel providing services for or on behalf of CSHM or CSHM Associated Dental Centers are expected to understand these policies and comply with them.

Elements

This Compliance Program consists of 7 parts:

1. Designation of Compliance Officer and a Compliance Committee
2. Internal Monitoring and Auditing
3. Operational Guidelines and Policies
4. Training and Education
5. Response to Detected Violations
6. Open Communication
7. Disciplinary Standards and Other Requirements

Note that this Compliance Program should be read with other policies and procedures of CSHM and CSHM Centers, including, but not limited to, the Office Manager Manual, the Clinical Coordinator Manual, the Patient Care Manual, the Infection Control Manual, and the Human Resources Manual.

1. Designation of Compliance Officer and a Compliance Committee

CSHM's Senior Vice President of Compliance is hereby designated as the CSHM Chief Compliance Officer:

[redacted] SVP Compliance
618 Church St., Ste. 520
Nashville, TN 37219
[redacted]

Questions regarding the Compliance Program may be directed to the Chief Compliance Officer by any interested person. The Chief Compliance Officer is responsible for overseeing implementation of this Compliance Program.

CSHM personnel may discuss compliance questions or concerns with the Chief Compliance Officer, with their Center's Compliance Liaison, or by using the toll-free number for the Ethics and Compliance Hotline, [redacted] which is referenced hereinafter in Section 6.

2. Internal Monitoring and Auditing

The Chief Compliance Officer will regularly monitor services and claims of Associated Dental Centers (hereinafter, "Centers") for compliance with industry standards and legal requirements. The Compliance Officer may request from Centers such reports and other information as he or she deems reasonable to further this purpose.

At least quarterly, an internal audit will be conducted including a random sampling of charts reviewed to verify the services provided and the appropriateness of the claims billed. Audits will be performed by the Chief Compliance Officer and/or her designee(s), and may be provided by a third party in the Chief Compliance Officer's discretion.

Audits will be conducted in order to make findings as to whether the patients at CSHM Associated Dental Centers are receiving the quality of care consistent with professionally recognized standards of health care, including but not limited to, any applicable federal and state statutes, state dental board requirements, regulations, and directives, and the American Academy of Pediatric Dentistry Reference Manual and guidelines.

Findings of all such audits shall be provided to the CSHM Compliance Committee and CSHM Board of Directors, as well as other CSHM Senior Management, as necessary, as soon as practicable upon completion.

3. Operational Guidelines and Policies

The operations of CSHM shall at all times conform to the requirements of all applicable federal and state laws and regulations, including, but not limited to, state and federal false claims acts, anti-kickback statutes, self-referral laws and other statutes and regulations.

CSHM's Human Resources and Operating Procedures Manual, Office Manager Manual and Lead Dentist Manual further describe procedures to be followed in CSHM's day to day operations with respect to these matters. However, in all instances CSHM and the Centers shall adhere to the following principles:

A. Billing

- All submissions of claims for dental services provided by Centers will accurately reflect the services provided and all other material facts (including, but not limited to, the date of service, patient information, and provider information).
- All bills for services will comply with the requirements of the applicable payor.

- Each employee involved in the preparation of claims will review the requirements of the Medicaid program regarding claims submission.

- The Office Manager of Centers shall warrant for the Medicaid program, upon request, that claims submitted to the Medicaid program are accurate and reflect the services actually provided and documented in the patient record.

- Each employee involved in the preparation of claims or documentation in the patient record will only include accurate statements in such claims or records, and will include all material facts available.

B. Services

- All dental services provided by Centers will be performed in accordance with guidelines established by the American Dental Association and the American Academy of Pediatric Dentistry, and in compliance with the standards of the state Medicaid program and state dental regulations.

- Patient records will be maintained by Centers in accordance with the American Dental Association's guidelines, in compliance with state and Federal law and Medicaid requirements.

- Patient information will be kept private and secure in accordance with HIPAA regulations and state law.

- Centers will obtain preauthorization for services when required, and the preauthorization request will be true and contain all material facts in accordance with the requirements of the Medicaid program.

C. Referrals and Marketing

- CSHM will not, directly or indirectly, engage in any activities intended to induce, influence, or reward the referral of patient for whom payment for services rendered may be made by any state of federal government payor. This prohibition shall include, but not be limited to, the payment of kickbacks, bribes, rebates or other payments in exchange for patient steerage.

- CSHM will abide by restrictions under state law and dental codes regarding advertising. All advertising will be truthful and not misleading.

- Neither CSHM nor Centers will provide gifts to patients or their parents in order to induce them to receive services at Centers. Nominal items or services provided during the course of care may be provided if in accordance with CSHM's Gifts Policy.

D. Relationships with Excluded Individuals

- CSHM policy prohibits the employment of individuals who have been convicted of a criminal offense related to health care or who are listed as debarred, excluded, or otherwise ineligible for participation in federal or

state health care programs. Prior to employment of any new person, the Licensing and Credentialing function within the Compliance Department shall review databanks to confirm that the prospective employee is not excluded, which databanks shall include, but may not be limited to, the following:

OIG List of Excluded Individuals/Entities (maintained by the HHS Office of Inspector General): available on the internet at http://oig.hhs.gov/fraud/exclusions/listofexcluded.html

GSA Excluded Parties List System (maintained by the US General Services Administration) available on the internet at http://www.epls.gov/

- Similarly, new independent contractors (anyone providing services that are reimbursable) should be screened to confirm the prospective contractor has not been convicted of a criminal offense related to health care and is not listed as debarred, excluded, or otherwise ineligible for participation in federal or state health care programs.

4. Training and Education

CSHM shall conduct general compliance training for its employees annually. All CSHM and CSHM Center employees shall participate in such training. All new hires will participate in such training before beginning their employment duties. Independent contractors of CSHM and CSHM Centers may also be required to attend routine compliance training, as appropriate. Compliance training shall be provided by either the Chief Compliance Officer or designee.

Each CSHM and CSHM Center employee shall be made aware of the location of manuals in CSHM and CSHM Center offices describing specific legal requirements for further review.

In addition to annual training, CSHM and CSHM Center employees shall be provided periodic additional training as determined necessary or as a result of changes in legal requirements. Each employee will be required to acknowledge in writing the employee's review of and compliance with this Compliance Program.

5. Response to Violations

Any detected or alleged violation of the principles in this Compliance Program or state or federal law should be brought to the attention of the Chief Compliance Officer or reported using the Compliance Hotline. It is the responsibility of each employee to adhere to these principles.

The Chief Compliance Officer will immediately investigate each alleged or detected violation brought to the Chief Compliance Officer's attention or reported on the Ethics and Compliance Hotline. The Chief Compliance Officer may utilize additional resources, including third party contractors, as deemed appropriate based on the situation. The investigation shall be documented in a report describing the allegation, the investigatory steps, and the findings.

The report shall be provided to CSHM's Compliance Committee and other Senior Management as appropriate and necessary, along with a recommendation regarding follow-up action, if

necessary. Such action, depending on the severity of the violation, may include, but is not limited to: additional employee training, employee disciplinary action, up to, and including termination, repayment of funds, and/or self-reporting to applicable government authorities.

In all instances in which overpayments are determined to have occurred, CSHM will return the excess funds to the Medicaid program (or other relevant payor) or, if applicable, treat the funds as a credit balance in accordance with the relevant payor's policies or otherwise treat the funds in accordance with the payor's policies and industry accepted procedures.

Employees who make reports in good faith of alleged wrongdoing will not be punished for making the report. The employee's involvement in any wrongdoing could still be subject to corrective action even if it is self-reported, however.

6. Open Communication

Communication of CSHM's commitment to compliance with applicable law and regulation is a priority of CSHM.

CSHM has established an Ethics and Compliance Hotline at the number [redacted]. The Ethics and Compliance Hotline is staffed twenty-four (24) hours per day and seven (7) days per week, during which time confidential messages may be left. Callers may choose to remain anonymous when calling the Ethics and Compliance Hotline. Contact information for the Compliance Hotline will be posted in the employee break room.

Reminders of the availability of the Chief Compliance Officer and the Ethics and Compliance Hotline to report concerns shall be routinely given to staff. From time to time, staff meetings shall include discussions of new compliance developments or activities, and reminders of how to avoid errors. Any updates to the Compliance Program shall be disseminated to staff as soon as is appropriate and practical. Copies of such updates shall be posted and/or otherwise made available to all employees.

Each employee who terminates employment with the CSHM or CSHM Center will be asked to participate in an exit interview (written or oral) with the Chief Compliance Officer, the Senior VP of Human Resources for the Management Company, or their designee. During the exit interview, the departing employee will be specifically asked to confirm whether or not the employee is aware of any violations of law or the principles contained in this Compliance Program. If applicable, the Chief Compliance Officer will review all such interview reports, and initiate investigation of any allegations.

7. Disciplinary Standards

The Human Resources and Operating Procedures Manual, Officer Manager Manual, Lead Dentist Training Manual, Employee Handbook and this Compliance Program provide documentation on the policies and procedures of CSHM and CSHM Centers. Additional policies and procedures of CSHM and CSHM Centers may be developed from time to time, as necessary, and will be disseminated to employees as soon as practicable after their development.

The Human Resources and Operating Procedures Manual describe corrective actions which may be administered to employees, and how and when such actions will be administered.

Violations of the standards or principles in this Compliance Program are violations which may result in corrective actions which may include, but not be limited to, counseling, training, verbal or written warnings, and termination, as described in the Manual(s) listed above.

Created on 11/11/2008, revised 12/17/2010

Code of Ethics and Business Conduct

Statement of [redacted]
CSHM Chairman and CEO

This Code of Conduct provides guidance to assist us in carrying out our daily activities while upholding our obligation to comply with the laws and regulations that govern the healthcare industry, as well as Church Street Health Management (CSHM)'s and Associated Dental Centers' policies and procedures. It governs our relationships with patients, third-party payors, subcontractors, independent contractors, vendors, consultants, government agencies and one another. This Code is an integral component of CSHM's and Associated Dental Centers' Compliance Programs and reflects our commitment to achieve our goals within the framework of the law through a high standard of business ethics and compliance.

The Compliance Programs have been established to prevent the occurrence of illegal or unethical behavior, to stop any such behavior as soon as reasonably possible after it has been discovered, to discipline the individuals involved (including those who know of violations but fail to report them), and to recommend and implement changes in policy and procedure necessary to avoid a recurrence of any prior violation.

This Code of Conduct will address many areas, but is not intended to be the only source of guidance. Some topics may require additional guidance and we will attempt to provide such guidance through a variety of means. Every employee should be aware that he or she has the responsibility to seek guidance and direction whenever he or she is unsure of the propriety of any particular course of action. In order to support a comprehensive Ethics and Compliance program, CSHM has appointed [redacted] Senior Vice President, Compliance, and an Ethics and Compliance Committee. [redacted] reports directly to the Chief Executive Officer and the Board of Directors, and oversees vigorous corporate-wide efforts to promote a positive, ethical work environment for all employees. All employees and affiliates are urged to contact [redacted] with any questions or concerns about ethics and business conduct that cannot readily be addressed by supervisors, or to call the Ethics and Compliance Hotline.

[redacted]
CSHM Chairman and CEO

III. MAINTAIN A LEGAL, ETHICAL AND POSITIVE WORK ENVIRONMENT

All CSHM and Associated Dental Center employees want and deserve a workplace where they feel respected and appreciated—one in which they feel that they are making a valuable contribution. Harassment or discrimination of any kind, including, but not limited to, discrimination on the basis of race, color, national origin, religion, gender, age, disability, and veteran status, is unacceptable and *shall not be tolerated* in our work place environment. Providing an environment of honesty, integrity, trust, responsibility, and good citizenship permits every employee and affiliate the opportunity to achieve excellence in our workplace. Everyone who works for CSHM or Associated Dental Centers must contribute to the creation and maintenance of such an environment.

IV. WORK SAFELY: PROTECT YOURSELF AND OTHER EMPLOYEES

CSHM and Associated Dental Centers are committed to providing a drug-free, safe, and healthy work environment. Each employee is responsible for compliance with environmental, health, and safety laws and regulations. Employees of CSHM and Associated Dental Centers shall observe posted warnings and regulations and shall immediately report to the Office Manager any accident or injury sustained on the job or any environmental or safety concerns.

V. KEEP ACCURATE AND COMPLETE RECORDS

Employees of CSHM and Associated Dental Centers shall maintain accurate and complete organizational and patient care records including, but not limited to, time records, billing records and documentation of care. Misrepresentation of facts and record falsification in any manner or degree is unethical and is always inappropriate. Falsifying documents is illegal. Such action shall not be tolerated and shall result in immediate disciplinary action, including, but not limited to, separation from employment.

VI. MAINTAIN CONFIDENTIALITY OF INFORMATION

CSHM and Associated Dental Centers respect patients' privacy and confidentiality. The confidentiality of patient information is of paramount importance. Personal health information about patients (including, but not limited to, treatment information, billing information, and pharmacy records) contained in patients' dental records or maintained in any other form shall be treated confidentially in accordance with the Health Insurance Portability and Accountability Act, as well as other applicable federal and state laws and regulations.

VII. RECORD, REPORT AND SUBMIT FINANCIAL DATA PROPERLY

CSHM and Associated Dental Centers shall comply with all applicable federal and state health care program billing requirements, including preparing and submitting accurate claims consistent with such requirements.

Transactions between CSHM and Associated Dental Centers, CSHM and other individuals and companies, including, but not limited to, federal and state governments, and Small Smiles and other individuals and companies, including, but not limited to, federal and state governments shall be promptly and accurately entered in our books and reported in accordance with our contractual obligations and applicable laws. Employees and their supervisors are responsible for ensuring that all costs are accurately recorded and charged on the company's records. These costs include, but are not limited to, routine patient services, labor, normal contract work, routine business costs, required governmental cost reports, and bid and proposal activities.

VIII. STEER CLEAR OF CONFLICTS OF INTEREST

Employees and affiliates of CSHM and Associated Dental Centers should avoid any relationship, influence, or situation that might impair, or appear to impair, their abilities to make objective and fair decisions in performing their duties and meeting the responsibilities of their employment or terms of their affiliation. Employees must fully disclose the facts of any questionable situation to their Center's Compliance Liaison or to [redacted], Senior Vice President, Compliance, [redacted]

Some examples of potential conflicts of interest might include, but are not limited to, the following:

- Employment by a current Associated Dental Center client, patient or supplier;
- Placement or solicitation of business with a firm owned or controlled by an employee or his or her family;
- Ownership of, or substantial interest in, a company which is a competitor;
- Acting as an unauthorized consultant to a CSHM or Associated Dental Center facility partner or vendor.

IX. AVOID ILLEGAL OR QUESTIONABLE GIFTS OR FAVORS

As long as the interaction does not violate the recipient's or CSHM's policy, it is an acceptable practice to provide meals, refreshments, and continuing professional education seminars and materials of reasonable value in conjunction with business and professional discussions of mutual benefit with non-governmental personnel.

CSHM and Associated Dental Centers have placed annual limits on the amounts of gifts, which may be given or received by CSHM or Associated Dental Centers employees acting on either company's behalf. CSHM and Associated Dental Centers

have also developed a specific detailed policy on gifts of which all CSHM or Associated Dental Center employees should be aware. The giving or acceptance of gifts or incentives that violate the federal anti-kickback statute or similar state or federal laws or regulations is prohibited. Such incentives may include, but are not limited to, the provision of discounts or rebates for items or services, which may be billed to Medicare or Medicaid. You should contact your Center's Compliance Liaison, CSHM's Senior Vice President, Compliance, [redacted] or call the Ethics and Compliance Hotline [redacted] if you have any concerns or questions about this policy.

Federal, state, and local government departments and agencies are governed by laws and regulations concerning acceptance by their employees of entertainment, meals, gifts, gratuities, and other things of value from companies and persons with whom these departments and agencies have business relations or over whom they have regulatory authority. All personnel must comply with all applicable laws and regulations. You should contact CSHM's Senior Vice President, Compliance, [redacted] if you have any questions about these laws or regulations.

X. USE ETHICAL MARKETING AND ADVERTISING PRACTICES

Neither CSHM nor Associated Dental Centers engage in illegal or unethical marketing or advertising practices. Under no circumstances may an individual offer or provide a gift or business courtesy to a patient referral source in an attempt to influence the referral of patients or business to any Associated Dental Center. Further, high-pressure marketing or improper soliciting or advertising of unnecessary services is not allowed.

An employee who is in doubt about whether a situation involving the giving or receiving of something of value is acceptable, should ask his or her supervisor, or CSHM's Senior Vice President, Compliance, [redacted]

XI. MAINTAIN INTEGRITY WITH OUTSIDE AGENTS, CONSULTANTS AND VENDORS

Business integrity is a key standard for the selection and retention of individuals and entities that represent CSHM and Associated Dental Centers. Agents, representatives, consultants or vendors should be made aware of CSHM's and Associated Dental Centers' policies and procedures and should be encouraged to follow our Code of Conduct. Some specific examples of inappropriate, and often illegal, conduct that will not be tolerated include: paying bribes or kickbacks; engaging in industrial espionage; obtaining proprietary or confidential data of a third party without authorization; and gaining inside information or influence. Such actions could give such individuals, entities, CSHM or Associated Dental Centers an unfair competitive advantage, and they could result in various violations of law. We only obtain information about other organizations, including our competitors, through legal and ethical means such as public documents, public presentations and other published or spoken information.

We do not obtain proprietary or confidential information about a competitor through illegal means. Nor do we seek proprietary or confidential information when doing so would require anyone to violate a contractual agreement, such as a confidentiality agreement with a prior employee or employer. Such unethical and/or illegal actions will not be tolerated and will result in disciplinary action up to, and including, separation from employment or termination of any applicable relationship with CSHM or Associated Dental Centers.

XII. FOLLOW THE LAW AND USE COMMON SENSE IN POLITICAL CONTRIBUTIONS AND ACTIVITIES

While CSHM and Associated Dental Centers promote individual involvement in the political process, endorsement of candidates for public offices by employees during office hours is prohibited.

XIII. CAREFULLY BID, NEGOTIATE, AND PERFORM CONTRACTS

CSHM complies with the laws and regulations that govern the acquisition of goods and services. CSHM competes fairly and ethically for all business opportunities.

CSHM employees involved in proposals, bid presentations, or contract negotiations, must be certain that all statements, communications, and representations to prospective clients are accurate and truthful. Once obtained, all contracts should be performed in compliance with the terms of the contracts. Please contact CSHM's AVP, Legal, [redacted] if you find that you are unable to perform a contract in compliance with its terms.

XIV. PROTECT PROPRIETARY INFORMATION

Proprietary information may not be disclosed to anyone without proper authorization. CSHM and Associated Dental Centers employees and affiliates should keep proprietary documents protected and secure. In the normal course of business activities, vendors, facilities, and competitors may sometimes divulge information that is proprietary to their business; these confidences should be respected.

XV. USE ORGANIZATION ASSETS WISELY

Proper use of CSHM and Associated Dental Centers property is the responsibility of each entity's employees. Each such employee should use and maintain these assets with the utmost care and respect, and should guard against waste and abuse. Employees should be cost-conscious and alert for opportunities to improve performance while reducing costs. The use of organization time, material, or facilities for purposes not directly related to CSHM or Associated Dental Centers business is prohibited. The removal or borrowing of company property without a supervisor's permission is also prohibited. Employees of CSHM and Associated Dental Centers

are responsible for complying with the requirements of software copyright licenses related to software packages used in fulfilling job requirements.

XVI. COOPERATE WITH GOVERNMENT INVESTIGATIONS

CSHM and Associated Dental Centers, as well as their employees and agents, shall cooperate fully, to the extent required by law, with all official government investigations. CSHM and Associated Dental Centers have an obligation to protect the privacy of patients and the confidentiality of their records. Accordingly, the response to any investigation should be timely and appropriate.

Any employee of CSHM or an Associated Dental Center who is approached by a person identifying him or herself as a government investigator shall *immediately* contact his or her Center's Lead Dentist or Compliance Liaison, CSHM's Senior Vice President, Compliance, [redacted] or CSHM's AVP, Legal, [redacted]. The same procedure should be followed if an employee of CSHM or Associated Dental Center receives a subpoena or any other written request for information from a government representative, entity or agency. It is essential that such communications receive a prompt and appropriate response. CSHM's Senior Vice President, Compliance, CSHM's Manager, Legal, and/or the Dental Center's Compliance Liaison shall assist the employee in following the proper procedure for cooperating with the investigation.

CSHM and Associated Dental Center employees or their agents *shall not*:

- Destroy or alter any records in anticipation of a request for the document or record by a government agency or court;
- Lie or make false or misleading statements to any government investigator or court; or
- Attempt to persuade any other employee or agent to make false or misleading statements.

In the event that government agents appear with a search warrant, employees should be professional and polite with the agents at all times. Nothing should be done to interfere with a search even if what is taking place is viewed as improper. Do not obstruct or impede the search, but also do not give "consent" to search. If agents ask for consent to search or seize anything, inform them that you do not have the authority to provide consent for the search or seizure of anything. Only the Center owner(s) have the authority to consent to a search.

XVII. LICENSE AND CERTIFICATION RENEWALS

Persons who are required to maintain professional licenses, certifications, or credentials must maintain these items in a current and up-to-date status while complying with all pertinent federal, state, or local requirements governing their field of expertise. CSHM and/or Associated Dental Centers require proof of current

professional licenses, certifications, or credentials or the intent to obtain them within an appropriate timeframe. No persons requiring a professional license, certification, or credential will be allowed to perform their job duties or contracted assignments until such time he/she meets this requirement.

Employees shall immediately advise their Office Manager, Regional Manager, or CSHM's Director, Licensing and Credentialing at [redacted] if any action is taken which suspends, adversely impacts or limits their license or credentials.

XVIII. HIRING OR RETENTION OF EXCLUDED INDIVIDUALS OR ENTITIES

CSHM and Associated Dental Centers will not knowingly hire, retain, employ or contract with any individuals or entities that have been excluded from participation in any government program. Nor will we knowingly conduct business or continue to conduct business with any individuals or entities, whether independent contractor, subcontractors, suppliers, or vendors, who have been excluded from participation in any government program.

XIX. COMPLIANCE WITH ANTITRUST LAWS

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. CSHM and Associated Dental Centers are committed to compliance with antitrust laws and regulations.

Antitrust laws prohibit agreements or actions that may illegally restrain trade or reduce competition. Examples of activities that violate these laws include, but are not limited to, agreements among competitors to

- fix or stabilize prices;
- allocate patients;
- refrain from competing in certain geographic areas;
- refrain from accepting patients from certain geographic areas;
- refrain from accepting patients with certain insurance.

Antitrust laws also prohibit inappropriate exclusive dealings, and boycotts of specified suppliers or customers. Antitrust laws could be violated by discussing CSHM or Associated Dental Centers business with a competitor, such as disclosing the terms of supplier relationships or labor costs. In general, avoid discussing sensitive topics with competitors or suppliers, unless you are proceeding with the advice of company counsel. Also, do not provide any information in response to oral or written inquiry concerning an antitrust matter without first contacting CSHM's AVP, Legal, [redacted]

XX. REPORT CONCERNS PROMPTLY

All CSHM and Associated Dental Centers employees have a responsibility to immediately report credible allegations of patient harms. Further, all CSHM and Associated Dental Centers employees have a responsibility to report any concerns about actual or potential violations of applicable laws, rules and regulations or any CSHM policy or procedure, including all applicable state dental board requirements, all applicable Federal and state health care program requirements or any part of this Code of Conduct, including, but not limited to, deviations from professional standards of health care including AAPD guidelines. Reports of suspected violations shall be made to the Associated Dental Center's Compliance Liaison, the Center's Regional Manager, CSHM's Senior Vice President, Compliance, other member of CSHM Senior Management, any member of CSHM's Ethics and Compliance Committee, the Ethics and Compliance Hotline, or other appropriate manner within 30 days of the CSHM or Associated Dental Center employee's credible suspicion or actual knowledge of a violation. All reports shall be complete, full, and honest. Failure to report knowledge of actual wrongdoing is a serious offense, which could result in disciplinary action up to, and including, separation from employment.

CSHM policy prohibits retaliation against or harassment of employees who report suspected wrongdoing.

Employees are encouraged to communicate their concerns directly with their Center's owner(s) or Compliance Liaison, CSHM's Senior Vice President, Compliance or any member of CSHM's Ethics and Compliance Committee. A current list of compliance committee members is posted in each Center's break room. Concerns may also be reported to the Ethics and Compliance Hotline [redacted] Ethics and Compliance Hotline calls may be reported anonymously 24 hours per day, 7 days per week. Although callers to both the internal number and the hotline may remain anonymous, please remember that, to enable a thorough investigation, you are encouraged to disclose as much information as possible, including names. Reports through any mechanism shall remain confidential to the fullest extent possible or as permitted by law.

XXI. CONCLUSION

These principles form the basis for our commitment to ethical behavior that complies with all legal requirements. However, we cannot include in this document every legal or ethical issue that may arise. You must also use your own judgment. If you have a concern about a legal or ethical issue, please report it to your supervisor. If your supervisor does not provide you with a satisfactory response in a reasonable amount of time, please raise your concern to the Dental Center owner. Additionally, you may contact the CSHM Compliance Office at [redacted] or you may call the toll-free Ethics and Compliance Hotline at [redacted] staffed by an outside service to receive reports. This hotline is available to you 24 hours a day and 7 days a week.

ACKNOWLEDGEMENT and CERTIFICATION

I hereby certify that I have received, read, and understood CSHM's and Associated Dental Centers' Code of Ethics and Business Conduct. I agree to abide by its content.

For the good of the Dental Center's patients, fellow employees, and CSHM and the Associated Dental Center, I promise to report any future concerns about any behaviors or practices that may be in conflict with this Code of Ethics and Business Conduct to the appropriate individuals, as identified in this Code of Ethics and Business Conduct.

Signature: _____

Printed Name: _____

Associated Dental Center Name and Location: _____

_____

Date: _____

EXHIBIT 18

4/13/2011 Daily Patient Flow

	Total Appointments Scheduled			Patient Visits				Broken Appointment Ratio			New Patients Scheduled			New Patients Seen		
	Daily	MTD Avg.	YTD Avg.	Daily	Budget	MTD Avg.	YTD Avg.	Daily	MTD Avg.	YTD Avg.	Daily	MTD Avg.	YTD Avg.	Daily	MTD Avg.	YTD Avg.
Syracuse, NY	117	132	136	46	64	61	60	61 %	54 %	56 %	2	6	8	6	7	7
Rochester, NY	138	133	136	67	83	61	65	54 %	55 %	53 %	9	14	11	11	9	8
Albany, NY	64	54	61	25	42	26	28	61 %	53 %	55 %	7	4	5	7	3	4
Richmond, VA	54	54	64	24	43	32	35	56 %	42 %	46 %	0	5	5	4	5	4
Roanoke, VA	172	177	185	87	102	93	96	49 %	47 %	49 %	8	15	15	17	14	13
Baltimore, MD	100	108	115	54	54	53	54	46 %	51 %	54 %	12	11	9	10	7	7
Washington, DC	154	163	185	79	93	74	82	51 %	57 %	58 %	22	19	20	13	14	14
North Baltimore, MD	105	90	99	49	55	52	51	54 %	43 %	49 %	6	11	11	7	10	8
Manassas, VA	64	73	88	32	45	41	45	52 %	47 %	50 %	6	9	10	6	9	9
Oxon Hill, MD	127	152	158	74	68	70	71	43 %	56 %	57 %	11	10	11	6	9	9
DC 2, DC	75	77	76	31	55	33	33	59 %	58 %	58 %	19	25	29	23	20	20
SubTotal: East SubRegion	106	110	119	52	64	54	57	53 %	51 %	53 %	9	12	12	10	10	9
SubTotal: North/Eastern Region	112	116	119	55	64	59	58	51 %	49 %	52 %	10	11	11	9	10	9
Total All Clinics	111	113	116	58	64	59	59	48 %	48 %	49 %	10	10	11	9	9	8

EXHIBIT 19

Table 1 cont. Guidelines for Prescribing Radiographs in the Pediatric Patient[1,2,3]

11.	Developmental or acquired disability
12.	Xerostomia
13.	Genetic abnormality of teeth
14.	Many multisurface restorations
15.	Chemo/radiation therapy
16.	Eating disorders
17.	Drug/alcohol abuse
18.	Irregular dental care

Source: American Dental Association, U.S. Food and Drug Administration. The selection of Patients For Dental Radiograph Examinations. Available at: www.ada.org

needed to successfully take the radiograph. The child is seated in the parent's lap with the parent resting their arms around the child's upper body and their legs wrapped around the child's lower body. Not only does this provide additional emotional security for the child and, thus, increased cooperation but also enables the parent to adequately restrain child should there be any unexpected sudden movements.

Obtaining the least difficult radiograph first (such as an anterior occlusal) desensitizes the child to the procedure. Since many children have difficulty keeping the film in their mouth for extended periods of time, be certain the correct settings are made on the apparatus and the x-ray head is properly positioned before placing the film in the child's mouth. A positioning device such as a Snap-A-Ray can be used to aid the parent in positioning and securing the film. Be sure to adequately protect the parent and child with lead aprons to reduce radiation exposure. (Figures 3 & 4)

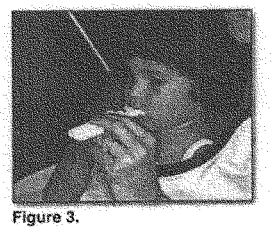


Figure 3.

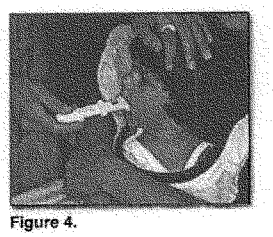


Figure 4.

If the child is uncooperative, then additional restraint by a second adult may be necessary to successfully obtain the radiograph. With the first adult restraining the child as described previously, a second adult stabilizes the child's head with one hand while the other hand positions the x-ray holder in the patient's mouth. Under no circumstances should staff be asked to perform this task.

If a second adult is not available, it may be necessary to place the child in a mechanical restraining device (Papoose Board) to adequately restrain the child. This frees the parent to stabilize the child's head and properly position the radiograph in the child's mouth. (Figures 5 & 6)

If the child is still too uncooperative, it may be necessary to manage the child pharmacologically with inhalation, oral, or parental sedatives. (Figure 7)

Older children may also be uncooperative for a variety of reasons. These can range from the jaw being too small to adequately accommodate the radiograph, fear of swallowing the radiograph,

EXHIBIT 20

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted] J.D.
Compliance Officer
FORBA Holdings, LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor
FORBA Holdings, LLC

Clinic Report
Phoenix, Arizona

Deliverable #1-13

December 23, 2010

Executive Summary

Introduction

The Office of Inspector General (OIG) and FORBA Holdings, LLC (FORBA), a Tennessee corporation, on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that FORBA would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Children's Medicaid Dental Clinic, P.C. (d/b/a Small Smiles Dental Centers of Phoenix), 5115 West Thomas Road, Phoenix, Arizona 85031 (Clinic).

Overall Clinic Impression

The staff members were accommodating and made efforts to provide copies of requested documents in a timely fashion. The Clinic was well-kept.

Overall Summary of Critical Findings and Observations

The Monitor conducted an on-site review that was comprised of patient treatment observations, patient record reviews, document reviews, and interviews. The following highlights the Monitor's critical findings and observations for this Clinic.

Two manuals, the *Patient Care Manual* and the *Infection Control Manual,* were introduced into this Clinic during the past quarter. The *Patient Care Manual* was not being used by staff members and there had been no training on the contents or use of this manual. Conversely, the *Infection Control Manual* has a sign-in sheet at the back of the manual indicating that all staff had read it; staff interviews revealed that discussions if its content had occurred within the Clinic; and two new procedures had been implemented as a result of the new manual.

There was one adverse event reported with respect to this Clinic. It was included in the *Center Adverse Event Log.* The *Adverse Event Disclosure Log* reflected that two individuals had requested to see the log in September 2010.

The operative procedures forms (Op Sheets) did not document the Dose Calculated for Patient's Weight (DCPW) in the local anesthesia section. Instead of filling in the maximum amount of local anesthetic calculated, the dentists placed a check mark on the line designated DCPW to indicate that it had been calculated on the Local Anesthetic Calculation Worksheet, which is contained in the record. In addition, it is unclear what methodology should be used in calculating the maximum dosage or whether alternative methodologies are acceptable. The *Clinical Coordinator's Manual* sets forth one method for calculating the maximum dose of local anesthesia using a worksheet to be included in the patient record. Alternatively, the more recent *Patient Care Manual* sets forth a method for this calculation using a chart that is available in the Clinic. Neither manual references both methods, yet an e-mail from FORBA indicates either method is acceptable.

Stabilization is not being documented in the Account History. Without this record of stabilization in the Account History, FORBA cannot accurately monitor the use of stabilization in this Clinic.

The Monitor's review of patient records revealed that many primary teeth were receiving pulpotomies when, radiographically, the caries did not appear to be close enough to the pulp to warrant such treatment. In an interview with the Lead Dentist, the Monitor brought charts demonstrating the questionable lesions for discussion. Several charts involved primary anterior teeth, and the Lead Dentist told the Monitor that she automatically performed pulpotomies on all primary anterior teeth receiving NuSmile Crowns. The Lead Dentist expressed belief that the amount of tooth structure removal necessary to prepare the teeth for the crowns endangered the pulp and necessitated pulpotomies. She also believed the DVD from the manufacturer, with instructions to users, directed her to perform "pulp therapy" for these teeth. The Monitor viewed the manufacturer's DVD with the Lead Dentist, and the DVD stated that the amount of tooth structure removed could occasionally result in pulp exposure, but did not direct the user to automatically perform pulpotomies. The issue of how close the caries had to be to the pulp to make it medically necessary to perform pulpotomies remained unresolved, and the Monitor and the Lead Dentist agreed that FORBA's Chief Dental Officer should be included to resolve this issue.

Findings related to the methods employed for pain management in this Clinic are as follows:

- The full range of behavior management tools available were not being used and children became hysterical during treatment. For example, behavior management tools that can be used include distraction during local anesthetic injections, through lip shaking and verbal communication; tell, show and do; positive reinforcement; and basic communication with the children during the entire appointment. The Monitor recognizes that many of these children only speak Spanish, complicating communication between the dentist and child. Many techniques are nonverbal, however, and therefore the language barrier is less of an obstacle. In addition, while the Monitor observed nitrous oxide/oxygen analgesia being used a couple of times, it could be used more often as a behavior management tool.
- The Monitor observed that practitioners did not confirm that patients had profound anesthesia of areas to be treated before beginning treatment. Tools are available to make that determination. It was very difficult to determine whether the children the Monitor observed were crying and hysterical because treatment hurt or because they were frightened. One cannot be assured that because local anesthetic was administered, it was effective.
- The Monitor observed that the oral mucosa was not being dried prior to application of topical anesthetic in preparation to administer local anesthetic. In addition, the topical anesthetic was not left in place for one minute to achieve maximum effectiveness. According to the *Clinical Policies and Guidelines for*

FORBA Associated Clinics, Local Anesthetic Guidelines, page 16: "Topical anesthetic should be applied to dried mucosa, and should be given time to be effective."

Overall Summary of Recommendations

Set forth below is a summary of the recommendations contained in the report:

- Develop a methodology to ensure that individuals understand and implement FORBA policies and procedures.
- Ensure that all manuals, policies, and procedures are current and old policies are removed.
- Update the *Clinical Coordinator's Manual* Formulary to reflect the correct percentage concentration of the formocresol.
- Clarify the *Clinical Coordinator's Manual* and the *Patient Care Manual* to reflect that there are alternative methods to calculate the maximum dose of local anesthesia.
- Ensure all staff members have received the required training pursuant to the CIA.
- Ensure appropriate staff members have received training on the Patient Care Manual.
- Ensure that the billing issue identified in the August chart audit has been resolved.
- Better define the roles of the Compliance Liaison, the Clinical Coordinator, and the Lead Dentist, with respect to monitoring the day-to-day compliance activities, specifically to ensure that new policies and procedures are disseminated to appropriate personnel.
- Ensure staff members review the HIPPA form with the parent/guardian and verify the correct completion of each section of the form.
- Ensure staff members are documenting which hygiene procedures they performed by their signature at the bottom of the Hygiene Procedures form.
- Ensure staff members document existing conditions and restorations on the upper odontogram of the Tooth Chart.
- Ensure staff members are recording decay on the upper portion of the tooth chart to document the medical necessity of treatment.
- Ensure staff members are verifying that treatment provided on the Op Sheet matches the documentation on the tooth chart and the treatment plan.
- Ensure staff members are correctly labeling X-rays and including the date of exposure.
- Ensure staff members are completing all documentation related to stabilization on the Op Sheet as well as the back of the Consent for Stabilization form.

- Ensure staff members are keeping appointment times under one hour, especially when providing treatment with a stabilization device.
- Ensure front office staff members are verifying when stabilization is used and recording the code for stabilization in the patient's Account History.
- Ensure front office staff members are using the correct codes when billing, and that the billing errors for patients #005 and #009 are corrected.
- Ensure staff members are documenting the local anesthesia DCPW, dose, and location information on the Op Sheet.
- Ensure the *Restorative Dentistry Checklist* is completed correctly.
- Determine why consent is being obtained for nitrous oxide/oxygen analgesia and yet not being used.
- Provide additional training for the dentist and staff about behavior management with particular emphasis on injection techniques with young children and techniques to determine the adequacy of anesthetic.
- Request that the Chief Dental Officer review patient records of children receiving NuSmile crowns to allow his input about whether the routine use of pulpotomies is warranted. Provide the Chief Dental Officer with the records reviewed with the Lead Dentist during the on-site to allow his input about whether the caries were close enough to the pulp to warrant pulpotomies.
- Provide additional training and oversight to ensure that the *Restorative Dentistry Checklist* is being completed prior to treatment.
- Provide additional training on the technique for placement of topical anesthetic in preparation for administering the local anesthetic injections so that it is in compliance with the *Clinical Policies and Guidelines for FORBA Associated Clinics*, under Local Anesthesia Guidelines, Injection technique.

Clinic On-site Report

Introduction

The Office of Inspector General (OIG) and FORBA Holdings, LLC (FORBA), a Tennessee corporation, on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that FORBA would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Children's Medicaid Dental Clinic, P.C. (d/b/a Small Smiles Dental Centers of Phoenix), 5115 West Thomas Road, Phoenix, Arizona 85031 (Clinic).

Implementation

The OIG approved an unannounced on-site visit to be conducted from December 8-10, 2010, at the Clinic. Immediately prior to arrival at the Clinic, [redacted], FORBA Compliance Officer, was called and informed of the Monitor's impending visit.

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. Staff members promptly provided copies of items requested by the Monitor. The Clinic was well-kept.

Entrance Conference

An entrance conference was held on December 8, 2010. The Monitor Team of [redacted], RDH, and [redacted], DDS, attended and Clinic staff members [redacted], Office Manager and Compliance Liaison, and [redacted], DMD and Lead Dentist, attended. An overview of the process was discussed, including the point of contact information, the intent to conduct treatment observations, and the need to interview individuals employed by the Clinic.

General

The testing attributes in this section are designed to ensure that the required personnel and notifications are present in the Clinic as required by the CIA and FORBA policies and procedures. The relevant findings are as follows:

- The Clinic has a designated Compliance Liaison, as required by the CIA, Section III.A.3.
- Two posters are displayed in the waiting room titled *The Small Smiles Pledge to Children, Families & Communities* (one in English and one in Spanish). The posters contained content as required in the CIA, Section III.A.4, to reflect "FORBA's commitment to ensuring that all dental services and items provided meet professionally recognized standards of care." As required by the CIA, Section III.B.2.m, both posters included contact information for filing or

registering a complaint with the parent compliance hot line, the Arizona State Dental Board, and the OIG.

- A sign in the waiting room in English and Spanish indicates that parents have a right to accompany their child in the treatment area.
- An *Ethics and Compliance Hotline* poster, with a toll-free phone number, is displayed in the employee break room. The poster indicates that callers may choose to remain anonymous when calling and that there will be no retribution toward anyone who reports a suspected violation in good faith, as required by the CIA, Section III.F. It also contained the phone number for the Arizona State Dental Board.
- A current *Quality of Care Dashboard* was not posted in the break room. The dashboard was dated August 2010. During the exit conference, the Monitor was informed it had been updated during the Monitor's visit. The Monitor validated this after the exit conference.
- A list of current compliance committee members is in the break room, as required by FORBA's *Code of Ethics and Business Conduct*. It was updated in October 2010 to reflect the change in the composition of the compliance committee.
- Health Insurance Portability and Accountability Act (HIPAA) signs and forms are in English and Spanish.
- Individuals interviewed were able to name the Compliance Officer.

Review of Quality Control System

The testing attributes in this section are designed to determine whether the clinical policies and procedures are up to date and distributed; whether the *Code of Ethics and Business Conduct* has been signed by each employee; whether required training has been conducted; whether internal audits were performed; whether the Clinic provided a timely and appropriate response to any internal audit findings; and how complaints were handled at the Clinic-level.

Policies and Procedures

The CIA, Section III.B, requires that a code of conduct and specific policies and procedures be developed and implemented. The relevant findings are as follows:

- Each employee signed the acknowledgement and certification related to FORBA's *Code of Ethics and Business Conduct* with the exception of one dentist. For this dentist, documentation was produced that he signed a different Code of Conduct that preceded the date of the CIA.
- The Code of Conduct Acknowledgement and Certification was updated in accordance with the OIG's request.
- The *Policy and Procedures for FORBA Associated Dental Centers* notebook includes the *Clinical Policies and Guidelines for FORBA Associated Dental Centers*.

- Two new policies titled *Documentation of Intracoronal Restorations* and *Patient Identification Policy* and dated November 1, 2010, were provided to the Monitor upon request. Included in the materials provided was an October 28, 2010, e-mail, transmitting these policies to the Clinic. This e-mail stated that further clarification about where these policies should be stored would be forthcoming. On November 24, 2010, direction was provided to the Clinic to place these policies in the *Policy and Procedures for FORBA Associated Dental Centers* manual, but they had not yet been included.
- The Monitor was provided a *Compliance and Ethics Signature Sheet for Receipt/Review of Policies*. This document was signed by all employees and states: "I have received and reviewed the policies. I am aware of where I can find them should I need to review them at other times." There was a date indicating it was faxed on May 25, 2010, which means it was completed prior to this date.

- The *Operations and Human Resources Manual* is present in the Clinic and contains a *Code of Ethics* different from the *Code of Ethics and Business Conduct* set forth in the *Office Manager's Manual*.
- The *Infection Control Manual* was present in the Clinic. A staff member reported that the policy related to maintenance of the water lines represented a new procedure and, as a result, changes were made in the manner that these lines were maintained. In addition, staff members reported a new procedure being implemented to clean the consult rooms. This evidenced both knowledge and implementation of new policies.
  - There was a sign-in sheet in the notebook indicating that staff members were trained on the contents of the manual
  - Replacement sheets for C-5, C-7, C-19, and C-27 were in the manual and the old pages were in the back of the notebook.
- The *Patient Care Manual* was present in the Clinic.
  - The Clinical Coordinator reported that there had been no training related to this manual and that they had not yet read it.
  - The Manual contained examples of forms that have been replaced with newer forms, such as the *Hygiene Procedures* form, *Odontograms Chart*, *Operative Procedures* form, and the *Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian* (HIPAA form).
- The *Clinical Coordinator's Manual* was present in the Clinic.
  - *The Clinical Coordinator's Manual* contained an *Acknowledgment and Certification*, signed by the Clinical Coordinator on August 12, 2010.
  - The *Clinical Coordinator's Manual* does not contain an update to the formocresol ("Formo") to reflect the correct percentage in the formulary. The correct order number for formocresol for the 19 percent concentration is 1001391, but the manual contained order number 3121480.

- The *Clinical Coordinator's Manual* contains the *Local Anesthetic Calculation Worksheet*. This form, however, is not included in the *Patient Care Manual*, which reflects the process of utilizing the *Local Anesthetic Calculation Chart* posted in the Clinic. An e-mail, dated December 5, 2010, from [redacted] to the Office Managers, Lead Dentists, Clinical Coordinators, and Assistant Office Managers, indicated that there is a choice in which method can be used to calculate the maximum dose for patients.

- The *Office Manager's Manual* contains the *Office Manager's Manual Review Acknowledgement* form signed by the Office Manager and dated September 2, 2010.
  - The notebook contains the policy updates from July 26, 2010, and September 16, 2010; however, some of the old policies, such as *Non-Covered Services Billing Policy and Procedure* and *Parent Notification and Adverse Event Policy* remain in the binder, which can cause confusion as to which policy to reference.
  - The *Chart Audit Policy* is not the most recent version. A more recent version, dated May 20, 2010, is attached to the Lead Dentist's contract with FORBA. The Monitor also received another version, dated November 15, 2010. This was provided to the Clinic on November 24, 2010. The Compliance Liaison reported that this had not yet been included in the Office Manager's Manual because she is awaiting training.
- The Clinic is utilizing the new form titled *Restorative Dentistry Checklist* dated October 22, 2010.

Training

The CIA, Section III.C.1, requires two hours of general training related to the CIA requirements and FORBA's Compliance Program. This training must be performed within 90 days of the effective date, or 90 days after becoming a "covered person," whichever is later. In addition, three hours of "Clinic Quality Training" are required for each "Clinical Quality Covered Person." This training must be delivered within 10 days after the start of employment, or within 90 days after the effective date, whichever is later. The relevant findings are as follows:

- Documentation provided indicates the hourly training requirements of the CIA are met.
- Documentation supports that all employees who were on staff in January 2010 received training related to the CIA and FORBA's Compliance Program within the required time frames. Documentation also supports that all employees who were on staff in January 2010 received the *Clinic Quality Training* within the required time frames. There is no supporting documentation that employees who were hired after the initial January training received the training related to the CIA, FORBA's Compliance Program, or the *Clinic Quality Training*.
- Staff members reported periodic trainings on clinical and other issues are typically performed through webinars. Recent examples were provided, such as

a webinar related to chart documentation with a focus on the treatment sheet provided on December 2, 2010, and a webinar on October 28, 2010, related to the new *Restorative Dentistry Checklist* and the *Patient Identification Policy*.

- Staff members interviewed indicated there are no post tests or other mechanisms employed to determine if the material has been understood.
- Staff members were asked to read the *Infection Control Manual* and it was discussed as a group.
- Staff members reported they have not been trained on the new *Patient Care Manual* or the proper use of the *Restorative Dentistry Checklist*; however, the Monitor was provided an e-mail indicating a "Mandatory clinical staff Webinar Meeting" was held on October 28, 2010. This checklist was identified as part of the agenda.

Internal Audits

The CIA, Section III.B.2, requires FORBA to install measures designed "to promote the delivery of patient items or services at FORBA and FORBA facilities that meet professionally recognized standards of health care, including but not limited to appropriate documentation of dental records, including radiographs or digital photos consistent with professional recognized standards of health care." One of the required policies is a periodic audit of clinical quality. FORBA has developed a *Chart Audit Policy* that governs the process for chart audits by FORBA. The relevant findings are as follows:

- FORBA was compliant to date with its Chart Audit Policy for this Clinic. The policy requires each Associated Dental Center to receive four quarterly chart reviews consisting of five patient charts per dentist. The Monitor requested all chart audits from January 15, 2010, to present. The Clinic underwent an audit in February, May, August, and November 2010.
- The *Attestation Letter for Chart Review* for the August and November audits was provided. An attestation was not required at the time of the February audit. In addition, an attestation was not required for the May audit because FORBA personnel were on site supervising the copying of files. Beginning July 17, 2010, however, an attestation is required even if FORBA personnel are on site for the chart audit.
- The overall score for the Clinic for each of the audits completed was 90 percent or above and, therefore, no Corrective Action Plan (CAP) was required for the Clinic. The results of the November audit had not yet been provided.
- E-mails indicated billing issues were corrected within the 15 days required by the *Chart Audit Policy, Appendix "B" Audit Policy: Quarterly Audit Process and Procedures,* with the exception of one billing issue. The August chart audit identified a pulpotomy documented on the Account History but not documented on the Op Sheet as being performed by the Lead Dentist on April 8, 2010. The Office Manager could not find the pulpotomy on the Account History and

requested clarification. There is no documentation responding to her request and, therefore, it is uncertain whether this issue was resolved.

- One dentist had a failing score for the February chart audit. There was no follow-up CAP because he is no longer employed at the Clinic.

Complaints

The CIA, Section III.B.2.g, requires that "compliance issues are promptly and appropriately investigated" and, if substantiated, that FORBA implement "effective and timely corrective action plans" and monitor compliance with such plans. In addition, the CIA, Section III.D, requires the establishment of a disclosure program that includes a mechanism to enable individuals to disclose any issues in an anonymous manner. Finally, the CIA, Section III.A.4, requires the creation of a parent compliance hot line. Two FORBA policies address complaints: *Disclosure Program and Policy* and *Patient Advocate Policy and Procedure*. As noted above, these policies were present in the Clinic. The relevant findings are as follows:

- Interviews revealed that staff members generally defined a complaint as any complaint, comment, or concern.
- Staff members interviewed articulated the existence of the employee hot line and that complaints can be made anonymously.
- Staff members interviewed indicated that if they receive a complaint from a parent, they try to resolve it and inform either the dentist involved or the Office Manager. The Compliance Liaison reported she would inform the Lead Dentist and then the FORBA Compliance Officer, the Patient Advocate, the Senior Vice President of the Southwest Region, and the Regional Manager of any adverse event.
- There was one adverse event reported with respect to this Clinic. It was included in the *Center Adverse Event Log.*
- Complaints were received from parents in response to follow-up calls to the "Net Promoter Score System (NPS) Survey," anonymously, and from the Office Manager. The complaints are documented, investigated, and CAPs were implemented where appropriate. One complaint, received July 30, 2010, related to a dentist suctioning a runny nose. In response, the Chief Dental Officer issued a Best Practice E-mail on August 3, 2010, and stated: "Don't do it."

Recommendations

- Develop a methodology to ensure that individuals understand and implement FORBA policies and procedures.
- Ensure that all manuals, policies and procedures are current and old policies are removed.
- Update the *Clinical Coordinator's Manual* Formulary to reflect the correct percentage concentration of the formocresol.

- Clarify the *Clinical Coordinator's Manual* and the *Patient Care Manual* to reflect that there are alternative methods to calculate the maximum dose of local anesthesia.
- Ensure all staff members have received the required training pursuant to the CIA.
- Ensure appropriate staff members have received training on the Patient Care Manual.
- Ensure that the billing issue identified in the August chart audit has been resolved.

Review of Communication System

The testing attributes related to the communication system were designed to determine whether the communication system is effective. The CIA, Section III.E.I, states that the Monitor shall determine whether the "communication system is effective, allowing for accurate information, decisions, and results of decisions to be transmitted to the proper individuals in a timely fashion." The relevant findings are as follows:

- The Compliance Liaison has submitted compliance reports quarterly as required by the CIA, Section III.A.2. The adverse event on May 24, 2010, was reported in the second quarter report.
- The Monitor asked the Compliance Liaison to describe her role and responsibilities. She reported that her role is to resolve complaints and, when there is an adverse event, make a report. She reported that in her role to monitor the day-to-day compliance activities, she ensures that the documentation completed by the parents/guardians is complete and correct. She indicated that any issues related to the back office are monitored by the Clinical Coordinator and Lead Dentist. The Compliance Liaison was also able to identify specific forms and policies that she was responsible for disseminating, but further reported that she assumed that the e-mails and other information from the Chief Dental Officer were disseminated by the Lead Dentist. The Lead Dentist reported that she believed these were disseminated by the Compliance Liaison.
- There are no regular morning huddles; instead, the staff meets on an as-needed basis for announcements of new forms, policies, procedures, or manuals.

The CIA, Section III.B.2.m, requires FORBA to design measures to collect reports relating to patient care incidents, injuries, abuse, and neglect and to inform patients when a substantiated incident of patient harm occurs at the facility. The CIA, Section III.B.2.10, requires a policy related to parental accompaniment. FORBA policies allow patients, parents, and guardians to provide feedback using an "NPS parent survey" completed at the end of the visit. The survey asks the person completing it whether he or she can be contacted. In addition, communication between the Clinic and patients, parents, and guardians is facilitated by preprinted Parent Comment Cards, a parent hot line, e-mails, and the option to report issues to a staff member. FORBA's *Parent Notification and Adverse Event Policy* is designed to inform patients, parents, and legal guardians of substantiated incidents of patient harm. In addition, FORBA's *Parent*

Absence/Presence Policy is designed to ensure parents and guardians have a right to accompany children into treatment. The relevant findings are as follows:

- Staff members articulated the correct policy on informed consent and that a parent or guardian can accompany children into treatment.
- The "NPS parent survey" is available at the checkout desk. The response rate for the week ending December 3, 2010, indicated that the Clinic had a year-to-date response rate of 97 percent.
- Preprinted Parent Comment Cards in English and Spanish were available to the parents at the checkout desks.
- A sign informs parents of their right to accompany the child in the treatment rooms. The most recent October *Smile Factor Snapshot*, which records the results on a Clinic-level from the "NPS parent survey," indicates that 100 percent of the respondents were aware that they could accompany their child during treatment and 66.7 percent of the respondents chose to accompany their child. Each of the staff members interviewed articulated that the Clinic's policy allowed a parent to accompany the child into a treatment room or the hygiene bay.
- The *Smile Factor Snapshot* also rates the Clinic on other factors, such as ease of scheduling, cleanliness, demeanor of the staff, wait time, and explanation of paperwork and procedures. For the months of August, September and October, the Clinic received ratings higher than the company average with the exception of a September score related to whether the dentist was cheerful and friendly. For this factor, the Clinic received a rating of 3.0 (the highest rating is 5.0).
- The Clinic has a *Center Adverse Event Log*, which documented the one adverse event reported at this Clinic. Notification of the existence of this log is located on the Health History form. The *Adverse Event Disclosure Log* indicates two individuals asked to review the *Center Adverse Event Log* in September 2010.
- There are several staff members who serve as translators for Spanish-speaking individuals. There is also a staff member who serves as a translator for Vietnamese-speaking patients.
- Education materials are readily available in English and Spanish.
- Staff members interviewed report that the dentists present the treatment plans and, when appropriate, provide alternatives to proposed treatment, and the dental assistants obtain the requisite signatures.

Recommendations

- Better define the roles of the Compliance Liaison, the Clinical Coordinator, and the Lead Dentist, with respect to monitoring the day-to-day compliance activities, specifically to ensure that new policies and procedures are disseminated to appropriate personnel.

Review of Dental Record Documentation

The testing attributes related to the dental record documentation were designed to determine whether the documentation was complete and accurate, including HIPAA-related forms, medical necessity, and consent forms. A random sample of 30 visits, representing 30 separate patients and records, was identified from the patient listing provided by the Clinic Office Manager, based on all Medicaid patients seen for operatory visits from July 1, 2010, through December 7, 2010.

Of the 30 operatory visits identified, 9 visits included hygiene procedures. The Monitor's pediatric dentist provided consultation on 11 of the 30 visit records reviewed. In addition, the Monitor's pediatric dentist reviewed 9 of the 30 visit records to determine the quality of the radiographs.

The relevant findings from the review of the 30 visit records are as follows:

- Fourteen records did not have correctly completed HIPAA forms.
- Four records reviewed were missing information on the Health History form.
- The following findings are related to the nine visit records that included hygiene procedures:
  - According to the American Dental Association (ADA), codes 1110 (adult prophylaxis) and 1120 (child prophylaxis) are defined as, "a scaling and polishing procedure performed to remove plaque, calculus, and stains." While a dental assistant may perform coronal polishing, if certified by the Arizona State Board of Dental Examiners, they are not certified to perform scaling and, therefore, billing of a prophylaxis should not occur unless such services are provided by a licensed dental hygienist or dentist.
    - Five records recorded removal of plaque; however, there was insufficient documentation to determine who performed the scaling, polishing, or fluoride application procedures.
    - The record for patient #016 did not document removal of plaque, calculus, or stain; however, billing for a prophylaxis was recorded on the Account History Report.
- Eleven records documented X-rays were taken on the audited date of service; however, all radiographs that applied to the date of service were reviewed by the Monitor regardless of when the X-rays were taken. The following are the Monitor's findings related to diagnostic radiographs:
  - The quality of the radiographs were generally good, even on very young patients; however, some of the bitewing radiographs demonstrated overlapping of tooth contact areas, causing them to be non-diagnostic for interproximal caries.
  - Two records had X-rays that were not labeled with the date of service.

- The record of patient #009 did not document the interpretation of the post-operative peri-apical X-rays on the Tooth Chart or the Operative Procedures form (Op Sheet). Upon review of the X-rays, the Monitor noted evidence of a large radiolucency apical to tooth #K with what appeared to be displacement of teeth #20 and #21. Further review of X-rays taken at previous appointments showed evidence and progression of a radiolucency indicating failure of the pulpotomy previously performed on tooth #K with no documentation of pathology in the patient's record. The tooth buds of #20 and #21 were visible on previous radiographs.
- The duplicate bitewing X-rays, dated August 18, 2010, received for patient #006 were reversed, making it difficult for the Monitor to perform a follow-up review of this record.
- Upon review of the radiographs for patient #010, the Monitor noticed a large amount of residual cement on the distal of tooth #J, which could lead to potential problems. There was no note in the record to address this radiographic finding.

- The following findings are related to documentation on the Tooth Chart:
  - Three records did not correctly document decay on the upper odontogram of the Tooth Chart.
  - Four records did not record all existing conditions and restorations on the upper odontogram of the Tooth Chart.
- Five records did not show medical necessity for the treatment provided:
  - The Monitor's pediatric dentist reviewed the X-rays of patient #001 and did not see sufficient evidence to support the medical necessity for the pulpotomy performed on tooth #T.
  - Patient #005 received an occlusal-buccal (OB) amalgam on tooth #30. There was no documentation of buccal (B) decay on the upper odontogram of the Tooth Chart for tooth #30 and the Treatment Plan did not include consent for the filling performed on the (B) surface.
  - Patient #007 had pulpotomies performed and prefabricated stainless steel crowns with resin placed on teeth #D, E, and F. Upon review of the maxillary occlusal radiograph, the Monitor's pediatric dentist could not determine the medical necessity for the pulpotomy treatment provided to teeth #D, E, and F. Subsequently, there was no digital photograph to further support the medical necessity for the treatment provided.
  - Patient #013 received a pulpotomy and Stainless Steel Crown (SSC) on tooth #L. According to the Monitor's pediatric dentist, the radiograph, dated September 16, 2010, of tooth #L does not show the medical necessity for the pulpotomy performed on that tooth. Upon further review of the patient's record, a very small, shallow distal-occlusal (DO) composite filling on tooth #L

was performed on September 15, 2009. X-rays dated March 3, 2010, showed evidence of the previously placed filling on tooth #L and no documentation of recurrent caries or a faulty restoration. On September 16, 2010, the tooth was diagnosed with DO caries and the treatment plan included SSC with possible nerve treatment. On September 20, 2010, a pulpotomy and SSC were performed on tooth #L with no record of a Prior Service Acknowledgement (PRSA).

- Patient #030 received a facial (F) composite filling on tooth #C. Upon review of the radiographs, the Monitor's pediatric dentist found no evidence of caries and there was no photograph to support the medical necessity for the treatment provided to tooth #C.

- In three records, the *Restorative Dentistry Checklist* did not have the box indicating confirmation of the odontogram checked.
- The following findings are related to documentation on the Op Sheet:
  - A slash was marked in the line designated for break time at the bottom of the Op Sheet making it difficult for the Monitor to determine if there was no break or one break allowed for the patient during treatment.
  - Patient #001 received a pulpotomy and SSC on tooth #S. The Op Sheet did not record the PRSA for tooth #S. X-rays dated March 16, 2010, show no restoration on tooth #S; however, the X-rays and Tooth Chart, dated September 24, 2010, show an existing occlusal composite restoration with recurrent caries.
  - Patient #002 had treatment performed on teeth #A, J, K, and L on March 24, 2010. According to the Monitor's pediatric dentist, these teeth were restored with slot preps without occlusal extension, yet billed as two surface restorations. Furthermore, the filling on tooth #L was lost and seven months later received a pulpotomy and SSC with no documentation of PRSA on the November 1, 2010, Op Sheet.
  - The written summary on the Op Sheet for patient #005 stated: "patient complains of pain on #J and not #14. Patient may need possible root canal therapy (RCT) next visit." There was no record of a diagnostic work-up to justify the proposed RCT on tooth #14 and no treatment plan to extract tooth #J. The November 1, 2010, radiograph shows that tooth #J is over-retained and tooth #13 had nearly complete root formation. According to the notes, the chief complaint was not addressed.
- The following are findings related to the local anesthetic documentation on the Op Sheet:
  - None of the operative procedures forms (Op Sheets) in the 30 reviewed records documented the Dose Calculated for Patient's Weight (DCPW) in the local anesthesia section. The DCPW is the maximum dose of local anesthetic that can be administered to that patient based upon the patient's weight.

Instead of filling in the maximum amount of local anesthetic calculated, the dentists were placing a check mark on the line designated DCPW. During the interview with the staff dentist, it was determined that the *Local Anesthetic Calculation Worksheet* was filled out during the dental hygiene/initial examination visit and placed in the chart. The dentists were checking the DCPW line on the Op Sheet to indicate that the dose had been calculated, and they stated they had only been told the Friday before the Monitor's on-site visit that the maximum dose should be written on the Op Sheet.

- One record did not record the dose or location for local anesthesia.
- The record for patient #006 had an incorrect calculation of the maximum number of lidocaine cartridges on the *Local Anesthetic Calculation Worksheet*. The worksheet recorded 4.11 cartridges as the maximum that could be administered, when the correct calculation was 2.41 cartridges. There was no record of the DCPW on the Op Sheet, so the Monitor was unable to determine if the provider was referring to the correct DCPW. The anesthetic dosage recorded in the patient's record was 2.5 cartridges, which slightly exceeded the correct DCPW.

- The following are findings related to the documentation for protective stabilization:
  - Fifteen records documented use of stabilization (i.e. use of a papoose) on the Op Sheet; however, none of the 15 records recorded the code for stabilization (9920) on the Account History Report. When these findings were brought to the Office Manager's attention, she stated that they were recently told to make sure and record the code for stabilization in the Account History Report. The date ranges of the records related to these findings were from August 12, 2010, to as recent as December 7, 2010. Therefore, without the record of stabilization in the Account History, FORBA is unable to accurately monitor the use of stabilization in this Clinic.
  - Two of the 15 records that documented use of stabilization on the Op Sheet did not have adequate documentation regarding duration, evaluation, and/or behavior.
    - The record for patient #003 did not include justification for stabilization on the Op Sheet dated August 31, 2010. The documented start and stop times on the stabilization form do not match the times recorded on the Op Sheet. The stabilization verification portion was incomplete with no response by open airway, peripheral circulation, and proper placement. There was also no documentation of the outcome of stabilization.
    - The record for patient #006 documented stabilization time from 1:40 p.m. to 3:25 p.m. (1 hour and 45 minutes) with no record of vitals or evaluation for the final 45 minutes. There was also no record of bathroom or other type of break for the patient and no reasonable explanation for appointment time exceeding one hour. According to the *Clinical Policies*

and Guidelines for FORBA Associated Clinics, the guidelines for Protective Stabilization states: "careful, continuous monitoring of the patient is mandatory during protective stabilization." The section titled "Appropriate Length of Treatment Visits and Amount of Treatment in an Individual Visit" states: "The guideline for maximum appointment length in Associated Practices is one hour. This guideline may be extended if, in the dentist's professional judgment, continuation of the procedure for an additional limited time period (e.g., 10-15 minutes) would allow for completion of on-going procedures or additional procedures in order to complete planned treatment. Extension of the one hour guideline should be minimized for all patients, particularly those undergoing protective stabilization."

- None of the records documented use of nitrous oxide/oxygen analgesia; however, 28 of the 30 records had received consent for the use of nitrous oxide/oxygen analgesia from the parent/guardian on the Treatment Plan.
- The following are findings related to the Account History Report:
  - The procedure billed for patient #005 on tooth #30 does not match the Treatment Plan or the upper odontogram of the Tooth Chart. Therefore, since the treatment plan was not amended and the tooth chart was not updated, the (B) surface should not have been billed for this patient.
  - The extraction code 7140 was used when billing for the extraction of teeth #B and #S on patient #009; however, the Op Sheet recorded 7111 as the extraction code. Upon review of the X-rays, the Monitor confirmed that teeth #B and #S should have been billed using the 7111 code.
  - The Clinic received an overpayment of $71.88 for the services provided on October 20, 2010, for patient #024. It is unclear why there was an overpayment.
  - The Account History Report of patient #028 documents the incorrect provider for the services performed, according to the Op Sheet dated December 1, 2010.

Observations

- The following observation was made upon review of the record for patient #029. Based upon this child's caries pattern (no evidence of early childhood caries) and radiographic evidence, the medical necessity for pulpotomies on teeth #B and #I would be better documented with the use of digital photographs.

Recommendations

- Ensure staff members review the HIPPA form with the parent/guardian and verify the correct completion of each section of the form.
- Ensure staff members are documenting which hygiene procedures they performed by their signature at the bottom of the Hygiene Procedures form.

- Ensure staff members document existing conditions and restorations on the upper odontogram of the Tooth Chart.
- Ensure staff members are recording decay on the upper portion of the tooth chart to document the medical necessity of treatment.
- Ensure staff members are verifying that treatment provided on the Op Sheet matches the documentation on the tooth chart and the treatment plan.
- Ensure staff members are correctly labeling X-rays and including the date of exposure.
- Ensure staff members are completing all documentation related to stabilization on the Op Sheet as well as the back of the Consent for Stabilization form.
- Ensure staff members are keeping appointment times under one hour, especially when providing treatment with a stabilization device.
- Ensure front office staff members are verifying when stabilization is used and recording the code for stabilization in the patient's Account History.
- Ensure front office staff members are using the correct codes when billing, and that the billing errors for patients #005 and #009 are corrected.
- Ensure staff members are and documenting the local anesthesia DCPW, dose, and location information on the Op Sheet.
- Ensure the *Restorative Dentistry Checklist* is completed correctly.
- Determine why consent is being obtained for nitrous oxide/oxygen analgesia and yet not being used.

Treatment Observations, Findings, and Staff Interviews Related to Care

The treatment observation testing attributes were designed to determine if care is performed in accordance with FORBA's policies and procedures, the *AAPD Guidelines*, and professionally recognized standards of care.

The on-site review included observations of treatments and interactions with patients, review of work space and manuals, and review of dental records. Observation of treatment and patient interactions included observation of treatment on six patients who were receiving invasive dental treatment and one patient in the dental hygiene bay who was receiving a topical fluoride application. The review of work space and manuals included observation of activities in the dental hygiene and sterilization areas. Six individuals were interviewed, including the Lead Dentist, the Staff Dentist, the Office Manager, the Clinical Coordinator, one dental assistant, and a dental hygienist.

The CIA, Section III.A.2, specifies that the Chief Dental Officer is to be "responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by FORBA and FORBA facilities meet the professionally recognized standards of health care." Such language directs that possessing knowledge

of and following these policies are not at the discretion of the Clinic dentists and staff. The Monitor interviewed the dentist about her familiarity with the policies with two important sources of information that direct patient care, the *Clinical Policies and Guidelines for FORBA Associated Clinics* and the recent Best Practice E-mails and Internal Memorandum that modify, clarify, and add to existing policies and guidelines.

- The Lead Dentist demonstrated moderate knowledge of the *Clinical Policies and Guidelines for FORBA Associated Clinics* and the information from recent Best Practices E-mails and Internal Memorandum, but the staff dentist demonstrated scant knowledge of the information from recent Best Practices E-mails and Internal Memorandum.

The Monitor also had the following relevant findings:

- There are many very young children with high levels of dental disease being treated in this Clinic. Four of the six patients the Monitor observed receiving invasive dental treatment were four years of age or younger.
- The full range of behavior management tools available were not being used and children became hysterical during treatment. The four very young children the Monitor observed receiving invasive treatment were hysterical (screaming, kicking, and bucking) during the entire time dental care was being provided and required either a papoose board or active restraint by the dental assistants and parents. The Monitor determined during interviews with the Lead Dentist and the Staff Dentist that they would appreciate additional training on managing the behavior of very young children and a site visit from the Chief Dental Officer to observe them and provide feedback. For example, behavior management tools that can be used include distraction during local anesthetic injections, through lip shaking and verbal communication; tell, show and do; positive reinforcement and basic communication with the children during the length of the appointment. The Monitor recognizes that many of these children only speak Spanish, complicating communication between the dentist and child; however, many techniques are nonverbal, and therefore the language barrier is less of an obstacle. In addition, while nitrous oxide/oxygen analgesia was observed being used a couple of times, it could be used more often as a behavior management tool.
- The Monitor observed nitrous oxide/oxygen analgesia used appropriately and effectively to manage the behavior of two anxious patients receiving invasive dental treatment.
- The Monitor determined during an interview with the Lead Dentist that nitrous oxide/oxygen analgesia is not being used on very young, frightened children for whom it could have benefited because of problems with authorization by insurance companies and because many of the young dental assistants are either pregnant or trying to become pregnant, and they are concerned about being in an environment where nitrous/oxide analgesia is being used.
- The Monitor observed that the practitioners did not confirm that patients had profound anesthesia of areas to be treated before beginning treatment. Tools are available to make that determination. It was very difficult to determine whether

the children the Monitor observed were crying and hysterical because treatment hurt or because they were frightened. One cannot be assured that just because local anesthetic was administered, it was effective.

- The Monitor observed that the oral mucosa was not being dried prior to application of topical anesthetic in preparation to administer local anesthetic. In addition, the topical anesthetic was not left in place for one minute to achieve maximum effectiveness. According to the *Clinical Policies and Guidelines for FORBA Associated Clinics,* Local Anesthetic Guidelines, page 16: "Topical anesthetic should be applied to dried mucosa, and should be given time to be effective."
- The Monitor observed during patient observations and chart reviews that the maximum amount of local anesthetic is frequently administered. While this in not dangerous, it leaves no means to safely reinforce anesthesia if, in the course of preparing tooth structures to receive restorations or pulpotomies, it is determined that the supplemental injections are required for patient comfort.
- The Monitor observed during record reviews that many primary teeth were receiving pulpotomies when, radiographically, the caries did not appear to be close enough to the pulp to warrant such treatment. In an interview with the Lead Dentist, the Monitor brought charts demonstrating the questionable lesions for discussion. Several charts involved primary anterior teeth, and the Lead Dentist told the Monitor that she automatically performed pulpotomies on all primary anterior teeth receiving NuSmile Crowns. The Lead Dentist expressed belief that the amount of tooth structure removal necessary to prepare the teeth for the crowns endangered the pulp and necessitated pulpotomies. She also believed the DVD from the manufacturer, with instructions to users, directed her to perform "pulp therapy" for these teeth. The Monitor viewed the manufacturer's DVD with the Lead Dentist, and the DVD stated that the amount of tooth structure removed could occasionally result in pulp exposure, but did not direct the user to automatically perform pulpotomies. The issue of how close the caries had to be to the pulp to make it medically necessary to perform pulpotomies remained unresolved, and the Monitor and the Lead Dentist agreed that FORBA's Chief Dental Officer should be included to resolve this issue.
- The Monitor observed that the "Restorative Dentistry Checklist" is not being consistently completed prior to beginning treatment. During an interview with the Lead Dentist, she indicated she was unaware that this was to be completed prior to treatment.

Recommendations

- Provide additional training for the dentist and staff about behavior management with particular emphasis on injection techniques with young children and techniques to determine the adequacy of anesthetic.
- Request that the Chief Dental Officer review patient records of children receiving NuSmile crowns to allow his input about whether the routine use of pulpotomies is

warranted. Provide the Chief Dental Officer with the records reviewed with the Lead Dentist during the on-site to allow his input about whether the caries were close enough to the pulp to warrant pulpotomies.

- Provide additional training and oversight to ensure that the *Restorative Dentistry Checklist* is being completed prior to treatment.
- Provide additional training on the technique for placement of topical anesthetic in preparation for administering the local anesthetic injections so that it is in compliance with the *Clinical Policies and Guidelines for FORBA Associated Clinics*, under Local Anesthesia Guidelines, Injection technique.

Exit Conference

The exit conference was held on December 10, 2010, at approximately 11:40 a.m. Present at the conference were the Monitor Team of [redacted] RDH, and [redacted] DDS, and Clinic staff members [redacted] Office Manager and Compliance Liaison, and [redacted], DMD, Lead Dentist. The preliminary findings discussed at the exit conference included the following:

- Staff members were welcoming and accommodating.
- Policies and Notices are appropriately displayed and up to date with the exception of the "Quality of Care Dashboard," which was dated August 2010. The Monitor was informed that this was updated after the Monitor had completed the review for compliance with this requirement. After the exit interview, the Monitor validated that this update had occurred.
- The Clinic has complied with the FORBA directions to return outdated manuals.
- The recent policy updates were incorporated into the *Policy and Procedures for FORBA Associated Dental Clinics* and *Officer Manager's Manual*, except for the updates issued November 1, 2010, and November 23, 2010.
- Forms are up to date.
- The *Patient Care Manual* has not been integrated into the Clinic.
- The records that documented use of stabilization did not include the code for stabilization (9920) on the Account History Report.
- HIPAA forms were not correctly completed.
- The *Restorative Dentistry Checklist* was completed and in the chart; however, the box indicating confirmation of the odontogram was not always checked and it was not being completed prior to beginning patient care.
- None of the records reviewed documented the maximum number of local anesthetic carpules in the designated area for DCPW on the Op Sheet.
- The staff members and dentists demonstrated a mixed level of familiarity with the communication concerning clinical policies and procedures, specifically those communicated from Chief Dental Officer through Best Practice E-mails, Internal Memoranda, and White Papers.

- The Op Sheet did not consistently include the DCPW. Instead of filling in the maximum amount of local anesthetic calculated, the dentists were placing a check mark on the line designated DCPW to indicate that it had been calculated on the Local Anesthetic Calculation Worksheet, which was contained in the record.
- The quality of radiographs on very young children is generally very good. It is difficult to obtain good quality radiographs on very young children, and this is commendable.
- There are a large number of very young children with high dental disease levels receiving invasive dental care in this Clinic. These children present challenges for the practitioners due to their young age and potential anxiety.
- The full range of behavior management tools available is not being used. For example, distraction during local anesthetic injections, through lip shaking and verbal communication; tell, show and do; and positive reinforcement throughout the procedures are techniques that could be employed but were not observed. In addition, while nitrous oxide/oxygen analgesia was observed being used, it could be used more often as a behavior management tool.
- Practitioners are not confirming that patients have profound anesthesia of the areas to be treated prior to beginning treatment. Tools are available to make that determination. It was very difficult to determine whether the children who were crying and hysterical during treatment were doing so because treatment hurt or because they were afraid. One cannot be assured that because local anesthetic was administered, it was effective.
- Maximum levels of local anesthetic are being administered, leaving no opportunity to reinforce anesthesia with additional local anesthetic if, in the course of providing care, it is determined that the child is not adequately anesthetized.
- Oral mucosa is not being dried prior to applying topical anesthetic, and the topical is not being left on long enough to achieve maximal effectiveness.
- When nitrous oxide/oxygen analgesia is being used, its use is appropriate and effective in managing the behavior of anxious children.
- The Monitor and the Lead Dentist had a difference of opinion on some treatment approaches related to the degree of pulpal encroachment by caries that determines the medical necessity for performing pulpotomies. The Monitor and the Lead Dentist agreed that the Chief Dental Officer should review the radiographs and be involved to resolve this issue.

EXHIBIT 21

PEDIATRIC DENTISTRY V 33 / NO 7 NOV / DEC 11

Scientific Article

Pulpotomy to Stainless Steel Crown Ratio in Children With Early Childhood Caries: A Cross-sectional Analysis

Sarat Thikkurissy, DDS, MS[1] • Dennis McTigue, DDS, MS[2] • Sophie Matracia, DMD, MS[3] • Paul Casamassimo, DDS, MS[4]

Abstract: ***Purpose:*** *This study's purpose was to determine the pulpotomy-to-crown ratio (PCR) in a high-early childhood caries patient population and factors associated with choice of pulpotomy and crown treatments.* ***Methods:*** *This was a retrospective quality assurance chart review. Five calibrated examiners (kappa=0.86) rated radiographic caries from available films. Demographic data, including age, health status, medications, and pain score, were collected along with pulpotomy- and crown-related treatment characteristics of location of tooth, treatment site, and level of operator skill.* ***Results:*** *The record review of 521 patients (mean age=5.1±1.9 years old) revealed 1,365 stainless steel crowns (SSCs) performed with 461 pulpotomies in a 6-month period, in both operating rooms (1,043 SSCs) and ambulatory settings (322 SSCs). The mean PCR was 0.34, with PCR decreasing with increasing patient age. Pulpotomy and crown treatments increased with radiographic caries severity with a significant association between pulpotomy and radiographic severity (P<.001). More severe pain was associated with greater likelihood of pulpotomy (P<.001). Age, operator type, and site of treatment did not affect choice of pulpotomy.* ***Conclusions:*** *The mean pulpotomy-to-crown ratio in this high-early childhood caries pediatric population was 0.34. Pain, the American Society of Anesthesiologists classification system, and radiographic caries severity were predictors of pulpotomy, but operator type and location of treatment were not. (Pediatr Dent 2011;33:496-500) Received March 30, 2010 | Last Revision October 7, 2010 | Accepted October 10, 2010*

KEYWORDS: RESTORATIVE DENTISTRY, PULP THERAPY/ENDODONTICS, INFANT ORAL HEALTH, EARLY CHILDHOOD CARIES, ETHICS, MEDICOLEGAL ISSUES

Early childhood caries (**ECC**) is one of the most prevalent public health issues today, found in nearly 30% of all US children[1] with a higher prevalence in those of lower socioeconomic status.[2,3] Children who experience ECC as infants/toddlers are more likely to have subsequent caries in their primary and permanent dentition.[4]

Deep interproximal caries in primary molars is often an indication for vital pulp therapy and placement of stainless steel crowns (**SSCs**) to maintain a functional dentition and arch health. Depending on the dentist's educational background and work experience, the recommended restorative procedure for deep proximal caries in primary molars can be different.[5,6] SSCs are recommended for primary teeth in many situations, including significant ECC.[7] After a pulpotomy, a tooth may become brittle and prone to fracture[8], so an SCC is strongly recommended to prevent fracture, provide strength to the devitalized teeth, reduce microorganism invasion, and maintain space.

Little evidence supports pulpotomy as the most appropriate technique for primary teeth,[9] and often a dentist chooses this technique based on educational background and individual preference. In the United Kingdom, the national clinical guideline in pediatric dentistry recommends a pulpotomy when more than two thirds of the marginal ridge of a primary molar is compromised with caries.[10] Alternatively, Fuks et al., strongly recommend an indirect pulp capping procedure as the most appropriate treatment for symptom-free primary teeth with deep ECC.[9] Coll et al., suggest not performing a pulpotomy, but rather a pulpectomy when the pulp is already exposed from caries, due to the chance of radicular pulp infection and the low likelihood of a totally vital tooth.[11]

The patient's age can also influence decision-making; the earlier a child is affected by ECC, the greater the risk of future caries in the child.[12] In a young high-risk population, more aggressive treatment, such as pulpotomy followed by SSC, may be recommended to arrest deep proximal caries. Depending on the setting where dental care is delivered, at a clinic or private practice, the treatment decision to perform pulpotomy may vary.[7] Due to cooperation issues and the extent of dental disease, children may be placed under general anesthesia (**GA**) to receive comprehensive dental care. This is a costly procedure with increased risk.[7] Considering cost, health risk, and a historically low level of compliance with follow-ups, an aggressive approach to dental rehabilitation under GA may be considered, resulting in a higher number of pulpotomies and crowns.[1] A recent report on ECC among American Indian and Alaskan Native children suggests that this aggressive approach has application in high-caries children.[13]

The pulpotomy-to-crown ratio (**PCR**) is an informal measure used in a variety of ways to understand how dental interventions are employed in children with high caries risk. This numeric value is simply the number of pulpotomies per teeth treated with SSCs and can be portrayed as a percentage or a fraction:

$$\frac{\textit{Teeth crowned with pulpotomies} \times 100}{\textit{Total teeth crowned}} = \textit{PCR score}$$

[1]*Dr. Thikkurissy is an assistant professor and* [2]*Dr. McTigue is a professor, Department of Pediatric Dentistry, College of Dentistry, The Ohio State University;* [3]*Dr. Matracia is a pediatric dentist in private practice; and* [4]*Dr. Casamassimo is a professor and Chair, Department of Dentistry, Children's Hospital, Columbus, Ohio.*
Correspond with Dr. Casamassimo at casamasp@chi.osu.edu

The PCR concept has been used by third parties as a gauge of appropriateness of care and potential "over-treatment" by dental providers.[14] The PCR may also be used as a surrogate measure of ECC severity, reflecting both real caries incidence and professionally perceived risk, as manifested in treatment choices. The PCR is relative, since no reports assign a PCR value according to a level of caries severity. In cases of third-party use, the PCR may be compared to a typical or acceptable profile of a cross-section of dentists providing those services.

A reasonable PCR determination in a high-risk ECC population would provide a guide to clinicians and others for assessment of provider practice when judging appropriateness of care, as opposed to using a profile based on aggregate services from a cross-section of high and low caries-risk populations. The purpose of this study was to determine the pulpotomy-to-crown ratio in a population of low-income children with severe early childhood caries and to relate the PCR to variables employed in treatment decisions.

Methods

This retrospective, cross-sectional quality assurance study involved a chart review of patients treated at the Nationwide Children's Hospital (NCH) Dental Clinic, Columbus, Ohio, over a 6-month period. The publication of the impersonal analyzed data was authorized as exempt by the human subjects committee of NCH.

Sample. Data were collected from 521 patients who received either SSCs alone or SSCs with pulpotomies on at least 1 primary molar or canine. Children who had primary teeth present, restorable, and with a reasonable projected lifespan at the time of treatment, as judged by the respective provider, were included in the study.

Procedures. Data were collected from patient records by trained examiners and included the patient's medical history, medications, face pain scale[15] score (0-10), and location of treatment (NCH ambulatory Dental Clinic or NCH Dental Surgery Center). History of over-the-counter pain medication use and the names of medication were also obtained.

A standardized radiographic template and scoring system were established and piloted, with calibration of examiners and a subsequent inter-rater reliability analysis of examiners conducted. Without magnification and using standard dental viewing illumination, 5 calibrated examiners evaluated the radiographic findings on bitewing and periapical radiographs of the treated primary teeth, and the extent of caries was determined according to the following ordinal scoring scale:

0=clinical decalcification (white spot), no radiographic caries noted;
1=radiographic caries confined to enamel;
2=radiographic caries confined to the outer half of dentin;
3=radiographic caries extended to the inner half of dentin; and
4=radiographic caries contacting the pulp chamber.

The total teeth treated at each visit and tooth type were also recorded. The type of treatment (whether SSCs only or pulpotomies plus SSCs), and any record of repeated visits for the same teeth, were also assessed. All pulpotomies were performed using ferric sulfate as an intrapulpal medicament followed by zinc oxide – eugenol cement in the pulp chamber. SSCs (3M ESPE Corp, Minneapolis, Minn) were used to restore the pulpotomized teeth, and all SSCs were cemented with Ketac, a glass ionomer luting cement (3M ESPE Corp). No teeth received a pulpotomy without an SSC, as recommended by American Academy of Pediatric Dentistry guidelines.[16] Primary teeth with a history of swelling, visible radiographic resorption, pathologic mobility, and periapical or furcal radiolucency were excluded at the time of treatment.

Statistical analysis. Data were entered into a database (Microsoft Excel, Microsoft Corp, Redmond, Wash) from a hand-written data collection sheet. Data analysis of categorical and ordinal variables was done, respectively, using Fisher's exact test and a 2-tailed t test. Finally, multivariate linear regression was used to detect significant associations. Statistical significance was established at $P \leq .05$.

Results

Demographic information. Data from 521 patient charts were collected between July 2008 and December 2008, comprising 1,365 SSCs placed on primary teeth over that period. Most children treated (351; ~66%) were classified as healthy according to the American Society of Anesthesiologists' (ASA) system, with the remaining 170 (~34%) ASA Class II. A total of 1,043 crowns (~77%) were placed by 6 pediatric dentistry faculty members while the child was under GA. The remaining 322 (~24%) were placed by pediatric dental residents, in an ambulatory setting, with faculty supervision. Of all crowns placed, 610 (~45%) were on maxillary teeth and 755 (~55%) on mandibular teeth. A total of 461 pulpotomies were performed on the teeth with SSCs.

Patient ages. Of 521 patients, 43 (~8%) were 0- to 36-months-old, 258 (~50%) were 37- to 72-months-old, and 220 (~42%) were older than 72-months-old, with a mean age of 5.1±1.9 years old. Only 123 (9%) of the teeth treated were performed in 0- to 36-month-old children. Children older than 72 months had 377 (~30%) of the total teeth treated with either SSCs or pulpotomies (Figure 1). There was no significant association between the patient's age and the overall number of teeth treated per child ($P > .13$).

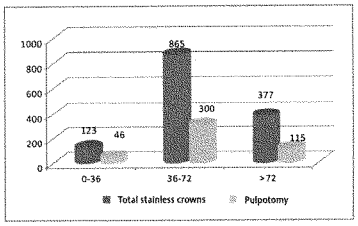


Figure 1. No. of teeth treated as a function of different age groups with stainless steel crowns (SSC) and pulpotomy.

PCR values. The PCR was: 37% for 0- to 36-month-olds; 35% for 37- to 72-month-olds; 31% for children older than 72-months-old; and 34% overall when all 1,365 SSCs were placed. The PCR difference between the 0- to 36-month-olds and 36- to 72-month-olds was not significant.

Radiographic score. Radiographs were present for 1,336 (~98%) of all SSCs placed. A weighted kappa of 0.86 was obtained for the examiners, indicating a good level of inter-rater

Table 1. PROCEDURES AND PULP-TO-CROWN RATIO (PCR) BASED ON RADIOGRAPHIC SCORE

Radiographic score	Stainless steel crowns	Pulpotomy	PCR
0	12	1	0.08
1	51	3	0.06
2	234	9	0.04
3	709	197	0.27
4	337	251	0.78
Total procedures and mean PCR	1,343	461	0.35

reliability. Table 1 shows radiographic and PCR scores. Less than 1% (12) of the teeth was scored as a "0," meaning no radiographic decay was noted by the examiners and no clinical decalcification was noted in the patients' records. A total of 51 teeth (~4%) was scored as having radiographic caries confined to enamel. Radiographic caries into dentin was noted in 943 (~71%) teeth, and this was further subdivided into caries in the outer half of dentin (234/~18%) and inner ½ of dentin (709/~53%). Finally, 337 of the teeth (~25%) had caries, which on radiographs appeared to contact the pulp chamber. There was a significant association between an increase in radiographic score and a pulpotomy being performed (P<.001). A graphic representation of the relationship between radiographic score and treatment performed is presented in Figure 2.

PCR ratio. When the subsample of 1,343 SSC teeth with available radiographs was considered, the overall PCR was 34%. The remaining PCR values by radiographic score are presented in Table 1.

Variables associated with pulpotomy. Multivariate linear regression was performed to determine the relationship between pulpotomy and other variables collected (Table 2). Significant associations were found with parental reports on the faces pain scale (P<.001). Children reporting a higher pain level were more likely to have a pulpotomy performed. Additionally, if a child's medical status was ASA II, there appeared to be a significant association with pulpotomy therapy (P=.05). Fewer pulpotomies per crown were performed on ASA II patients. The breakdown of pulp therapy and ratios based on ASA status is presented in Table 3. Within the ASA II group, the most common diagnosis was asthma (32%) followed by behavior disorders (autism spectrum disorder=~10%; attention deficit disorder/attention deficit hyperactivity disorder=~9%).

Regression analysis determined that teeth with higher radiographic scores were more likely to have pulpotomy therapy (P<.001). We also were interested in testing the concept that children with a higher caries rate, as manifested by a higher number of crowns, would be more likely to have a higher PCR because clinicians would treat them more aggressively. In other words, was a child with extensive ECC considered more likely to have pulpal involvement by a clinician vs a child with 1 or 2 isolated carious lesions. Figure 3 shows a strong correlation (R^2=0.90) between the number of SSCs and the number of pulpotomies, and the PCR increased from 0.32 for children with 2 SSCs to 0.36 for those who received 8 SSCs.

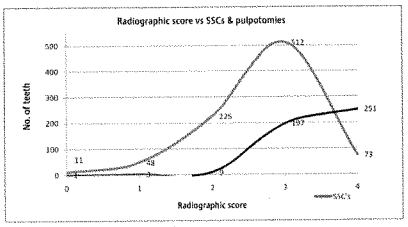


Figure 2. Overall number of teeth with stainless steel crowns (SSCs; gray) and pulpotomies (black) based on radiographic score.

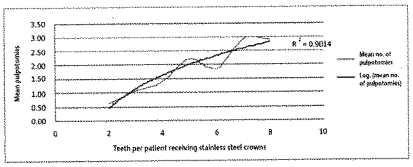


Figure 3. Mean pulpotomies and stainless steel crowns (SSCs) per patient.

Discussion

This quality assurance project was 1 clinical monitor in a larger global program of corporate integrity that involved billing, record keeping, trainee supervision, and other indicators of consistency within a very busy children's hospital clinical enterprise. Recent legal challenges to corporate dentistry and initiatives in the area of Medicaid fraud identification and prosecution nationally suggested that self-profiling would be a good exercise.[16]

The PCR is a clinical indicator that may show how certain dental procedures are deployed in various populations. There is some debate as to the utility of this figure, since scant literature exists on the topic. A higher ratio might indicate that more crowned teeth are being treated with pulpotomies, but not necessarily due to disease status of the teeth. In unstable socioeconomic populations, where caries prevalence is high and timely recall visits low, dentists may treat deep carious primary teeth with more aggressive and definitive pulp therapy, resulting in an increase in a higher PCR. The opposite may also be true, with dentists practicing in stable socioeconomic populations and performing fewer pulpotomies because the caries rate and risk is lower and return visits are more predictable. To date, no benchmark value for PCR has been proposed, but some data on PCRs from clinics and pediatric dentistry educational programs are available.[17]

The radiographic diagnosis was a significant diagnostic predictor for primary pulp treatment (P<.001) in our population. Radiographs were available for approximately 98% of all SSCs placed (N=1,343). Expectedly, as the caries involvement became more extensive, the radiographic score increased and pulpotomies and crowns became more common. Also, as expected, "no radiographic evidence" or "just enamel etching" (scores 0 and 1 respectively) were associated with a lower PCR.

Table 2. REGRESSION ANALYSIS OF PREDICTORS FOR PULPOTOMY

Variable	*P*-value	r^2
Age	>.13	0.02
Faces pain scale score	<.001*	0.05
American Society of Anesthesiologists status	.05*	0.006
Maxillary or mandibular tooth	.28	0.007
Radiographic score	<.001*	0.03
Operator type	>.14	0.578
General anesthesia or ambulatory	>.31	0.578
Repeat visit	.09	0.007
Use of over-the-counter medications	<.24	0.002

* Significant at *P*=.05.

Table 3. PULP-TO-CROWN RATIO (PCR) BASED ON AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) STATUS

ASA status	Stainless steel crowns	Pulpotomy	Pulpotomy-to-crown ratio (%)
I	899	319	35
II	462	142	31
Total and mean PCR	1,361*	461	34

*ASA status not available for all subjects.

It should be noted, however, that some teeth without radiographic evidence of caries did receive crowns. The professional decision to do so in these patients may have been because of clinically detected decay, decalcification or even perceived future risk or likelihood of noncompliance with recalls. These few cases accounted for only 5% of teeth crowned. Our results suggest that crowning may be justified in the absence of radiographic findings in some children, and that, while not common, legitimate treatment may be rendered without corroborating radiographs, providing that the dentist has proper documentation to justify the treatment, such as a caries risk assessment or photograph. Unfortunately auditing bodies, dental consultants, and others often consider a corroborating radiograph as the "gold standard." Consequently, whenever possible and ethical, it is strongly recommended to secure indicated radiographs before treatment.

The faces pain scale score was also a strong predictor of pulpal treatment in primary teeth ($P<.001$), with a patient with an increased pain score more likely to receive a pulpotomy. This corresponds to existing literature, which reports that carious painful permanent molars often receive more endodontic treatment than asymptomatic teeth.[18] The pain scale may also have served as a surrogate or adjunctive measure of pulpal health for the treating dentist, who then became more aggressive in determining pulpal health of teeth treated in that patient. This finding supports the fact that clinicians, particularly those who treat a high ECC population, use indirect or corroborative factors in treatment planning, based on their experience.

The operator type—resident or faculty—did not seem to affect the decision-making process yielding a pulpotomy ($P>.14$). Residents accounted for approximately 24% of all crowns placed and were trained with similar curricular and clinical guidelines to those used by faculty. Type of dental practitioner and varied experience influence treatment, but a potential weakness of our study is that resident preference might have been based on attitudes and experiences of attending faculty for some cases they supervised.

Based on multivariate regression, the patient's age was not a reliable indicator for pulp therapy in primary teeth ($P>.13$). The data from this study, however, indicated that most primary teeth were treated in 36- to 72-month-olds. A total of 865 crowns were placed within this age group, accounting for 63% of those placed in the sample. This finding corresponds with the current state of literature regarding the treatment of young primary molars. Seale[7] strongly recommends restoring multisurface caries in primary molars with SSCs when the patient is younger than 6-years-old or when the restoration lifespan is required to be longer than 2 years.[7] It is the patient's chronological age, as well as size of the carious lesion, that should be considered when determining restoration options for primary teeth.[7]

Additional limitations or weaknesses in this study include: its retrospective nature and use of chart review; operative treatment performed by a number of dentists, including pediatric dental faculty members and pediatric dental residents at NCH with varying skills and knowledge; 5 examiners to review the treatment notes/charts, with some possibility of examiner variance; and use of periapical and nonstandardized bitewing radiographs. Finally, it should be noted that the range of the correlation coefficient (R^2) values associated with the regression analysis was 0.002 to 0.578. This demonstrates that, even while the overall statistic was significant, the amount of variance of the outcome variable explained by the predictor variable(s) was small. No other studies examining the PCR have been conducted on this magnitude, and it is entirely possible that this study was inadequately powered, with inadequacy masked by a sizeable sample.

If this study is repeated, collapsing the radiographic categories 2 and 3, which were most often the cause of question, could simplify the rating scale. This would potentially reduce rater variance, although doing this would reduce the sensitivity of results. The inter-rater kappa was 0.86, which demonstrated good agreement, so variance may not have been an issue.

The mean PCR from the NCH Dental Clinic was approximately 34%. This compares favorably with other reported PCRs from corporate dental clinics and educational programs.[17] Although this PCR may not represent the "absolute" value for the metric, it does provide some evidence of a reasonable value in a high-ECC population. These results also suggest that the PCR in such a population may range widely. Since auditing often relies on profiling and the use of an aggregate pool of providers is heavily weighted with general dentists, these results offer a more realistic vision of pulp therapy. General dentists tend to recommend amalgam restoration more often in proximal decay in primary teeth while pediatric dentists recommend a higher percentage of SSCs.[19] Since most general dentists have little experience with SSCs, they tend to restore proximal lesions more with amalgam,

while pediatric dentists most often use SSCs for the same lesions.[19] Dentists who treated an average of 6 to 16 children per week in their practices are also more likely to recommend restoration with pulp therapy than those who were not currently involved in treating children.[20]

Conclusions

Based on this study's results, the following conclusions can be made:

1. There was significant association between the pain scale (P=.001) and the radiographic score (P<.001) and pulpotomies being performed.
2. The operator type (P>.14) and the location of the treatment (P>.31) had no significant association with treatment performed.
3. The overall pulpotomy-to-crown ratio was 34% at Nationwide Children's Hospital.

References

1. American Academy of Pediatric Dentistry Clinical Affairs Committee. Policy on early childhood caries: Unique challenges and treatment options. Reference Manual 2007-08. Pediatr Dent 2007;29:42-4.
2. Dye BA, Tan S, Smith V, et al. Trends in oral health status: United States, 1988-1994 and 1999-2004. National Center for Health Statistics. Vital Health Stat 2007;11(248):1-92.
3. Tang JM, Altman DS, Robertson DC, O'Sullivan DM, Douglass JM, Tinanoff N. Dental caries prevalence and treatment levels in Arizona preschool children. Public Health Rep 1997;112:319-29.
4. Burt B, Spencer AJ, Schou L (eds).Proceedings of the Conference on Early Childhood Caries, Bethesda, Md. Comm Dent Oral Epidemiol 1998;26(suppl):1-119.
5. Marinho VC, Richards D, Niederman R. Variation, certainty, evidence, and change in dental education: Employing evidence-based dentistry in dental education. J Dent Educ 2001;65:449-55.
6. Omar R, Al-Korani M, Abu Nassif L, Khan N. Influence of dentist-related factors on the time spent on providing prosthodontic services among general dentists. Saudi Dent J 2003;15:2-10.
7. Seale NS. The use of stainless steel crowns. Pediatr Dent 2002;24:501-5.
8. Holan G, Fuks AB, Ketlz N. Success rate of formocresol pulpotomy in primary molars restored with stainless steel crown vs amalgam. Pediatr Dent 2002;24:212-6.
9. Fuks AB. Vital pulp therapy with new materials for primary teeth: New directions and treatment perspectives. Pediatr Dent 2008;30:211-9.
10. Llewelyn DR. UK national clinical guidelines in pediatric dentistry: The pulp treatment of the primary dentition. Int J Paediatr Dent 2000;10:248-52.
11. Coll JA. Indirect pulp capping and primary teeth: Is the primary tooth pulpotomy out of date? Pediatr Dent 2008; 30:230-6.
12. Hintze H, Wenzel A, Danielsen B, Nyvad B. Reability of visual examination, fiber-optic transillumination, bite-wing radiography, and reproducibility of direct visual examination following tooth separation for the identification of cavitated carious lesions in contacting approximal surfaces. Caries Res 1998;32:204-9.
13. Council on Access, Prevention, and Interprofessional Relations, American Dental Association. Symposium on Early Childhood Caries in American Indian and Alaska Native Children. November 2009, Chicago, IL: The American Dental Association.
14. Department of Health and Human Services, Office of the Inspector General. State Medicaid Fraud Control Units, Annual Report, Fiscal Year 2008. Available at: "http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/annual_reports/mfcu_2008.pdf". Accessed December 19, 2009.
15. Hockenberry MJ, Wilson D, Winkelstein ML. Wong's Essentials of Pediatric Nursing. 7th ed. St. Louis, Mo: Mosby; 2005:1259.
16. Council on Clinical Affairs, American Academy of Pediatric Dentistry. Guideline on pulp therapy for primary and immature permanent teeth. Pediatr Dent 2009;31:179-86.
17. Kool Smiles quality report, November 2009. Available at: "http://Koolsmilespc.com/media/files/quality-reports/Kool%20Smiles%20Quality%20Report%20for%20November%202009.pdf". Accessed December 19, 2009.
18. Bjørndal L, Laustsen MH, Reit C. Danish practitioners' assessment of factors influencing the outcome of endodontic treatment. Oral Surg Oral Med Oral Pathol Oral Radio Endol 2007;103:570-5.
19. Hanes CM, Myers DR, Dushku JC. The influence of practice type, region, and age on treatment recommendations for primary teeth. Pediatr Dent 1992;14:240-5.
20. Qudeimat MA, Al-Saiegh FA, Al-Omari Q, Omar R. Restorative treatment decisions for deep proximal carious lesions in primary molars. Eur Arch Paediatr Dent 2007;8: 37-42.

EXHIBIT 22

Arizona Health Care Cost Containment System

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	**Description**	**Fee-for-Service Rate Effective 01/01/2007**
D0120	PERIODIC ORAL EXAMINATION	28.00
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	37.00
D0145	ORAL EVALUATION FOR PATIENT UNDER THREE YEARS OF AGE AND COUNSELING W/PRIMARY CAREGIVER	35.00
D0150	COMPREHENSIVE ORAL EVALUATION NEW OR ESTABLISHED PT	41.00
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION-PROBLEM FOCUSED, BY REPORT	41.00
D0180	COMPREHENSIVE PERIO EVAL - NEW OR ESTABLISHED PT	43.00
D0210	INTRAORAL-COMPLETE SERIES (INCLUDI	73.00
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	15.00
D0230	INTRAORAL-PERIAPICAL-EACH ADDITION	12.00
D0240	INTRAORAL-0CCLUSAL FILM	15.00
D0250	EXTRAORAL-FIRST FILM	17.00
D0260	EXTRAORAL-EACH ADDITIONAL FILM	13.00
D0270	BITEWING-SINGLE FILM	12.00
D0272	BITEWINGS-TWO FILMS	24.00
D0273	BITEWINGS - THREE FILMS	30.00
D0274	BITEWINGS-FOUR FILMS	35.00
D0277	VERTICAL BITEWINGS- 7 TO 8 FILMS	35.00
D0290	POSTERIOR-ANTERIOR OR LATERAL SKUL	37.00
D0310	SIALOGRAPHRY	55.00
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCL. INJECTION	115.00
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS	55.00
D0330	PANORAMIC FILM	62.00
D0340	CEPHALOMETRIC FILM	53.00
D0350	ORAL/FACIAL IMAGES	21.00
D0470	DIAGNOSTIC CASTS	52.00
D0502	OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT	25.00
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE,	BR
D1110	PROPHYLAXIS-ADULT	50.00
D1120	PROPHYLAXIS-CHILD	43.00
D1203	TOPICAL APPLICATION OF FLUORIDE (E	16.00
D1204	TOPICAL APPLICATION OF FLUORIDE (E	16.00
D1206	TOPICAL FLOURIDE VARNISH, THERAPEUTIC APPL	16.00
D1351	SEALANT-PER TOOTH	27.00
D1510	SPACE MAINTAINER-FIXED UNILATERAL	149.00
D1515	SPACE MAINTAINER-FIXED BILATERAL	213.00
D1520	SPACE MAINTAINER-REMOVABLE UNILATE	149.00
D1525	SPACE MAINTAINER-REMOVABLE BILATER	213.00
D1550	RECEMENTATION OF SPACE MAINTAINER	34.00
D1555	REMOVAL OF FIXED SPACE MAINTAINER	34.00
D2140	AMALGAM-ONE SURFACE PRIMARY OR PERMANENT	73.00
D2150	AMALGAM-TWO SURFACES PRIMARY OR PERMANENT	88.00
D2160	AMALGAM-THREE SURFACES PRIMARY OR PERMANENT	106.00
D2161	AMALGAM-FOUR OR MORE SURFACES PRIMARY OR PERMANENT	127.00
D2330	RESIN-ONE SURFACE, ANTERIOR	87.00
D2331	RESIN-TWO SURFACES, ANTERIOR	110.00
D2332	RESIN-THREE SURFACES, ANTERIOR	138.00
D2335	RESIN-FOUR OR MORE SURFACES OR INV	166.00

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
D2390	RESIN-BASED COMPOSITE CROWN ANTERIOR	200.00
D2391	RESIN-BASED COMPOSITE - ONE SURFACE POSTERIOR ADULT	73.00
D2392	RESIN-BASED COMPOSITE - TWO SURFACE POSTERIOR ADULT	88.00
D2393	RESIN-BASED COMPOSITE - THREEE SURFACE POSTERIOR ADULT	106.00
D2394	RESIN-BASED COMPOSITE - 4 OR MORE SURFACES POSTERIOR	127.00
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBL	569.00
D2751	CROWN-PROCELAIN FUSED TO PREDOMINA	569.00
D2752	CROWN-PORCELAIN FUSED TO NOBLE MET	569.00
D2790	CROWN-FULL CAST HIGH NOBLE METAL	569.00
D2791	CROWN-FULL CAST PREDOMINANTLY BASE	569.00
D2792	CROWN-FULL CAST NOBLE METAL	569.00
D2794	CROWN-TITANIUM	569.00
D2910	RECEMENT INLAY	46.00
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE	46.00
D2920	RECEMENT CROWN	46.00
D2930	PREFABRICATED STAINLESS STEEL CROW	135.00
D2931	PREFABRICATED STAINLESS STEEL CROW	157.00
D2932	PREFABRICATED RESIN CROWN	133.00
D2933	PREFABRICATED STAINLESS STEEL CROW	158.00
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY	158.00
D2940	SEDATIVE FILLING	51.00
D2950	CORE BUILD-UP, INCLUDING ANY PINS	140.00
D2951	PIN RETENTION-PER TOOTH, IN ADDITI	40.00
D2952	CAST POST AND CORE IN ADDITION TO	212.00
D2954	PREFABRICATED POST AND CORE IN ADD	134.00
D2970	TEMPORARY CROWN (FRACTURED TOOTH)	105.00
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	BR
D3110	PULP CAP-DIRECT (EXCLUDING FINAL R	34.00
D3120	PULP CAP-INDIRECT (EXCLUDING FINAL	34.00
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING F	81.00
D3221	PULPAL DEBRIDEMENT	81.00
D3230	PULPAL THERAPY (RESORBABLE FILLING)- ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RE	110.00
D3240	PULPAL THERAPY (RESORBABLE FILLING)- POSTERIOR,PRIMARY TOOTH (EXCLUDING FINAL RE	114.00
D3310	ANTERIOR (EXCLUDING FINAL RESTORAT	370.00
D3320	BICUSPID (EXCLUDING FINAL RESTORAT	447.00
D3330	MOLAR (EXCLUDING FINAL RESTORATION	561.00
D3331	TREATMENT ROOT CANAL DESTRUCTION NON SURG ACCESS	104.00
D3332	INCOMPLETE ENDODONTIC THERAPY INOPER OR FX TOOTH	213.00
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	118.00
D3346	RETREATMENT-ANTERIOR, BY REPORT	475.00
D3347	RETREATMENT-BICUSPID, BY REPORT	500.00
D3348	RETREATMENT-MOLAR, BY REPORT	595.00
D3351	APEXIFICATION/RECALCIFICATION-INIT	89.00
D3352	APEXIFICATION/RECALCIFICATION-INTE	75.00

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
D3353	APEXIFICATION/RECALCIFICATION-FINA	240.00
D3410	APICOECTOMY/PERIRADICULAR SURGERY-	340.00
D3421	APICOECTOMY/PERIRADICULAR SURGERY-	340.00
D3425	APICOECTOMY/PERIRADICULAR SURGERY-	394.00
D3426	APICOECTOMY/PERIRADICULAR SURGERY	170.00
D3430	RETROGRADE FILLING-PER ROOT	119.00
D3450	ROOT AMPUTATION-PER ROOT	196.00
D3470	INTENTIONAL REPLANTATION (INCLUDING NECESSARY SPLINTING)	427.00
D3920	HEMISECTION (INCLUDING ANY ROOT RE	196.00
D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	BR
D4210	GINGIVECTOMY/PLASTY 4/> CONT OR BONDTEETH PER QUAD	272.00
D4211	GINGIVECTOMY/PLASTY ONE TO 3 TEETH PER QUADRANT	108.00
D4240	GINGIVAL FLAP PRO INC ROOT PLAN 4 OR > CONTIG TEETH	310.00
D4241	GING FLAP PROC INCL ROOT PLANNIN 1-3 TEETH EACH QUADRANT	186.00
D4249	CLINICAL CROWN LENGTHENING	400.00
D4260	OSSEOUS FLAP & COLS 4 OR > CON/BONDED TEETH PER QUADRANT	496.00
D4261	OSS SURG INCL FLAP ENTRY & CLOS 1-3 TEETH EACH QUADRANT	324.00
D4263	BONE REPLACEMENT GRAFT-FIRST SITE IN QUADRANT	275.00
D4264	BONE REPLACEMENT GRAFT-EACH ADDITIONAL SITE IN QUADRANT	260.00
D4265	BIOLOGICAL MATTER TO AID IN SOFT & OSSEUOS TISS REGEN	295.00
D4266	GUIDED TISSUE REGENERATION-RESORBABLE BARRIER, PER SITE, PER TOOTH	283.00
D4267	GUIDED TISSUE REGENERATION NON-RESORBABLE	305.00
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDUR	304.00
D4271	FREE SOFT TISSUE GRAFT PROCEDURE (	362.00
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES	515.00
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGI	319.00
D4275	SOFT TISSUE ALLOGRAFT	401.00
D4276	COMBINED CONNECTIVE TISSUE & DOUBLE PEDICLE GRAFT	520.00
D4292		
D4320	PROVISIONAL SPLINTING-INTRACORONAL	176.00
D4321	PROVISIONAL SPLINTING-EXTRACORONAL	135.00
D4341	PERIODONTAL SCA ROOT 4 OR >CONTIG/BOUN TEETH QUAD	145.00
D4342	PERIO SCALING AND ROOT PLANNING 1-3 TEETH PER QUAD	86.00
D4355	FULL DEBRIDEMENT TO ENABLE CONPR EVALU & DIAGNOSIS	75.00
D4910	PERIODONTAL MAINTENANCE	72.00
D4920	UNSCHEDULED DRESSING CHANGE (BY SO	30.00
D4999	UNSPECIFIED PERIODONTAL PROCEDURE,	BR
D5110	COMPLETE UPPER	738.00
D5120	COMPLETE LOWER	738.00
D5130	IMMEDIATE UPPER	828.00
D5140	IMMEDIATE LOWER	828.00

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
D5211	UPPER PARTIAL-RESIN BASE (INCLUDIN	690.00
D5212	LOWER PARTIAL-RESIN BASE (INCLUDIN	690.00
D5213	UPPER PARTIAL-CAST METAL BASE WITH	810.00
D5214	LOWER PARTIAL-CAST METAL BASE WITH	810.00
D5281	REMOVABLE UNILATERAL PARTIAL DENTU	360.00
D5410	ADJUST COMPLETE DENTURE-UPPER	40.00
D5411	ADJUST COMPLETE DENTURE-LOWER	40.00
D5421	ADJUST PARTIAL DENTURE-UPPER	40.00
D5422	ADJUST PARTIAL DENTURE-LOWER	40.00
D5510	REPAIR BROKEN COMPLETE DENTURE BAS	106.00
D5520	REPLACE MISSING OR BROKEN TEETH-CO	81.00
D5610	REPAIR RESIN SADDLE OR BASE	74.00
D5620	REPAIR CAST FRAMEWORK	85.00
D5630	REPAIR OR REPLACE BROKEN CLASP	87.00
D5640	REPLACE BROKEN TEETH-PER TOOTH	81.00
D5650	ADD TOOTH TO EXISTING PARTIAL DENT	96.00
D5660	ADD CLASP TO EXISTING PARTIAL DENT	128.00
D5710	REBASE COMPLETE UPPER DENTURE	308.00
D5711	REBASE COMPLETE LOWER DENTURE	308.00
D5720	REBASE UPPER PARTIAL DENTURE	308.00
D5721	REBASE LOWER PARTIAL DENTURE	308.00
D5730	RELINE UPPER COMPLETE DENTURE (CHA	170.00
D5731	RELINE LOWER COMPLETE DENTURE (CHA	170.00
D5740	RELINE UPPER PARTIAL DENTURE (CHAI	156.00
D5741	RELINE LOWER PARTIAL DENTURE (CHAI	156.00
D5750	RELINE UPPER COMPLETE DENTURE (LAB	238.00
D5751	RELINE LOWER COMPLETE DENTURE (LAB	238.00
D5760	RELINE UPPER PARTIAL DENTURE (LABO	202.00
D5761	RELINE LOWER PARTIAL DENTURE (LABO	202.00
D5820	INTERIM PARTIAL DENTURE (UPPER)	340.00
D5821	INTERIM PARTIAL DENTURE (LOWER)	340.00
D5850	TISSUE CONDITIONING, UPPER-PER DEN	85.00
D5851	TISSUE CONDITIONING, LOWER-PER DEN	85.00
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	BR
D5911	FACIAL MOULAGE (SECTIONAL)	BR
D5912	FACIAL MOULAGE (COMPLETE)	BR
D5913	NASAL PROSTHESIS	BR
D5914	AURICULAR PROSTHESIS	BR
D5915	ORBITAL PROSTHESIS	BR
D5916	OCULAR PROSTHESIS	BR
D5919	FACIAL PROSTHESIS	BR
D5922	NASAL SEPTAL PROSTHESIS	BR
D5923	OCULAR PROSTHESIS, INTERIM	BR
D5924	CRANIAL PROSTHESIS	BR
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	BR
D5926	NASAL PROSTHESIS, REPLACEMENT	BR
D5927	AURICULAR PROSTHESIS, REPLACEMENT	BR
D5928	ORBITAL PROSTHESIS, REPLACEMENT	BR
D5929	FACIAL PROSTHESIS, REPLACEMENT	BR

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
D5931	OBTURATOR PROSTHESIS, SURGICAL	BR
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	BR
D5933	OBTURATOR PROSTHESIS, MODIFICATION	BR
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE	BR
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE	BR
D5936	OBTURATOR/PROSTHESIS, INTERIM	BR
D5937	TRISMUS APPLIANCE (NOT FOR TM TREATMENT)	BR
D5951	FEEDING AID	BR
D5952	SPEECH AID PROSTHESIS, PEDIATRIC	BR
D5953	SPEECH AID PROSTHESIS, ADULT	BR
D5954	PALATAL AUGMENTATION PROSTHESIS	BR
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE	BR
D5958	PALATAL LIFT PROSTHESIS, INTERIM	BR
D5959	PALATAL LIFT PROSTHESIS, MODIFICATION	BR
D5960	SPEECH AID PROSTHESIS, MODIFICATION	BR
D5982	SURGICAL STENT	BR
D5983	RADIATION CARRIER	BR
D5984	RADIATION SHIELD	BR
D5985	RADIATION CONE LOCATOR	BR
D5986	FLUORIDE GEL CARRIER	BR
D5987	COMMISSURE SPLINT	BR
D5988	SURGICAL SPLINT	BR
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	BR
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE	BR
D7111	CORONAL REMNANTS-DECIDIOUS TOOTH	60.00
D7140	EXTR ERUPT TOOTH/EXPOS ROOT ELEV AND/OR FORC REMOV	79.00
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	128.00
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TIS	157.00
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALL	200.00
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETE	234.00
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETE	290.00
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH	128.00
D7260	ORAL ANTRAL FISTULA CLOSURE	300.00
D7261	PRIMARY CLOSURE OR SINUS PERFORATION	300.00
D7270	TOOTH REIMPLANT AND/ORSTABIL EVULSED DISPL TOOTH	290.00
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	216.00
D7281	SURGICAL EXPOSURE OF IMPACTED OR UNERUPTED TOOTH	130.00
D7282	MOBIL OF ERUPTED OR MALPOS TOOTH TO AID ERUPTION	130.00
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	53.00
D7285	BIOPSY OF ORAL TISSUE-HARD	153.00
D7286	BIOPSY OF ORAL TISSUE-SOFT	153.00
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION	75.00
D7292	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP	BR
D7293	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP	BR
D7294	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE WITHOUT SURGICAL FLAP	BR
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTE	BR

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
7998	INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJ. W/FRACTURE	BR
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH	152.00
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	96.00
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION W	200.00
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	133.00
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	106.00
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	235.00
D7412	EXCISION OF BENIGN LESION COMPLICATED	275.00
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	210.00
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM	310.00
D7415	EXCISION OF MALIGNANT LESION COMPLICATED	325.00
D7440	EXCISION OF MALIGNANT TUMOR-LESION	205.00
D7441	EXCISION OF MALIGNANT TUMOR-LESION	305.00
D7450	REM BENIGN ODONTOGENIC CYST/TUMOR-LESION TO 1.25CM	152.00
D7451	REM BENIGN ODONTOGENIC CYST/TUMOR-LESION >1.25 CM	195.00
D7460	REM BEN NONODONTOGENIC CYST/TUMOR-LESION TO 1.25CM	111.00
D7461	REM BEN NONODONTOGENIC CYST/TUMOR-LESION >1.25CM	155.00
D7465	DESTRUCTION OF LESION(S) BY PHYSIC	75.00
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	250.00
D7472	REMOVAL OF TORUS PALANTINUS	350.00
D7473	REMOVAL OR TORUS MANDIBULARIS	550.00
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	285.00
D7490	RADICAL RESECTION OF MANDIBLE WITH	3,450.00
D7510	INCISION AND DRAINAGE OF ABSCESS-I	75.00
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSU	250.00
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT	135.00
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT COMPL	275.00
D7530	REM FOREIGN BODY MUCOSA SKIN/SUBQ ALVEOLAR TISSUE	93.00
D7540	REMOVAL OF REACTION-PRODUCING FORE	115.00
D7550	PART OSTECTOMY/SEQUESTRECTOMY REM NON-VITAL BONE	190.00
D7560	MAXILLARY SINUSOTOMY FOR REMOVAL O	365.00
D7610	MAXILLA-OPEN REDUCTION (TEETH IMMO	1,750.00
D7620	MAXILLA-CLOSED REDUCTION (TEETH IM	1,250.00
D7630	MANDIBLE-OPEN REDUCTION (TEETH IMM	2,132.00
D7640	MANDIBLE-CLOSED REDUCTION (TEETH I	1,100.00
D7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN R	1,250.00
D7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED	850.00
D7670	ALVEOLUS CLOSED REDU MAY INCL STABILIZATION TEETH	343.00
D7671	ALVEOLUS-OPEN REDUCT MAY INCLUDE STABILIZ OF TEETH	1,725.00
D7680	FACIAL BONES-COMPLICATED REDUCTION	2,850.00
D7710	MAXILLA-OPEN REDUCTION	1,950.00
D7720	MAXILLA-CLOSED REDUCTION	1,195.00
D7730	MANDIBLE-OPEN REDUCTION	2,050.00

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
D7740	MANDIBLE-CLOSED REDUCTION	1,290.00
D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN R	1,875.00
D7760	MALAR AND/OR ZYGOMATIC ARCH-CLOSED	1,295.00
D7770	ALVEOLUS OPEN REDUCTION STABILIZATION OF TEETH	1,250.00
D7771	ALVEOLUS CLOSED REDUCTION STABILZATION OF TEETH	725.00
D7780	FACIAL BONES-COMPLICATED REDUCTION	3,590.00
D7810	OPEN REDUCTION OF DISLOCATION	1,790.00
D7820	CLOSED REDUCTION OF DISLOCATION	155.00
D7830	MANIPULATION UNDER ANESTHESIA	235.00
D7840	CONDYLECTOMY	2,275.00
D7850	SURGICAL DISCECTOMY; WITH/WITHOUT	2,075.00
D7852	DISC REPAIR	BR
D7854	SYNOVECTOMY	2,590.00
D7856	MYOTOMY	1,358.00
D7858	JOINT RECONSTRUCTION	2,717.00
D7860	ARTHROTOMY	535.00
D7865	ARTHROPLASTY	2,717.00
D7870	ARTHROCENTESIS	164.00
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	300.00
D7872	ARTHROSCOPY-DIAGNOSIS, WITH OR WIT	465.00
D7873	ARTHROSCOPY-SURGICAL: LAVAGE AND L	1,215.00
D7874	ARTHROSCOPY-SURGICAL: DISC REPOSIT	1,215.00
D7875	ARTHROSCOPY-SURGICAL: SYNOVECTOMY	1,642.00
D7876	ARTHROSCOPY-SURGICAL: DISCECTOMY	1,642.00
D7877	ARTHROSCOPY-SURGICAL: DEBRIDEMENT	2,717.00
D7880	OCCLUSAL ORTHOTIC APPLIANCE	333.00
D7899	UNSPECIFIED TMD THERAPY, BY REPORT	249.00
D7910	SUTURE OF RECENT SMALL WOUNDS UP T	70.00
D7911	COMPLICATED SUTURE-UP TO 5 CM	116.00
D7912	COMPLICATED SUTURE-GREATER THAN 5	275.00
D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION, AND TYPE	BR
D7940	OSTEOPLASTY-FOR ORTHOGNATHIC DEFOR	1,250.00
D7941	OSTEOTOMY-RAMUS, CLOSED	3,450.00
D7943	OSTEOTOMY-RAMUS, OPEN WITH BONE GR	3,450.00
D7944	OSTEOTOMY-SEGMENTED OR SUBAPICAL-P	2,895.00
D7945	OSTEOTOMY-BODY OF MANDIBLE	3,125.00
D7946	LEFORT I (MAXILLA-TOTAL)	3,490.00
D7947	LEFORT I (MAXILLA-SEGMENTED)	3,195.00
D7948	LEFORT II OR LEFORT III (OSTEOPLAS	3,999.00
D7949	LEFORT II OR LEFORT III-WITH BONE	4,150.00
D7950	OSSEOUS, OSTEOPERIOSTEAL, PERIOSTE	895.00
D7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION - PER SIT	BR
D7955	REPAIR OF MAXILLOFACIAL SOFT AND H	905.00
D7960	FRENULECTOMY (FRENECTOMY OR FRENOT	146.00
D7963	FRENULOPLASTY	146.00
D7970	EXCISION OF HYPERPLASTIC TISSUE-PE	152.00
D7971	EXCISION OF PERICORONAL GINGIVA	74.00
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	125.00
D7980	SIALOLITHOTOMY	195.00

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
D7981	EXCISION OF SALIVARY GLAND	755.00
D7982	SIALODOCHOPLASTY	550.00
D7983	CLOSURE OF SALIVARY FISTULA	205.00
D7990	EMERGENCY TRACHEOTOMY	365.00
D7991	CORONOIDECTOMY	1,275.00
D7995	SYNTHETIC GRAFT-MANDIBLE OR FACIAL BONES, BY REPORT	BR
D7996	IMPLANT-MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING A	BR
D7997	APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE)	BR
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT	BR
D8010	LIMITED ORTHODIONTIC TREATMENT OF THE PRIMARY DENTITION	280.00
D8020	LIMITED ORTHODIONTIC TREATMENT OF THE TRANSITIONAL DENTITION	280.00
D8030	LIMITED ORTHODIONTIC TREATMENT OF THE ADOLESCENT DENTITION	280.00
D8040	LIMITED ORTHODIONTIC TREATMENT OF THE ADULT DENTITION	280.00
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	1,300.00
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	2,600.00
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	2,924.00
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	3,026.00
D8210	REMOVABLE APPLIANCE THERAPY	305.00
D8220	FIXED APPLIANCE THERAPY	335.00
D8660	PRE-ORTHODONTIC VISIT	45.00
D8670	PERIODONTIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	132.00
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RET)	200.00
D8690	ORTHODONTIC TREATMENT	65.00
D8691	REPAIR OF ORTHODONTIC APPLIANCE	BR
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	130.00
D8693	REBONDING OR RECEMENTING; AND/OR REPAIR OF FIXED RETAINER	46.00
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE,	BR
D9110	PALLIATIVE EMERGENCY TRMTS	57.00
D9120	FIXED PARTIAL DENTURE SECTIONING	52.00
D9210	LOCAL ANESTHESIA N0T IN CONJUNCTIO	10.00
D9220	DEEP SEDATION/GENERAL ANESTHESIA-FIRST 30 MINUTES	146.00
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EACH ADDIT 15 MIN	68.00
D9230	ANALGESIA	25.00
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA-1ST 30 MIN	133.00
D9242	INTRAVEN CONSC SEDATION/ANALGESIA-EA ADDIT 15 MIN	38.00
D9248	NON INTRAVENOUS CONSCIOUS SEDATION	60.00
D9310	CONSULTATION (DIAGNOSTIC SERVICE P	39.00
D9410	HOUSE CALL	45.00
D9420	HOSPITAL CALL	80.00

Arizona Health Care Cost Containment System

Arizona Health Care Cost Containment System - Schedule of Dental Rates		
CPT-5	Description	Fee-for-Service Rate Effective 01/01/2007
D9430	OFFICE VISIT FOR OBSERVATION (DURI	28.00
D9440	OFFICE VISIT-AFTER REGULARLY SCHED	63.00
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	19.00
D9612	THERAPEUTIC PARENTERAL DRUGS; TWO OR MORE ADMIN DIFFERENT MED	30.00
D9920	BEHAVIOR MANAGEMENT, BY REPORT	35.00
D9930	TREATMENT OF COMPLICATIONS (POSTSU	28.00
D9940	OCCLUSAL GUARD	180.00
D9951	OCCLUSAL ADJUSTMENT-LIMITED	49.00
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT	BR

EXHIBIT 23

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Clinic Review
Small Smiles Dental Centers of Manassas
Manassas, Virginia

Deliverable #1-35

September 22, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review, an expanded review of the records identified in the Clinical Risk Assessment Focus Tool (CRAFT), and an analysis of the CSHM systems designed to identify quality of care issues at Small Smiles Dental Centers of Manassas (Clinic), 9012 Mathis Avenue, Manassas, VA 20110.

Overall Summary of Critical Findings and Observations

[redacted] reviewed ten records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of ten records that CSHM audited during the first quarter of 2011.

Both dentists scored lower under the Monitor's review compared to the CSHM audit, with an automatic failure of one dentist due to insufficient documentation of medical necessity for treatment provided to patients #001 and #004. The Monitor's overall Clinic score of 92 percent was also lower than CSHM's overall Clinic score of 96 percent.

The record for patient #002 showed use of a stabilization device (papoose) for 1 hour and 45 minutes, which extends beyond the time guidelines established by CSHM.

The Account History Report for patient #006 showed billing for two periapical X-rays when X-rays were not taken. Although CSHM identified this billing error in their chart audit, the documentation provided to the Monitor does not demonstrate the billing error was corrected.

The X-rays of the maxillary anterior region (a panoramic X-ray and anterior occlusal X-ray) of patient #003 were of poor quality and insufficient to diagnose the abnormalities present in the anterior region.

The following are additional findings that were not captured in CSHM's Chart Audit Tool:

- The Spanish Health History form dated November 2, 2010, in the record for patient #001 did not appear to include a statement regarding the agreement with the Office of Inspector General (OIG) or the availability of an adverse event log for the Clinic.
- The record for patient #001 did not show documentation of interpretation or documentation of medical necessity to support the need for a panoramic X-ray.
- Two records (patients #006 and #010) showed that a prophylaxis was performed; however, fluoride was not applied to the teeth of children with severe early childhood caries.

- One record (patient #007) showed X-rays were not taken because they were "not due"; however, the chief complaint documented the patient was in pain and new disease was found upon examination.
- The following findings relate to the records reviewed for Dr. [redacted]
  - All five records showed infiltration of local anesthesia was used instead of an inferior alveolar nerve block to anesthetize lower teeth, which were treated with pulpotomies and Stainless Steel Crowns (SSCs).
  - All five records documented use of an inadequate amount of local anesthesia to provide proper pain control for the extent of treatment performed.
  - All five records recorded the provision of full mouth, invasive dental treatment for 8 to 12 teeth in one appointment.
  - All five records showed a total of 37 pulpotomies and SSCs were performed with a pulp-to-crown ratio of 100 percent.
  - Two of the five records (patients #001 and #004) did not show adequate documentation to support the medical necessity for treatment provided. The Tooth Chart for patient #001 did not document the medical necessity for the extraction of teeth #B, #E, #F, and #I. The X-rays for patient #004 did not support the medical necessity for the pulpotomies performed on teeth #B, #K, and #L.
  - Four of the five records reviewed showed use of the papoose board for patient stabilization. All four of these records contained notes indicating the patient cried and resisted treatment.

As part of the expanded review, the Monitor reviewed 34 records related to care rendered by Dr. [redacted] and whether the CSHM systems for identifying quality of care issues were effective. The critical findings are as follows:

- There were 244 pulpotomies performed; of these, the Monitor's pediatric dentist determined that 104 pulpotomies were not medically necessary. For every record the Monitor reviewed, there was inadequate documentation to support the medical necessity for at least one of the treatments provided.
- The method of local anesthesia documented in 29 of the 34 records was infiltration which is not considered the most effective standard for anesthetizing mandibular teeth planned for pulpotomy or extraction. A study conducted by Constantine Oulis reported, "mandibular infiltration is effective but not reliable for pulpotomy in a primary molar, either in primary or mixed dentition."[1] Specifically, when pulpotomies and extractions are performed on primary mandibular molars, scientific studies indicate the preferred method to obtain adequate anesthesia is the inferior alveolar block, and in the case of extraction, the long buccal. Infiltration, as a method for administration of anesthesia, frequently provides inadequate anesthesia for these procedures in the mandible, and the child can

[1] Oulis CJ, Vadiakas GP, Vasilopoulou A. The effectiveness of mandibular infiltration compared to mandibular block anesthesia in treating primary molars in children. *Pediatric Dentistry* 18:4, 1996.

experience pain. In the records identified, infiltration was used to anesthetize children receiving pulpotomies and/or extractions of primary mandibular molars.

- Of the 34 records where local anesthesia was administered, 24 records did not reflect a minimum of .5 carpules of local anesthesia for each quadrant or sextant.
- Of the 34 patients treated, stabilization was used for 26 patients and there was insufficient anesthesia administered for 20 of those patients. Of those 20 patients who were stabilized and had insufficient anesthesia, every patient had pulpotomies performed. The Monitor is concerned that these children were inadequately anesthetized for the procedures being performed and were resisting treatment because they were being hurt, which then led to stabilization.
- The CSHM systems designed to detect quality of care issues in the clinics were not effective in identifying the quality of care issues in this Clinic.

Summary of Recommendations

The following recommendations are based on the Monitor's findings from the review of the ten visit records:

- Ensure staff members are verifying correct completion of the Authorization for Disclosure of Protected Health Information and the Authorization of Persons to Consent for Treatment forms.
- Ensure requested materials sent to CSHM are complete and of a quality that will allow for accurate review.
- Ensure all requested materials sent to the Monitor are complete and of a quality that will allow for accurate review.
- Ensure staff members are properly reviewing the patient's Health History form for completeness of patient information and documenting findings related to missing information or explanations to "yes" responses.
- Ensure staff members are not obstructing the view of important patient identification or health information on the Health History form.
- Ensure staff members are correctly documenting existing conditions, restorations, planned treatment, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members are properly completing Hygiene Procedure form, operative procedures form (Op Sheet), and Treatment Plan.
- Ensure staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure the billing error for patient #006 is corrected and determine if it was corrected within the CSHM timeframes.
- Ensure staff members are using current Spanish Health History forms, which include the statement regarding the Office of Inspector General (OIG) and availability of the adverse event log.

- Ensure staff members are following the *American Dental Association (ADA) / Food and Drug Administration (FDA) Guide to Patient Selection for Dental Radiographs* and documenting interpretation of all exposed X-rays.
- Ensure staff members are correcting all documentation errors properly.
- Ensure staff members are providing fluoride treatment to all children or documenting the reason for not providing this service.
- Further assessment by the Chief Dental Officer (CDO) is needed to determine trends and training needs in this Clinic related to full mouth, invasive restorative procedures performed on young patients without the use of adequate local anesthesia and often utilizing stabilization.
- Further assessment by the CDO is needed to determine the pulpotomy-to-crown ratio with additional record reviews to determine if there is evidence of overtreatment in this Clinic.
- Ensure dentists are delivering an adequate dose of local anesthesia, using appropriate delivery methods, and performing an assessment to determine effectiveness of local anesthesia.
- Ensure dentists are following the *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* with respect to treatment time, stabilization, and when to refer a patient to a specialist.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure CSHM is clearly communicating billing issues as well as any required action by the Clinic to correct the billing error.
- Ensure clarification of guidelines related to quality of care issues are being communicated to clinic staff and CSHM auditors.
- Ensure that CSHM auditors are adequately trained to review X-rays, identify quality of care issues, and can properly determine when to consult the CDO.
- Ensure modifications are made to CSHM's Chart Audit Tool to capture all quality of care issues.
- Establish a process to evaluate and standardize CSHM auditors to establish a high degree of reliability in CSHM audit findings.

The following recommendations relate to the Monitor's evaluation of CSHM's systems for identifying quality of care issues in its Clinics:

- Ensure the information being provided in the Clinical Risk Assessment Focus Tool (CRAFT) reports is used to determine which Clinics need further investigation about possible quality of care issues.
- Ensure the chart audits are designed in a manner to identify possible quality of care issues.

Clinic Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Manassas (Clinic), 9012 Mathis Avenue, Manassas, VA 20110.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of Manassas. On March 25, 2011, the Monitor notified the Clinic and CSHM's Compliance Officer via mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. On April 4, 2011, the Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the first quarter of 2011
  - E-mail to the Clinic with results for the first-quarter audit
  - First-quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], JD, CHD, CSHM's Patient Advocate, and Dr. [redacted] CSHM's Chief Dental Officer (CDO), prior to conducting audits; Auditor has received ongoing supervision by Dr. [redacted]
  - Training reference tools used
    - *Chart Audit Policy*
    - *Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*
    - *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*

CSHM initially requested the Clinic's records on January 6, 2011. The Clinic provided the records on January 14, 2011. A licensed dental hygienist completed the chart audit on January 25, 2011. CSHM indicated the Clinic and all dentists passed the audit;

therefore, no CAP was required, according to the *Chart Audit Policy*. The CDO did not participate in the review of any charts for this audit.

Upon review of the chart audit results, the Monitor had significant findings related to the number of pulpotomies and crowns that were being performed and the amount of local anesthesia that was used during the procedures. The Monitor noted the Clinical Risk Assessment Focus Tool (CRAFT) reports repeatedly identified this Clinic as an outlier in identifying clinics that performed seven or more crowns or pulpotomies in a single visit. The Monitor determined an expanded review of this Clinic was warranted and on June 2, 2011, requested additional information to evaluate the quality of care being performed in the Clinic. Further, the Monitor sought information to evaluate whether the CSHM systems were identifying quality of care issues, implementing CAPs, and monitoring them over time for effectiveness. The Monitor requested all records that were identified in the CRAFT reports from February 2010 to present. CSHM was also requested to provide additional information about their follow-up to the CRAFT reports; chart audit information from January 15, 2010, to present; any internal audits or reviews related to this Clinic, such as reviews or visits by the CDO; internal investigations related to patient complaints, adverse events, and dental board inquires; and all exit interviews for employees who left the Clinic in 2010 or 2011.

The report is divided into three sections. The first section addresses the Monitor's review of CSHM's chart audit. The second section sets forth the Monitor's review of approximately half of the records identified in the CRAFT report. The third section analyzes CSHM systems and whether these systems were effective in identifying quality of care issues in this Clinic.

Desk Audit

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the first quarter of 2011 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on six of the ten visit records reviewed.

Review of CSHM Chart Audit

Ten records were reviewed, five for each dentist, following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentists. Both dentists scored lower under the Monitor's review compared to the CSHM audit, with an automatic failure of one dentist due to insufficient documentation for the medical necessity of treatment provided to patients #001 and #004. The Monitor's overall Clinic score of 92 percent was also lower than CSHM's overall Clinic score of 96 percent.

	Monitor Score	CSHM Score
Dr. [redacted]	Automatic failure	98%
Dr. [redacted]	97%	100%
Clinic Total Audit Score	92%	96%

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from an e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified. These findings are also included below.

Dr. [redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	There is no documentation on the upper odontogram of the Tooth Chart of the radiographically demonstrable abscesses of teeth #F and #I, evident on the X-rays dated November, 2, 2010. The CSHM audit tool spreadsheet showed "no" was scored for this question; however, there was no summary of the finding included in the e-mail to the Clinic.	
#43	Upon the Monitor's pediatric dentist's review of the X-rays and Treatment Plan, both dated November 2, 2010, the Treatment Plan appears to show an error regarding treatment options for teeth #I and #B. It shows to extract tooth #B (which appears radiographically to be restorable) and to restore it with a pulpotomy and stainless steel crown (SSC), or to extract tooth #I (which has a large radiographically demonstrable abscess in the furcation of the tooth and is definitely indicated for extraction). Both teeth #B and #I were extracted.	
#68	The duplicate X-rays dated November 2, 2010, were not labeled	X-rays- should be documented with name, date of birth (DOB), date of

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
	right and left.	service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
The current *Guidelines* do not address this issue.	The Spanish Health History form dated November 2, 2010, did not appear to include a statement regarding the agreement with the OIG or the availability of an adverse event log for the Clinic. No form identification code was visible on the scanned copy to determine which version was used by the Clinic.	
The current *Guidelines* do not address this issue.	A panoramic X-ray was taken on November 2, 2010, with no documentation of interpretation or the medical necessity to support the need for a panoramic examination. According to the *American Dental Association (ADA) / Food and Drug Administration (FDA) Guide to Patient Selection for Dental Radiographs*, the age and dental development of the child did not warrant the need for a panoramic examination. The Monitor is aware that Dr. [redacted], CDO, has addressed the issues pertaining to documentation of medical necessity and interpretation of radiographs in several Best Practices Internal Memorandums and webinars.	
The current *Guidelines* do not address this issue.	The local anesthesia section of the Op Sheet dated November 5, 2010, recorded infiltration as the only method of delivery for local anesthesia with no indication that an inferior alveolar nerve block was administered to anesthetize lower teeth, which were treated with pulpotomies and stainless steel crowns (SSCs). Review of the operative procedures	

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
	form (Op Sheet) indicates that two carpules of local anesthesia were administered by infiltration technique. The Monitor's pediatric dentist determined this is an inadequate amount of anesthesia to provide proper pain control for the extent of treatment performed. All diagnosed treatment for 12 teeth, in 5 separate sextants of the mouth, was provided in 1 appointment. Four fully rooted teeth were extracted, which requires palatal anesthesia, eight teeth received pulpotomies, which involves removing nerve tissue from the teeth, and eight teeth received SSCs.	
The current *Guidelines* do not address this issue.	There was inadequate documentation on the Tooth Chart dated November 2, 2010, to support the medical necessity for the extraction of teeth #B, #E, #F, and #I. The X-ray of tooth #B reveals a large carious lesion indicated for a pulpotomy and SSC; however, tooth #B was extracted with no documentation of medical necessity for the extraction and placement of a space maintainer. The only reasons for the extraction of tooth #B would be complaints of spontaneous pain or radiographic evidence of abscess and neither is documented. In addition, there was no medical necessity documented for the extraction of tooth #I and placement of a space maintainer, because there was no documentation of the interpretation of the radiographic findings of an abscess on tooth #I. There also was no medical necessity documented for the extraction of tooth #F, because there was no	

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
	documentation of the interpretation of the radiographic findings of an abscess on tooth #F. The X-ray of tooth #E shows a large carious lesion that could have been restored with a pulpotomy and SSC; however, the tooth was extracted and there was no documentation of medical necessity for the extraction.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#57	The time recorded for protective stabilization was 1 hour and 45 minutes. The Comments/Progress Notes form dated September 28, 2010, reports "mom wanted all treatment completed today" with the last entry stating "procedure over one hour due to multiple breaks and trying to calm patient." According to the *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services*, "The guideline for a maximum appointment length is one hour, exclusive of the dental hygiene portion. This guideline may be extended if, in the Dentist's professional judgment, continuation of the procedure for an additional limited time period (e.g., 10-15 minutes) would allow for completion of on-going procedures or additional procedures in order to complete planned treatment. Extension of the one-hour guideline should be minimized for all patients undergoing protective stabilization." The patient's mental and physical well-being should always come before a parent's desire to have treatment completed in one appointment.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#68	The duplicate X-rays dated September 22, 2010, and September 28, 2010, were not labeled right and left.	X-rays- should be documented with name, date of birth (DOB), date of service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
The current *Guidelines* do not address this issue.	The local anesthesia section of the Op Sheet dated September 28, 2010, recorded infiltration as the only method of delivery for local anesthesia with no indication that an inferior alveolar nerve block was administered to anesthetize lower teeth that were treated with pulpotomies and SSCs. Review of the Op Sheet indicates that 1.5 carpules of local anesthesia were administered by infiltration technique. This is an inadequate amount of anesthesia to provide proper pain control for the extent of treatment performed. All diagnosed treatment for 12 teeth, in 5 separate sextants of the mouth, was provided in 1 appointment. Nine teeth received nerve treatments and SSCs, and three teeth received fillings. In addition, the patient was placed in a papoose board for treatment, and the progress notes indicate the patient cried and resisted treatment. These behaviors are consistent with inadequate anesthesia. The amount of anesthesia administered and techniques documented certainly make it a possibility the child was being hurt during treatment.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The Guidelines indicate that "yes" is scored for this question when "the name, address, and telephone number in sections A & B are completely documented and form is signed and dated." Therefore, the Monitor scored "no" for this question because the parent did not complete section B of the Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian (Authorization) form.	
#15	The copy of the Health History form dated December 13, 2010, had two blackened-out sections, which made it difficult for the Monitor to determine completeness of the document. Speech/hearing problems and the area to mark "yes" were blackened out. The "no" area was not marked and there was no explanation whether "yes" was the answer. A portion of the Disabilities/Special Needs section was also blackened out. The Health History form does note "cleft lip and cleft palate" on the line for explanation for "yes" answers; however, there are no further details describing the patient's history with this significant oral manifestation and the associated repercussions for dental management.	
#20	There is no documentation of this patient's craniofacial abnormality (cleft lip/cleft palate) on the upper odontogram or in the notes section of the Tooth Chart.	
#67	The X-rays of the maxillary anterior	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
	region, a panoramic X-ray, and an anterior occlusal X-ray of this patient are of poor quality and insufficient to properly diagnose the abnormalities present in the anterior region. The diagnosis of a supernumerary tooth and the acquisition of consent to extract this tooth are of concern considering the poor quality of the diagnostic and radiographic work-up.	
#68	The duplicate X-rays dated, December 13, 2010, were not labeled right and left.	X-rays- should be documented with name, date of birth (DOB), date of service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
The current *Guidelines* do not address this issue.	The local anesthesia section of the Op Sheet dated December 22, 2010, recorded infiltration as the only method of delivery for local anesthesia. There was no indication that an inferior alveolar nerve block was administered to anesthetize lower posterior teeth treated with pulpotomies and SSCs. There was also no documentation of anesthesia administered to the palatal mucosa for the maxillary extractions that were performed. The Monitor's pediatric dentist reviewed the Op Sheet and determined the 1.5 carpules of local anesthesia were an inadequate amount to provide proper anesthesia for the extent of treatment performed. All diagnosed treatment for eight teeth, in four separate sextants of the mouth, was provided in one appointment. Seven teeth received nerve treatments and SSCs, and one fully rooted tooth was extracted. Painless extractions of maxillary teeth require palatal anesthesia, and there was no	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
	documentation to indicate this was administered. In addition, the patient was placed in a papoose board for treatment, and the progress notes indicate the patient cried and resisted treatment. These behaviors are consistent with inadequate anesthesia. The amount of anesthesia administered and techniques documented certainly make it a possibility the child was being hurt during treatment.	

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#60	The pulpotomies performed on teeth #S and #T were not recorded on the lower odontogram of the Tooth Chart.	
#68	The duplicate X-rays dated December 15, 2010, were not labeled right and left.	X-rays- should be documented with name, date of birth (DOB), date of service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
The current *Guidelines* do not address this issue.	Upon the Monitor's pediatric dentist's review of the bitewing X-rays dated December 15, 2010, proximal lesions on the distal of tooth #B, mesial of tooth #K, and distal of tooth #L were evident but did not appear deep enough into dentin to indicate the need for pulpotomies. Therefore, the X-rays do not support the medical necessity for the pulpotomies performed on teeth #B, #K, and #L because the decay did not extend half way to the pulp.	
The current *Guidelines* do not address	The local anesthesia section of the Op Sheet dated December 21, 2010, recorded infiltration as the only method of delivery for local anesthesia to the right side of the	

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
this issue.	mouth with no indication that an inferior alveolar nerve block was administered to anesthetize lower right teeth, which were treated with pulpotomies and SSCs. Review of the Op Sheet indicates that 1.5 carpules of local anesthesia were administered by infiltration and inferior alveolar technique on the left and infiltration only on the right side of the mouth. This is an inadequate amount to provide proper anesthesia for the extent of treatment performed. All diagnosed treatment for eight teeth, in four separate sextants of the mouth, was provided in one appointment. Seven teeth received nerve treatments and SSCs and one tooth received a filling. The patient was placed in a papoose board for treatment, and the progress notes indicate the patient cried and resisted treatment. These behaviors are consistent with inadequate anesthesia. The amount of anesthesia administered and techniques documented certainly make it a possibility the child was being hurt during treatment.	

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#14	The patient's gender was not indicated on the Health History form.	
#15	CSHM's auditor recorded a "yes" for this question on the audit tool spreadsheet; however, a finding was reported in the e-mail to the Clinic. The Health History form appears to have been completed on July 9, 2010, by the parent; however, the patient was not seen until October 5, 2010. The Monitor did not identify	Health history- the dates for the parent and dentist are 3 months apart.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
	this as a reportable finding since the dentist reviewed the Health History and recorded no change by her dated signature.	
#27	The Hygiene Procedures form dated October 5, 2010, recorded the incorrect date of birth for the patient.	
#37	The Hygiene Procedures form dated October 5, 2010, did not have initials or a diagonal line following the last entry in the notes section.	Hygiene sheet (10/05/10) – There should be a diagonal line or initials on the line immediately after the last note on the operative or hygiene sheet to show that no further entries were made.
#68	The duplicate X-rays dated October 5, 2010, were not labeled right and left.	X-rays- should be documented with name, date of birth (DOB), date of service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
The current *Guidelines* do not address this issue.	The local anesthesia section of the Op Sheet dated October 6, 2010, recorded infiltration as the only method of delivery for local anesthesia. There was no indication that an inferior alveolar nerve block was administered to anesthetize lower teeth, which were treated with pulpotomies and SSCs. The Monitor's pediatric dentist's review of the Op Sheet found that only half of one carpule (0.5) of local anesthetic had been administered. This is an inadequate amount of local anesthesia to provide proper anesthesia for the extent of treatment performed. All diagnosed treatment for eight teeth, in four separate sextants of the mouth, was provided in one appointment. Six teeth received nerve treatments and SSCs, and two teeth received fillings. The patient was placed in a papoose	

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
	board for treatment, and the progress notes indicate the patient cried and resisted treatment. These behaviors are consistent with inadequate anesthesia. The amount of anesthesia administered and techniques documented certainly make it a possibility the child was being hurt during treatment.	

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The entire maxillary anterior sextant was visible on the maxillary occlusal X-ray dated September 29, 2010, and the existing conditions for that sextant were properly documented; therefore, the Monitor recorded "yes" instead of "can't verify" for the documentation of existing conditions. This decision was based on the *Guidelines* description of "Common uses of Can't verify," which states: "Existing conditions are only verified for the quadrant that has received treatment. A can't verify is given for the existing conditions question (#20) when the x-rays do not show the entire quadrant/sextant." Due to the patient's age on the date of service (16 months), the Monitor felt the maxillary anterior X-ray was sufficient to assess the documentation of existing conditions pertaining to the maxillary anterior sextant.	Tooth chart (09/23/10) – the x-rays dated 09/29/10 does not show all teeth therefore can't verify if teeth have existing conditions. Treatment to be completed should not be documented on the upper tooth chart.
#59	The Monitor recorded "can't verify" for this question because the copy of the Op Sheet dated September 29, 2010, did not show the treatment time at the bottom of the form; therefore, the Monitor was unable to	

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
	determine the length of treatment time.	
#68	The duplicate X-rays dated September 29, 2010, were not labeled right and left.	X-rays- should be documented with name, date of birth (DOB), date of service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
#71	The Hygiene Procedures form dated September 23, 2010, shows that no X-rays were taken due to poor cooperation; however, the Account History Report, on that date of service, shows billing for a periapical X-ray of tooth #E and an additional periapical X-ray of tooth #O. The billing error was addressed in the chart audit results e-mail to the Clinic; however, the documentation received from the Clinic does not indicate this billing error was corrected.	Billing – The account history dated 09/23/10 has code 0220(periapical first film) and code 0230(x-ray-each additional film) but is not documented on the hygiene sheet dated 09/23/10.
The current *Guidelines* do not address this issue.	Errors on the Hygiene Procedures form dated September 23, 2010, were not initialed and dated.	Hygiene sheet (09/23/10) – Error corrections- When an error has been made please mark through the error with one line, document the date, and the initials of the person who made the correction.
The current *Guidelines* do not address this issue.	Fluoride varnish application was checked and the entire fluoride section was marked through on the Hygiene Procedures form dated September 23, 2010; however, there was no explanation why fluoride was not applied to a patient with severe early childhood caries.	
The current *Guidelines* do not address this issue.	The Monitor observed on the Health History form dated September 23, 2010, that the patient's preferred language was Spanish and a Spanish Acknowledgment, Authorization, and Health History form was completed; however,	

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
	English consent forms were used for stabilization, treatment authorization, local anesthesia, and nitrous oxide.	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The Monitor was unable to verify that existing conditions were properly documented because there were no new X-rays taken on the date of service. The X-rays provided to the Monitor were not only dated incorrectly (December 31, 2010, instead of December 31, 2009) but they were taken nine months prior to the date of service and prior to the patient receiving restorative dental treatment.	
#33	This specific question relates to the Hygiene Procedures form dated September 29, 2010. Neither X-rays nor digital pictures were taken during the hygiene appointment. The Guidelines instruct the auditor to score this question as "no" "when X-rays were not taken and digital pictures were not sent."	
#68	The duplicate X-rays dated December 31, 2010, were not labeled with the correct date or labeled right and left. The Account History Report records the date of service for these X-rays as December 31, 2009.	X-rays- should be documented with name, date of birth (DOB), date of service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
The current *Guidelines* do not address this issue.	Question #32 does not instruct the auditor to evaluate the appropriateness of the reason documented for not taking X-rays; therefore, the audit tool did not capture the following finding: The Hygiene Procedure form dated September 29, 2010, noted "not due" as the reason for not taking X-rays;	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
	however, the chief complaint documented the patient was in pain and new disease was found upon examination. The patient's report of pain and the new disease were an indication that X-rays were necessary and should have been taken to support the medical necessity for the planned treatment.	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The existing filling on tooth #7 was not recorded on the upper odontogram of the Tooth Chart. The filling on tooth #7 is evident on both the panoramic and maxillary periapical X-rays. However, the filling appears to be on tooth #10 on the periapical X-ray because the X-ray was duplicated incorrectly and was not labeled right or left.	
#62	There was no dentist's signature on the Op Sheet dated October 11, 2010.	
#63	There were no initials or a diagonal line following the last entry in the notes section on the Op Sheet dated October 11, 2010.	Operative sheet (10/11/10) - There should be a diagonal line or initials on the line immediately after the last note on the operative or hygiene sheet to show that no further entries were made.
#68	The CSHM audit tool spreadsheet showed "no" was scored for this question; however, there was no explanation of the finding included in the e-mail to the Clinic. Upon review of the X-rays, the Monitor found the September 23, 2010, maxillary periapical X-ray was duplicated incorrectly and was not labeled right or left.	

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#28	The temporomandibular joint (TMJ) section on the September 14, 2010, Hygiene Procedures form was not completed.	Hygiene sheet (09/14/10) – The TMJ was not documented under the dental evaluation section.
#68	The CSHM audit tool spreadsheet showed "no" was scored for this question; however, there was no explanation of the finding included in the e-mail to the Clinic. The duplicate X-rays dated September 14, 2010, were not labeled right and left.	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#14	The Medical Alert sticker covered the age and year of birth on the September 28, 2010, Health History form. The parent also did not indicate the patient's gender. According to the progress notes, the patient's father completed a new Health History form after the September 28, 2010, operative visit when the father revealed a health concern during treatment. The Appointment Inventory form does not record the presence of an initial Health History form and only records the Health History form dated September 28, 2010. The Monitor is curious whether a Health History form was completed prior to the initial exam and hygiene visit on September 23, 2010.	
#27	According to the patient's date of birth, the patient's age is recorded incorrectly on the Hygiene Procedures form dated September 23, 2010.	
#28	The occlusion section was not	Hygiene sheet (09/23/10) – The

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
	completed on the Hygiene Procedures form dated September 23, 2010.	occlusion was not documented under the dental evaluation section.
#46	The dentist did not sign the Local Anesthesia and Nitrous Oxide Consent form dated September 23, 2010.	Treatment plan (09/23/10) – The dentist did not sign the local anesthesia/nitrous oxide form.
#52	The Op Sheet dated September 23, 2010, did not have a check mark recorded for "New Patient" or "Recall Patient."	Operative sheet (09/23/10) – A check mark was not documented beside "new patient" or "recall appointment" in the reviewed medical history section.
#68	The duplicate X-rays dated September 23, 2010, and September 28, 2010, were not labeled right and left. Upon review of the bitewing X-rays dated September 28, 2010, the Monitor noticed the X-rays were labeled so they appeared upside down.	X-rays- should be documented with name, date of birth (DOB), date of service (DOS), labeled left and right, and duplicated in the correct order. This includes occlusal x-rays.
#71	This question asks if all procedures were billed accurately. Originally, the Monitor did not have this finding because the Hygiene Procedures form dated September 23, 2010, had single lines marked through most of the areas where services were not rendered. This practice makes it difficult for front office staff members and outside auditors to determine what services were actually provided. Upon further review of the Clinic's e-mail to CSHM concerning billing errors, the Monitor noted a comment from the Clinic's office manager stating that two bitewing X-rays were taken during the operative appointment on September 28, 2010, but had not been recorded on the Account History Report. This billing error was corrected. Since this	Billing- the hygiene sheet dated 09/23/10 has code 0274 (four bitewing film) documented but code 0274 (four bitewings) is not documented on the account history dated 09/23/10.

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
	may have been the billing error communicated by CSHM's auditor, the Monitor scored this question as "no."	
The current *Guidelines* do not address this issue.	The Hygiene Procedures form dated September 23, 2010, showed that fluoride was not applied to a patient with severe early childhood caries and there was no explanation given in the patient's record.	

The CSHM chart audit results e-mailed to the Clinic reported the following errors were most commonly found:

- X-rays should be documented with name, DOB, DOS, labeled left and right, and duplicated in the correct order. This includes occlusal X-rays.
- Please do not copy the entire patient chart when sending requested materials for quarterly chart audits. Please only send what is requested.

Below is a summary of the Monitor's findings:

- One record (patient #003) did not have Section B of the Authorization form completed by the parent.
- The following findings are related to the Health History form:
  - The Health History form for patient #003 had two blackened-out sections, which made it difficult for the Monitor to determine completeness of the document. There were also no details given regarding the patient's cleft lip and cleft palate.
  - CSHM's auditor recorded a "yes" for question #15 on the audit tool spreadsheet for patient #005; however, a finding was reported in the e-mail to the Clinic. The Health History form appears to have been completed on July 9, 2010, by the parent; however, the patient was not seen until October 5, 2010. The Monitor did not identify this as a reportable finding.
  - Two additional records (patients #005 and #010) contained Health History forms that did not indicate the sex of the patient.
  - The Health History form for patient #010 had a Medical Alert sticker placed over the child's age and year of birth. According to the notes on the Op Sheet dated September 28, 2010, the father mentioned a health condition during treatment that was not recorded on the Health History form. Treatment was stopped, a medical consult was requested, and the father was asked to complete a new Health History form. The Monitor received only the Health History form dated September 28, 2010, with the requested materials. The initial Health History form was not sent with the requested materials.

- The Monitor had the following findings with respect to the Tooth Chart:
  - Three records (patients #001, 003, and #008) did not show documentation of all existing conditions or restorations, pertaining to the treated quadrant, on the upper odontogram of the Tooth Chart.
  - The Monitor was unable to determine the accuracy of charting existing conditions and restorations in one record (patient #007) because there were no new X-rays taken on the date of service. The X-rays sent with the requested materials were taken nine months before the audited date of service, prior to any restorative dental treatment.
- The following findings are related to the Hygiene Procedures form:
  - Two records (patients #005 and #010) did not have the patient's date of birth or age recorded correctly.
  - Two records (patients #009 and #010) did not have the dental evaluation section completed correctly.
  - One record (patient #007) showed that X-rays and/or digital pictures were not taken on a patient who complained of pain and had disease diagnosed and treatment planned at the time of the hygiene visit.
  - One record (patient #005) did not have notes documented correctly.
- The Treatment Plan dated November 2, 2010, for patient #001 appears to show an error regarding treatment options for teeth #I and #B. It shows to extract tooth #B (which appears radiographically to be restorable) and to restore with pulpotomy and SSC or extract tooth #I (which has a large radiographically demonstrable abscess in the furcation of the tooth and is definitely indicated for extraction). Teeth #B and #I were extracted.
- One record (patient #010) did not have a dentist's signature on the Local Anesthesia and Nitrous Oxide Consent form.
- The Op Sheet for patient #010 did not have a check mark recorded to indicate whether the patient was a "New Patient" or "Recall Patient."
- One record (patient #002) showed use of a stabilization device (papoose) for 1 hour and 45 minutes, which extends beyond the time guidelines established by CSHM. The Comments/Progress Notes form dated September 28, 2010, reports "mom wanted all treatment completed today" with the last entry stating "procedure over one hour due to multiple breaks and trying to calm patient." The *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* state: "The guideline for a maximum appointment length is one hour, exclusive of the dental hygiene portion. This guideline may be extended if, in the Dentist's professional judgment, continuation of the procedure for an additional limited time period (e.g., 10-15 minutes) would allow for completion of on-going procedures or additional procedures in order to complete planned treatment. Extension of the one-hour guideline should be minimized for all patients undergoing protective stabilization."

- The copy of the Op Sheet of one record (patient #006) did not show the treatment time at the bottom of the form; therefore, the Monitor was unable to determine the length of treatment time.
- One record (patient #004) did not show documentation of the pulpotomies performed to teeth #S and #T on the lower odontogram of the Tooth Chart.
- The Op Sheet for patient #008 did not have the dentist's signature and the notes section was not completed correctly.
- The X-rays of the maxillary anterior region (a panoramic X-ray and anterior occlusal X-ray) of patient #003 were of poor quality and insufficient to diagnose the abnormalities present in the anterior region.
- All ten reviewed records contained duplicate X-rays that were not labeled right or left.
- CSHM reported two billing errors (patients #006 and #010); however, the billing error for patient #006 was not clearly communicated by the auditor and does not appear to have been corrected. The Account History Report showed billing for two periapical X-rays when X-rays were not taken. The documentation provided to the Monitor does not show the billing error was corrected.
- The following are additional findings that were not captured in CSHM's Chart Audit Tool:
  - The Spanish Health History form dated November 2, 2010, in the record for patient #001 did not appear to include a statement regarding the agreement with the OIG or the availability of an adverse event log for the Clinic.
  - The record for patient #001 did not show documentation of interpretation or documentation of medical necessity to support the need for a panoramic X-ray.
  - One record (patient #006) did not have proper error corrections on the Hygiene Procedures form.
  - Two records (patients #006 and #010) showed that a prophylaxis was performed; however, fluoride was not applied to the teeth of children with severe early childhood caries.
  - The record for patient #006 showed Spanish as the preferred language with a Spanish Health History, Acknowledgement and Authorization form completed by the parent; however, English consent forms were used for stabilization, treatment authorization, local anesthesia, and nitrous oxide.
  - One record (patient #007) showed X-rays were not taken because they were "not due"; however, the chief complaint documented the patient was in pain and new disease was found upon examination. The patient's report of pain and the new disease were an indication that X-rays were necessary and should have been taken to support the medical necessity for the planned treatment.
  - The following findings relate to the records reviewed for Dr. [redacted]

- All five records showed infiltration of local anesthesia was used instead of an inferior alveolar nerve block to anesthetize lower teeth, which were treated with pulpotomies and SSCs.
- All five records documented use of an inadequate amount of local anesthesia to provide proper pain control for the extent of treatment performed.
- All five records recorded the provision of full mouth, invasive dental treatment for 8 to 12 teeth in one appointment.
- All five records showed a total of 37 pulpotomies and SSCs were performed with a pulp-to-crown ratio of 100 percent.
- Two of the five records (patients #001 and #004) did not show adequate documentation to support the medical necessity of treatment provided. The Tooth Chart for patient #001 did not document the medical necessity for the extraction of teeth #B, #E, #F, and #I. The X-rays for patient #004 did not support the medical necessity for the pulpotomies performed on teeth #B, #K, and #L.
- Four of the five records reviewed showed use of the papoose board for patient stabilization. The four patients who received protective stabilization were one 3-year-old, one 4-year–old, and two 5-year-old patients. All four of these records contained notes indicating the patient cried and resisted treatment.
- All of the records included progress notes, which stated the parent requested all treatment completed on that day. The *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* sets forth the factors to be considered by the dentist when making the decision of how much treatment to accomplish in one appointment. While the parent's wishes is one factor, there are others, such as the child's ability to cooperate, the child's treatment needs, the amount of local anesthetic needed to accomplish the treatment, the technical skills of the operator, and the time available in the clinic for that child." The final statement regarding same day dental treatment reads: "The primary concerns of the Dentists should always be the health and safety of the patients."

The Monitor had the following observation:

- The majority of the Hygiene Procedures forms had single lines marked through most of the areas where services were not rendered. This practice makes it difficult for front office staff members and auditors to determine what services were actually provided.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the ten visit records:

- Ensure staff members are verifying correct completion of the Authorization for Disclosure of Protected Health Information and the Authorization of Persons to Consent for Treatment forms.
- Ensure requested materials sent to CSHM are complete and of a quality that will allow for accurate review.
- Ensure all requested materials sent to the Monitor are complete and of a quality that will allow for accurate review.
- Ensure staff members are properly reviewing the patient's Health History form for completeness of patient information and documenting findings related to missing information or explanations to "yes" responses.
- Ensure staff members are not obstructing the view of important patient identification or health information on the Health History form.
- Ensure staff members are correctly documenting existing conditions, restorations, planned treatment, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual.*
- Ensure staff members are properly completing Hygiene Procedure form, Op Sheet, and Treatment Plan.
- Ensure staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure the billing error for patient #006 is corrected and determine if it was corrected within the CSHM timeframes.
- Ensure staff members are using current Spanish Health History forms, which include the statement regarding the OIG and availability of the adverse event log.
- Ensure staff members are following the *American Dental Association (ADA) / Food and Drug Administration (FDA) Guide to Patient Selection for Dental Radiographs* and documenting interpretation of all exposed X-rays.
- Ensure staff members are correcting all documentation errors properly.
- Ensure staff members are providing fluoride treatment to all children or documenting the reason for not providing this service.
- Further assessment by the CDO is needed to determine trends and training needs in this Clinic related to full mouth, invasive restorative procedures performed on young patients without the use of adequate local anesthesia and often utilizing stabilization.
- Further assessment by the CDO is needed to determine the pulpotomy-to-crown ratio with additional record reviews to determine if there is evidence of overtreatment in this Clinic.
- Ensure dentists are delivering an adequate dose of local anesthesia, using appropriate delivery methods, and performing an assessment to determine effectiveness of local anesthesia.
- Ensure dentists are following the *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* with respect to treatment time, stabilization, and when to refer a patient to a specialist.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure CSHM is clearly communicating billing issues as well as any required action by the Clinic to correct the billing error.
- Ensure clarification of guidelines related to quality of care issues are being communicated to clinic staff and CSHM auditors.
- Ensure that CSHM auditors are adequately trained to review X-rays, identify quality of care issues, and can properly determine when to consult the CDO.
- Ensure modifications are made to CSHM's Chart Audit Tool to capture all quality of care issues.
- Establish a process to evaluate and standardize CSHM auditors to establish a high degree of reliability in CSHM audit findings.

Review of Records Identified in CRAFT Reports

The Monitor requested all patient records identified in the CRAFT reports from February 2010 through June 2, 2010 for this Clinic. The records identified in the CRAFT reports because there were seven or more pulpotomies or crowns performed during one visit. The Monitor received 70 records, of which, 63 were related to care rendered by Dr. [redacted]. After reviewing 40 records, the Monitor determined it had obtained sufficient information to understand the issues present in this Clinic related to quality of care. Of the 40 records reviewed, two did not have the correct X-rays and were removed from the sample. Of the remaining 38 records, 34 related to Dr. [redacted] These 34 records were used for the basis of the analysis provided below. The purpose of this analysis is to provide a macro picture of the types of issues identified related to the manner that care is being provided in this Clinic by this dentist. The Monitor then reviewed the CSHM systems to determine if any of these issues were identified, and if so, what CSHM's response was to them.

Figure one depicts the ages that were treated in these 34 records. As noted below, the majority of the patients were between the ages of three and six.

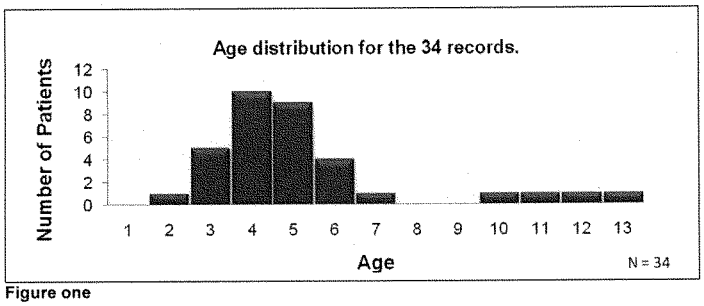


Figure one

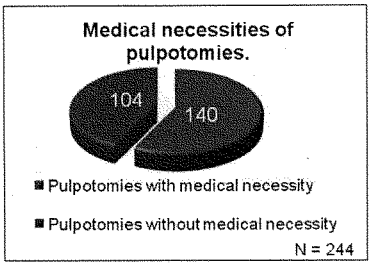


Figure two

The Monitor reviewed the number of pulpotomies performed by Dr. [redacted] in these 34 records. As Figure two demonstrates, 244 pulpotomies were performed. Of this number, the Monitor's pediatric dentist determined that 104 pulpotomies were not medically necessary. For every record the Monitor reviewed, there was inadequate documentation to support the medical necessity for at least one of the treatments provided. The Monitor also analyzed the ratio of pulpotomies to crowns. Dr. [redacted] had a 98 percent ratio for the treatment rendered in these 34 records.

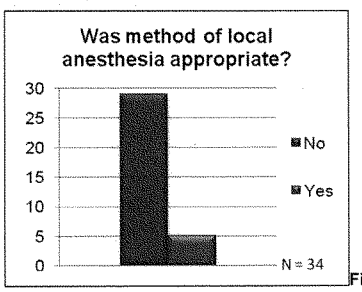


Figure three

Figure three indicates out of the 34 records where local anesthesia was administered, the method of local anesthesia documented in 29 records was not appropriate. The method of local anesthesia documented in 29 of the 34 records was infiltration which is not considered the most effective standard for anesthetizing mandibular teeth planned for pulpotomy or extraction. A study conducted by Constantine Oulis reported, "mandibular infiltration is effective but not reliable for pulpotomy in a primary molar, either in primary or mixed dentition."

Specifically, when pulpotomies and extractions are performed on primary mandibular molars, scientific studies indicate the preferred method to obtain adequate anesthesia is the inferior alveolar block, and in the case of extraction, the long buccal. Infiltration, as a method for administration of anesthesia, frequently provides inadequate anesthesia for these procedures in the mandible, and the child can experience pain. In the records identified, infiltration was used to anesthetize children receiving pulpotomies and/or extractions of primary mandibular molars.

In addition to reviewing whether the method was appropriate, the Monitor also reviewed whether a minimum dose of .5 carpule per quadrant or sextant was used for local anesthesia and the maximum Dose Calculated for Patient's Weight (DCPW) was not exceeded. Specifically, in order to achieve adequate anesthesia for teeth in each sextant, a minimum of .5 carpules should be provided using infiltration as the method of administration. If in the mandible, the inferior anveolar nerve block method of administration is used, a minimum of .5 carpules per quadrant would be necessary. If the infiltration method is used for the mandible, however, the amount of anesthesia necessary would be .5 carpules per sextant. The Monitor took a conservative approach in determining the minimum amount of anesthesia required. The Monitor used Stanley Malamed's recommendation of 0.5 carpule of local anesthetic for maxillary infiltration to anesthetize the permanent maxillary premolars and extrapolated that to 0.5 carpules per sextant for the infiltration method of administering anesthesia to anesthetize the primary teeth located in that sextant. When mandibular block anesthesia was used, the Monitor considered that a minimum of 0.5 carpule per quadrant was appropriate. Figure four indicates of the 34 records where local anesthesia was administered, 24 records did not have a minimum of .5 carpules of local anesthesia for each quadrant or sextant.

As depicted in Figure five, this information was also analyzed to determine the ages of the patients that did not receive adequate anesthesia.

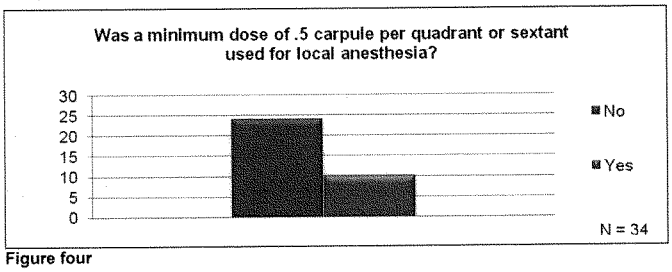


Figure four

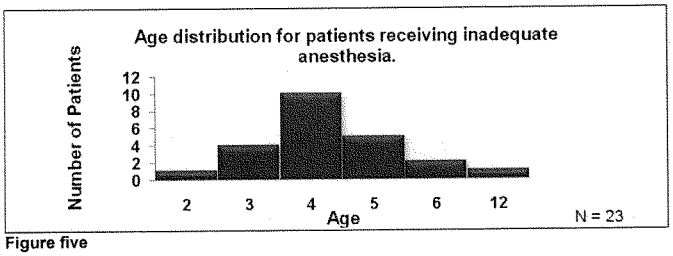


Figure five

Figure six illustrates that of the 34 patients treated, stabilization was used for 26 patients. Figure seven indicates that of those 26 patients where stabilization was used, there was insufficient anesthesia administered for 20 of those patients. Of those 20 patients who were stabilized and had insufficient anesthesia, every one of those patients had pulpotomies performed. The Monitor is concerned that these children were inadequately anesthetized for the procedures being performed and were resisting treatment because they were being hurt, which then led to stabilization.

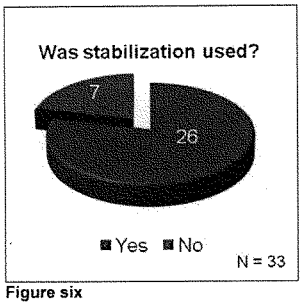


Figure six

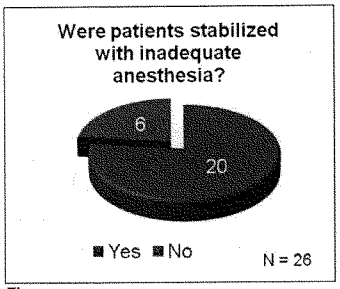


Figure seven

Evaluation of Systems

CSHM has implemented a number of systems designed to identify quality of care issues at their clinics. CRAFT reports are developed to identify various outliers and are reviewed monthly. Chart audits are conducted quarterly. Internal audits are performed, and the CDO performs on-site visits. Patient and employee complaints are captured and responded to, including issues that might be identified in an exit interview. The Monitor reviewed each of these systems to determine if the quality of care issues the Monitor has identified above were also identified by CSHM and investigated and addressed.

CRAFT Reports

Each month, CSHM issues a CRAFT Report that identifies clinics that are outliers in certain categories. During the kick-off meeting, CSHM identified these reports as a compliance resource to identify potential quality of care and/or compliance issues. These categories include, but are not limited to, seven or more SSCs or pulpotomies in a single visit, eleven or more fillings in a single visit, and six or more extractions in a single visit. This Clinic was identified in each of the CRAFT reports as an outlier for SSCs and/or pulpotomies from January 2010 through May 2011, with the exception of the October 2010 report. The Monitor noted Dr. [redacted] was on vacation for three weeks in September. The Monitor requested any follow-up CSHM conducted related to identification of this Clinic as an outlier. CSHM provided a spreadsheet that reflected "an analysis of the number of times a filling was billed a second time on the same tooth."

Chart Audits

CSHM conducts chart audits quarterly for each Clinic. According to the presentation provided during the kick-off meeting, the centers and dentists are scored on clinical, quality of care, billing, and documentation indicators. In addition, the management response to the June 28, 2010, internal audit indicated that "Over/Under Utilization of Dental Services are key areas reviewed in the chart audit process." Set forth below are the chart audit results for the Clinic and Dr. [redacted] from January 2010 to June 2011.

Date of Audit	Clinic's Results	Dr. [redacted] Results
January 2010	96%	100%
April 2010	98%	100%
July 2010	90%	91%
October 2010	99%	98%
January 2011	96%	98%
April 2011	98%	97%

The chart audits did not identify any quality of care issues.

Internal Audits

At the time of the request, there had been no internal audit reports issued for this Clinic.

Chief Dental Officer On-sites

The CDO did not conduct an on-site at this Clinic.

Complaints and Exit Interviews

There were 16 complaints provided to the Monitor. They related to a variety of issues, including wait times, rude staff, and having to view treatment from the consult room instead of the hygiene bay. The lead dentist reported a parent complaint that was investigated as a possible adverse event. A parent complained her child had a bruise on her chin. According to the report, this child was "kicking, moving, twisting her body, and pulling the nitrous off." The child was stabilized using a papoose board and a dental assistant held her head using a towel. The mother was in the room and signed a consent form for the stabilization. This child received an injection of Lidocaine. Attempts were made to contact the mother after her complaint. The CDO could not substantiate whether this was an adverse event because the bruise could have happened as a result of the injection or through her own movements.

Another complaint was made to the Virginia Department of Health Professions about care rendered by Dr. [redacted] The allegation stated the patient was "papoosed and wet her pants during a visit which lasted in total 1 hour," and the patient's mother, who had two other children with her, was not allowed to accompany her child. The last notation in the materials is dated October 19, 2010, indicating the Clinic received an e-mail "acknowledging no action required on their end at this time."

In summary, the systems designed to detect quality of care issues in the clinics were not effective in identifying the quality of care issues in this Clinic. There were a couple of complaints that related to quality of care and repeated CRAFT reports this Clinic was an outlier for the number of pulpotomies and crowns being performed in a single visit; however, CSHM did not conduct any further investigation or inquiry into the quality of care rendered in this Clinic.

Recommendations

The following recommendations relate to the Monitor's evaluation of CSHM's systems for identifying quality of care issues in its Clinics:

- Ensure the information being provided in the CRAFT reports is used to determine which Clinics need further investigation about possible quality of care issues.
- Ensure the chart audits are designed in a manner to identify possible quality of care issues.

EXHIBIT 24

Jan 14, 2012

CSHM policy on protective stabilization

The CSHM policy on protective stabilization is a set of clinical guidelines based on the section on *"Protective Stabilization"* from the American Academy of Pediatric Dentistry's "Guideline on Behavior Guidance for the Pediatric Dental Patient."[1]

In the **Overview** section of its *Reference Manual,*[2] AAPD defines guidelines as "intended to be more flexible than standards. Guidelines should be followed in most cases, but they recognize that treatment can and should be tailored to fit individual needs, depending on the patient, practitioner, setting, and other factors. Deviations from guidelines could be fairly common and could be justified by differences in individual circumstances. Guidelines are designed to produce optimal outcomes, not minimal standards of care." Thorough documentation is critically important when deviations occur from CSHM's policy on protective stabilization. For the protection of our patients and our dentists, it is crucial that the record reflect each judgmental factor considered when determining that a deviation is necessary and in the best interest in the patient.

CSHM recognizes that the communities of patients served by CSHM Associated Dental Centers vary not just geographically, but also in terms of prevailing parenting styles, access by families to the Dental Center, access to other dental care providers who treat economically disadvantaged patients, options available to the Dental Center for treatment of patients under sedation or general anesthesia, and options available to the Dental Center for referral for treatment under sedation or general anesthesia.

alternatives. Careful, continuous monitoring of the patient is mandatory during protective stabilization."

The guideline continues: "Partial or complete stabilization of the patient sometimes is necessary to protect the patient, practitioner, staff, or the parent from injury while providing dental care. Protective stabilization can be performed by the dentist, staff, or parent with or without the aid of a restrictive device. The dentist always should use the least restrictive, but safe and effective, protective stabilization. The use of a mouth prop in a compliant child is not considered protective stabilization, though it may be very helpful for the patient by assisting in keeping the mouth open.

"The need to diagnose, treat, and protect the safety of the patient, practitioner, staff, and parent should be considered prior to the use of protective stabilization. The decision to use protective stabilization must take into consideration:

1. alternative behavior guidance modalities, including the availability of viable referral options in the community for treatment under sedation or general anesthesia;
2. dental needs of the patient;
3. the effect on the quality of dental care;
4. the patient's emotional development;
5. the patient's medical and physical considerations.

3. facilitate delivery of quality dental treatment.

CSHM has adapted the AAPD indications for protective stabilization as follows:

Patient stabilization is indicated when:

1. a patient requires immediate diagnosis and/or limited treatment and cannot cooperate due to lack of maturity or mental or physical disability. Limited treatment in the context of passive protective stabilization refers to treatment of teeth whose supporting structures are infected (abscess, cellulitis), and/or teeth that are causing pain. Limited treatment also refers to teeth that in the judgment of the practitioner would become painful and/or infected within a short period of time if left untreated. Limited treatment in the context of active protective stabilization follows the same definition when persistent restraint of legs, arms, and/or head are necessary throughout the procedure. The requirement to provide only limited treatment is not applicable when active protective stabilization involves brief, intermittent control of a patient's hands/arms, as long as the length of the procedure is within the overall one-hour time limit for treatment.
2. the safety of the patient, staff, dentist, or parent would be at risk without the use of protective stabilization;
3. a cooperative patient becomes uncooperative in the midst of treatment and protective stabilization becomes necessary to complete the procedures (eg, tooth preparation, pulp therapy, restoration placement, extraction);

Precautions: The following precautions should be taken:

1. careful review of the patient's medical history to ascertain if there are any medical conditions (e.g., asthma), which may compromise respiratory function;
2. tightness and duration of the stabilization must be monitored and reassessed at regular intervals;
3. stabilization around extremities or the chest must not actively restrict circulation or respiration;
4. stabilization should be terminated as soon as possible in a patient who is experiencing severe stress or hysterics to prevent possible physical or psychological trauma.

Parental stabilization of patients undergoing radiographic examination or while employing the "knee-to-knee" control of a child shall not be subject to this policy.

Reference:

1. American Academy of Pediatric Dentistry. *Reference Manual.* Pediatr Dent 2011;33(6):167-8

EXHIBIT 25

Guideline on Behavior Guidance for the Pediatric Dental Patient

Originating Committee
Clinical Affairs Committee – Behavior Management Subcommittee

Review Council
Council on Clinical Affairs

Adopted
1990

Revised
1991, 1996, 2000, 2005, 2006, 2008, 2011

Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes that, in providing oral health care for infants, children, adolescents, and persons with special health care needs, a continuum of both nonpharmacological and pharmacological behavior guidance techniques may be used by dental health care providers. The various behavior guidance techniques used must be tailored to the individual patient and practitioner. Promoting a positive dental attitude, safety, and quality of care are of the utmost importance. This guideline is intended to educate health care providers, parents, and other interested parties about many behavior guidance techniques used in contemporary pediatric dentistry. It will not attempt to duplicate information found in greater detail in the AAPD's Guideline on Use of Nitrous Oxide for Pediatric Dental Patients,[1] Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update,[2] and Guideline on the Use of Anesthesia Personnel in the Administration of Office-based Deep Sedation/General Anesthesia to the Pediatric Dental Patient.[3]

Methods

This document is an update of the previous guideline adopted in 1990 and last revised in 2008. It was developed/revised following the AAPD's 1988 and 2003 conferences on behavior management for the pediatric dental patient.[4,5] This update reflects a review of those proceedings, other dental and medical literature related to behavior guidance of the pediatric patient, and sources of recognized professional expertise and stature including both the academic and practicing pediatric dental communities and the standards of the Commission on Dental Accreditation.[6] In addition, a systematic search of the MEDLINE/PubMed® electronic database was performed using the following parameters: Terms such as "behavior management in children", "behavior management in dentistry", "child behavior and dentistry", "child and dental anxiety", "child preschool and dental anxiety", "child personality and test", "child preschool personality and test", "patient cooperation", "dentists and personality", "dentist-patient relations", "dentist-parent relations", "attitudes of parents to behavior management in dentistry", "patient assessment in dentistry", "pain in dentistry", "treatment deferral in dentistry", and "patient restraint for treatment"; Fields: all; Limits: within the last 10 years, humans, English, birth through age 18. There were 5694 articles matching these criteria. Papers for review were chosen from this list and from references withing selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

Overview

Dental practitioners are expected to recognize and effectively treat childhood dental diseases that are within the knowledge and skills acquired during dental education. Safe and effective treatment of these diseases often requires modifying the child's behavior. Behavior guidance is a continuum of interaction involving the dentist and dental team, the patient, and the parent directed toward communication and education. Its goal is to ease fear and anxiety while promoting an understanding of the need for good oral health and the process by which that is achieved.

A dentist who treats children should have a variety of behavior guidance approaches and, in most situations, should be able to assess accurately the child's developmental level, dental attitudes, and temperament and to predict the child's reaction to treatment. The child who presents with oral/dental pathology and noncompliance tests the skills of every practitioner. By virtue of differences in each clinician's training, experience, and personality, a behavior guidance approach for a child may vary among practitioners. The behaviors of the dentist and dental staff members play an important role in behavior guidance of the pediatric patient. Through communication, the dental team can allay fear and anxiety, teach appropriate coping

mechanisms, and guide the child to be cooperative, relaxed, and self-confident in the dental setting. Successful behavior guidance enables the oral health team to perform quality treatment safely and efficiently and to nurture a positive dental attitude in the child.

Some of the behavior guidance techniques in this document are intended to maintain communication, while others are intended to extinguish inappropriate behavior and establish communication. As such, these techniques cannot be evaluated on an individual basis as to validity, but must be assessed within the context of the child's total dental experience. Each technique must be integrated into an overall behavior guidance approach individualized for each child. Therefore, behavior guidance is as much an art as it is a science. It is not an application of individual techniques created to "deal" with children, but rather a comprehensive, continuous method meant to develop and nurture the relationship between patient and doctor, which ultimately builds trust and allays fear and anxiety.

This guideline contains definitions, objectives, indications, and contraindications for behavior guidance techniques commonly taught and used in pediatric dentistry.[6-11] This document is reflective of the AAPD's role as an advocate for the improvement of the overall health of the child. Dentists are encouraged to utilize behavior guidance techniques consistent with their level of professional education and clinical experience. Behavior guidance cases that are beyond the training, experience, and expertise of individual practitioners should be referred to practitioners who can render care more skillfully.

Pain Management

Pain management during dental procedures is crucial for successful behavior guidance. Prevention of pain can nurture the relationship between the dentist and the patient, build trust, allay fear and anxiety, and enhance positive dental attitudes for future visits.[12-16] However, the subjective nature of pain perception, varying patient responses to painful stimuli, and lack of use of accurate pain assessment scales may hinder the dentist's attempts to diagnose and intervene during procedures.[12,14,17-20]

Children perceive and react to painful stimuli differently from each other. Children under age 4 are more sensitive to painful stimuli and are not able to communicate as well as older children and teens.[17,18] Observing behavior and listening to children during treatment are essential in any evaluation of pain. Facial expressions, crying, complaining, and body movement are important diagnostic criteria.[12-16]

At times, dental providers may underestimate a patient's level of pain or may develop "pain blindness" as a defense mechanism.[12,19,21-24] One of the possible causes of fear and/or behavior problems is a painful past medical or dental visit.[17,18] It has been shown that the patient is the best reporter of his/her pain.[14,17,19,24] Listening to the child and observing his/her behavior at the first sign of distress will help diagnose the situation and facilitate proper behavior guidance techniques.[14]

Use of a self-reported pain intensity scale has been helpful in the medical field.[19,20] While there are over 30 such scales in use, only 6 have have shown evidence of reliability and validity. Of these, the Faces Pain Scale-Revised (FPSR) appears to be the most validated for children between ages 4 and 12 and the Wong-Baker FACES Pain Scale for children over 3 years of age.[25,26] (See Appendix 1.)

Dental Team Behavior

The pediatric dental staff can play an important role in behavior guidance. The scheduling coordinator or receptionist will have the first contact with a prospective parent, usually through a telephone conversation. Information provided to the parent prior to an appointment will help set expectations for the initial visit. The internet and customized web pages are excellent ways of introducing parents/patients to one's practice. These encounters serve as educational tools that help the parent and child be better prepared for the first visit and may answer questions that help to allay fears. In addition, the receptionist is usually the first staff member the child meets. The manner in which the child is welcomed into the practice may influence future patient behavior.[27,28]

The clinical staff is an extension of the dentist in terms of using communicative behavior guidance techniques. Therefore, their communicative skills are very important. The dental team should work together in communicating with parents and patients. A child's future attitude toward dentistry may be determined by a series of successful experiences in a pleasant dental environment. All dental team members are encouraged to expand their skills and knowledge in behavior guidance techniques by reading dental literature, observing video presentations, or attending continuing education courses.[27]

Dentist Behavior

The dentist's communication skills play an important role in behavior guidance.[29] The health professional may be inattentive to communication style, but patients/parents are very attentive to it.[30] The communicative behavior of dentists is a major factor in patient satisfaction.[31,32] The dentist should recognize that not all parents may express their desire for involvement.[33] Dentist behaviors reported to correlate with low parent satisfaction include rushing through appointments, not taking time to explain procedures, barring parents from the examination room, and generally being impatient.[34] Relationship/communication problems have been demonstrated to play a prominent role in initiating malpractice actions. Even where no error occurred, perceived lack of caring and/or collaboration were associated with litigation.[35,36]

Studies of efficacy of various dentist behaviors in management of uncooperative patients are equivocal. Dentist behaviors of vocalizing, directing, empathizing, persuading, giving the patient a feeling of control, and operant conditioning have been reported as efficacious responses to uncooperative patient behaviors.[11,29,37,39]

Parental Influence

Parents exert a significant influence on their child's behavior,

especially if they had previous negative dental experiences.[19,40,41] An anxious or fearful parent may affect the child's behavior negatively.[19,40,42] Educating the parent before the child's first dental visit is important. Discussing the office procedures on the initial telephone call, followed by sending office information and an invitation to visit the office web site or even an office "pre-visit", may be helpful in reducing parental anxiety.[11]

Parenting styles in America have evolved in recent decades.[42] Practitioners are faced with challenges from an increasing number of children who many times are ill-equipped with the coping skills and self-discipline necessary to deal with new experiences in the dental office. Frequently, parental expectations for the child's behavior (eg. no tears) are unrealistic, while expectations for the dentist who guides their behavior are great.[27] Some parents may even try to dictate treatment, although their understanding of the procedure is lacking.[27] Effective communication with more demanding parents represents an opportunity for the dentist to carefully review behavior and treatment options and together decide what is in the child's best interests.[29]

Practitioners agree that good communication is important among the dentist, patient, and parent in building trust and confidence.[29,43] Practitioners also are united in the fact that effective communication between the dentist and the child is paramount and requires focus on the part of both parties. Most children respond positively when their parent is in the treatment area.[29,44-46] Occasionally, the presence of a parent has a negative effect on the necessary communication between the child and the dentist.[19,40] Each practitioner has the responsibility to determine the communication and support methods that best optimize the treatment setting, recognizing his/her own skills, the abilities of the particular child, and the desires of the specific parent involved.

Communication

Communication (ie, imparting or interchange of thoughts, opinions, or information) may be accomplished by a number of means but, in the dental setting, it is affected primarily through dialogue, tone of voice, facial expression, and body language.

The 4 "essential ingredients" of communication are:

1. the sender;
2. the message, including the facial expression and body language of the sender;
3. the context or setting in which the message is sent; and
4. the receiver.[47]

For successful communication to take place, all 4 elements must be present and consistent. Without consistency, there may be a poor "fit" between the intended message and what is understood.[47]

Communicating with children poses special challenges for the dentist and the dental team. A child's cognitive development will dictate the level and amount of information interchange that can take place. It is impossible for a child to perceive an idea for which he has no conceptual framework and unrealistic to expect a child patient to adopt the dentist's frame of reference. The dentist, therefore, must have a basic understanding of the cognitive development of children so, through appropriate vocabulary and body language, messages consistent with the receiver's intellectual development can be sent.[47]

Communication may be impaired when the sender's expression and body language are not consistent with the intended message. When body language conveys uncertainty, anxiety, or urgency, the dentist cannot effectively communicate confidence in his/her clinical skills.[47]

It is important to communicate with the child patient briefly at the beginning of a dental appointment to establish rapport and trust. Once a procedure begins, the dentist's ability to guide and shape behavior becomes paramount, and information sharing becomes secondary. The 2-way interchange of information gives way to 1-way guidance of behavior through commands. This type of interaction is called "requests and promises".[48] When action must take place to reach a goal (eg, completion of the dental procedure), the dentist assumes the role of the requestor. Requests elicit promises from the patient that, in turn, establish a commitment to cooperate. The dentist must assure the child is comfortable and feeling no pain during the procedure and may need to frame the request in a number of ways in order to make the request effective. For example, reframing a previous command in an assertive voice with appropriate facial expression and body language is the basis for the technique of voice control. While voice control is classified as one of the means of communicative guidance, it may be considered aversive in nature by some parents.[27,42,49-51]

The importance of the context in which messages are delivered cannot be overstated. The dental office may be made "child friendly" by the use of themes in its decoration, age-appropriate toys and games in the reception room or treatment areas, and smaller scale furniture. The operatory, however, may contain distractions (eg, another child crying) that, for the patient, produce anxiety and interfere with communication. Dentists and other members of the dental team may find it advantageous to provide certain information (eg, post-operative instructions, preventive counseling) away from the operatory and its many distractions.[27]

Patient Assessment

The response of a child patient to the demands of dental treatment is complex and determined by many factors. Multiple studies have demonstrated that a minority of children with uncooperative behavior have dental fears and that not all fearful children present dental behavior guidance problems.[41,52,53] Child age/cognitive level,[41,54-57] temperament/personality characteristics,[52,53,58-60] anxiety and fear,[41,53,61] reaction to strangers,[62] previous dental experiences,[41,55,63] and maternal dental anxiety[63-65] influence a child's reaction to the dental setting.

The dentist should include an evaluation of the child's cooperative potential as part of treatment planning. Information can be gathered by observation of and interacting with the child and by questioning the child's parent. For example,

questions concerning the child's behavior at the physician's office may provide valuable insight into fear levels during routine visits and visits where painful stimuli were used.[14,17,18] Ideal assessment methods are valid, allow for limited cognitive and language skills, and are easy to use in a clinical setting. Assessment tools that have demonstrated some efficacy in the pediatric dental setting, along with a brief description of their purpose, are listed in Appendix 2.[41,56,58,59,65-73] No single assessment method or tool is completely accurate in predicting a child patient's behavior for dental treatment, but awareness of the multiple influences on child behavior may aid in treatment planning for the pediatric patient.

Since children exhibit a broad range of physical, intellectual, emotional, and social development and a diversity of attitudes and temperament, it is important that dentists have a wide range of behavior guidance techniques to meet the needs of the individual child and be tolerant and flexible in their implementation.[11,29] Dentists also should record the child's behavior as a diagnostic aid for future visits.[18] One of the more reliable and frequently used behavior rating systems in both clinical dentistry and research is the Frankl Scale.[11,18] This scale (see Appendix 3) separates observed behaviors into 4 categories ranging from definitely negative to definitely positive.[11,24]

Barriers

Unfortunately, various barriers may hinder the achievement of a successful outcome. Developmental delay, physical/mental disability, and acute or chronic disease all are potential reasons for noncompliance. Reasons for noncompliance in the healthy, communicating child often are more subtle and difficult to diagnose. Major factors contributing to poor cooperation can include fears transmitted from parents, a previous unpleasant and/or painful dental or medical experience, inadequate preparation for the first encounter in the dental environment, or dysfunctional parenting practices.[41,54,55]

To alleviate these barriers, the dentist should become a teacher. The dentist's methods should include active listening and observation of the child's body language, assessing the patient's developmental level and comprehension skills, directing a message to that level, and having a patient who is attentive to the message being delivered (ie, good communication). To deliver quality dental treatment safely and develop an educated patient, the "teacher-student" roles and relationship must be established and maintained.[11,29] Another way to reduce barriers is to establish a dental home[74] as early as possible. The dental home provides an ongoing relationship between the dentist, patient, and parent to facilitate communication and positive attitude and behaviors.[29,74] Early preventive care leads to less dental disease, decreased treatment needs, and fewer opportunities for negative experiences.[29,74]

Deferred treatment

Dental disease usually is not life-threatening and the type and timing of dental treatment can be deferred in certain circumstances. When a child's behavior prevents routine delivery of oral health care using communicative guidance techniques, the dentist must consider the urgency of dental need when determining a plan of treatment.[75,76] Rapidly advancing disease, trauma, pain, or infection usually dictates prompt treatment. Deferring some or all treatment or employing therapeutic interventions [eg, interim therapeutic restoration (ITR),[77,78] fluoride varnish, antibiotics for infection control] until the child is able to co-operate may be appropriate when based upon an individualized assessment of the risks and benefits of that option. The dentist must explain the risks and benefits of deferred or alternative treatments clearly, and informed consent must be obtained from the parent.[76,79]

Treatment deferral also should be considered in cases when treatment is in progress and the patient's behavior becomes hysterical or uncontrollable. In such cases, the dentist should halt the procedure as soon as possible, discuss the situation with the patient/parent, and either select another approach for treatment or defer treatment based upon the dental needs of the patient. If the decision is made to defer treatment, the practitioner immediately should complete the necessary steps to bring the procedure to a safe conclusion before ending the appointment.[75,77,78]

Caries risk should be reevaluated when treatment options are compromised due to child behavior. The AAPD has developed caries risk-assessment forms and management protocols[80]; they provide a means of classifying caries risk at a point in time and can be applied periodically to assess changes in an individual's risk status along with suggestions on caries management. An individualized preventive program, including appropriate parent education and a dental recall schedule, should be recommended after evaluation of the patient's caries risk, oral health needs, and abilities. Topical fluorides (eg, brush-on gels, fluoride varnish, professional application during prophylaxis) may be indicated.[81] ITR may be useful as both preventive and therapeutic approaches.[77,78]

Informed consent

Regardless of the behavior guidance techniques utilized by the individual practitioner, all guidance decisions must be based on a subjective evaluation weighing benefits and risks to the child. The need for treatment, consequences of deferred treatment, and potential physical/emotional trauma must be considered.[76,79]

Decisions regarding the use of behavior guidance techniques other than communicative management cannot be made solely by the dentist. They must involve a parent and, if appropriate, the child. The dentist serves as the expert on dental care (ie, the timing and techniques by which treatment can be delivered). The parent shares with the practitioner the decision whether or not to treat and must be consulted regarding treatment strategies and potential risks. Therefore, the successful completion of diagnostic and therapeutic services is viewed as a partnership of dentist, parent, and child.[29,43,50]

Informing the parent about the nature, risk, and benefits of the technique to be used and any professionally-recognized

or evidence-based alternative techniques is essential to obtaining informed consent.[79] All questions must be answered to the parent's understanding.[76,79]

Communicative management, by virtue of being a basic element of communication, requires no specific consent. All other behavior guidance techniques require informed consent consistent with the AAPD's Guideline on Informed Consent[79] and applicable state laws. In the event of an unanticipated reaction to dental treatment, it is incumbent upon the practitioner to protect the patient and staff from harm. Following immediate intervention to assure safety, if techniques must be altered to continue delivery of care, the dentist must have informed consent for the alternative methods.[76,79]

Summary

1. Behavior guidance is based on scientific principles. The proper implementation of behavior guidance requires an understanding of these principles. Behavior guidance, however, is more than pure science and requires skills in communication, empathy, coaching, tolerance, flexibility, and active listening. As such, behavior guidance is a clinical art form and a skill built on a foundation of science.
2. The goals of behavior guidance are to establish communication, alleviate fear and anxiety, deliver quality dental care, build a trusting relationship between dentist, child, and parent, and promote the child's positive attitude toward oral/dental health and oral health care.
3. The urgency of the child's dental needs must be considered when planning treatment. Deferral or modification of treatment sometimes may be necessary until routine care can be provided using appropriate behavior guidance techniques.
4. All decisions regarding use of behavior guidance techniques must be based upon a benefit vs risk evaluation. As part of the process of obtaining informed consent, the dentist's recommendations regarding use of techniques (other than communicative guidance) must be explained to the parent's understanding and acceptance. Parents share in the decision-making process regarding treatment of their children.
5. The staff must be trained carefully to support the dentist's efforts and welcome the patient and parent into a child-friendly environment that will facilitate behavior guidance and a positive dental visit.
6. Pain management during dental procedures is crucial for successful behavior guidance and enhancing positive dental attitudes for future visits. Listening to the chld and observing his/her behavior at the first sign of distress will be helpful in diagnosing the situation and facilitating proper behavior guidance techniques.
7. Parents exert a significant influence on the behavior of their children. Educating the parents before their child's visit may be helpful and promote a positive dental experience.
8. Dentists should record the patient's behavior at each visit. This will serve as a documentation of past behavior and aid in diagnosis for future visits.

Recommendations

Basic behavior guidance

Communication and communicative guidance

Communicative management and appropriate use of commands are used universally in pediatric dentistry with both the cooperative and uncooperative child. In addition to establishing a relationship with the child and allowing for the successful completion of dental procedures, these techniques may help the child develop a positive attitude toward oral health. Communicative management comprises a host of techniques that, when integrated, enhance the evolution of a cooperative patient. Rather than being a collection of singular techniques, communicative management is an ongoing subjective process that becomes an extension of the personality of the dentist. Associated with this process are the specific techniques of tell-show-do, voice control, nonverbal communication, positive reinforcement, and distraction. The dentist should consider the cognitive development of the patient, as well as the presence of other communication deficits (eg, hearing disorder), when choosing specific communicative management techniques.

Tell-show-do

- Description: Tell-show-do is a technique of behavior shaping used by many pediatric professionals. The technique involves verbal explanations of procedures in phrases appropriate to the developmental level of the patient (tell); demonstrations for the patient of the visual, auditory, olfactory, and tactile aspects of the procedure in a carefully defined, nonthreatening setting (show); and then, without deviating from the explanation and demonstration, completion of the procedure (do). The tell-show-do technique is used with communication skills (verbal and nonverbal) and positive reinforcement.[10,28,29]
- Objectives: The objectives of tell-show-do are to:
  1. teach the patient important aspects of the dental visit and familiarize the patient with the dental setting;
  2. shape the patient's response to procedures through desensitization and well-described expectations.
- Indications: May be used with any patient.
- Contraindications: None.

Voice control

- Description: Voice control is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior. Parents unfamiliar with this possibly aversive technique may benefit from an explanation prior to its use to prevent misunderstanding.[10,11,28,29]
- Objectives: The objectives of voice control are to:
  1. gain the patient's attention and compliance;
  2. avert negative or avoidance behavior;
  3. establish appropriate adult-child roles.
- Indications: May be used with any patient.
- Contraindications: Patients who are hearing impaired.

Nonverbal communication

• Description: Nonverbal communication is the reinforcement and guidance of behavior through appropriate contact, posture, facial expression, and body language.[10,28,29,50]

• Objectives: The objectives of nonverbal communication are to:

1. enhance the effectiveness of other communicative management techniques;
2. gain or maintain the patient's attention and compliance.

• Indications: May be used with any patient.

• Contraindications: None.

Positive reinforcement

• Description: In the process of establishing desirable patient behavior, it is essential to give appropriate feedback. Positive reinforcement is an effective technique to reward desired behaviors and, thus, strengthen the recurrence of those behaviors. Social reinforcers include positive voice modulation, facial expression, verbal praise, and appropriate physical demonstrations of affection by all members of the dental team. Nonsocial reinforcers include tokens and toys.

• Objective: To reinforce desired behavior.[10,11,47,48]

• Indications: May be used with any patient.

• Contraindications: None.

Distraction

• Description: Distraction is the technique of diverting the patient's attention from what may be perceived as an unpleasant procedure. Giving the patient a short break during a stressful procedure can be an effective use of distraction prior to considering more advanced behavior guidance techniques.[11,47,48]

• Objectives: The objectives of distraction are to:

1. decrease the perception of unpleasantness;
2. avert negative or avoidance behavior.

• Indications: May be used with any patient.

• Contraindications: None.

Parental presence/absence

• Description: The presence or absence of the parent sometimes can be used to gain cooperation for treatment. A wide diversity exists in practitioner philosophy and parental attitude regarding parents' presence or absence during pediatric dental treatment. As establishment of a dental home by 12 months of age continues to grow in acceptance, parents will expect to be with their infants and young children during examinations as well as during treatment. Parental involvement, especially in their children's health care, has changed dramatically in recent years.[29,82] Parents' desire to be present during their child's treatment does not mean they intellectually distrust the dentist. It might mean they are uncomfortable if they visually cannot verify their child's safety. It is important to understand the changing emotional needs of parents because of the growth of a latent but natural sense to be protective of their children.[45] Practitioners should become accustomed to this added involvement of parents and welcome the questions and concerns for their children. Practitioners must consider parents' desires and wishes and be open to a paradigm shift in their own thinking.[27,29,4,44,45]

• Objectives: The objectives of parental presence/absence are:

For parents to:

1. participate in infant examinations and/or treatment (if asked);
2. offer very young children physical and psychological support;
3. observe the reality of their child's treatment.

For practitioners to:

1. gain the patient's attention and improve compliance;
2. avert negative or avoidance behaviors;
3. establish appropriate dentist-child roles;
4. enhance effective communication among the dentist, child, and parent;
5. minimize anxiety and achieve a positive dental experience;
6. facilitate rapid informed consent for changes in treatment or behavior guidance.

• Indications: May be used with any patient.

• Contraindications: Parents who are unwilling or unable to extend effective support (when asked).

Nitrous oxide/oxygen inhalation

• Description: Nitrous oxide/oxygen inhalation is a safe and effective technique to reduce anxiety and enhance effective communication. Its onset of action is rapid, the effects easily are titrated and reversible, and recovery is rapid and complete. Additionally, nitrous oxide/oxygen inhalation mediates a variable degree of analgesia, amnesia, and gag reflex reduction. The need to diagnose and treat, as well as the safety of the patient and practitioner, should be considered before the use of nitrous oxide/oxygen analgesia/anxiolysis. Detailed information concerning the indications, contraindications, and additional clinical considerations may be found in the Guideline on Use of Nitrous Oxide for Pediatric Dental Patients.[1]

Advanced behavior guidance

Most children can be managed effectively using the techniques outlined in basic behavior guidance. These basic behavior guidance techniques should form the foundation for all of the management activities provided by the dentist. Children, however, occasionally present with behavioral considerations that require more advanced techniques. These children often cannot cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical disability. The advanced behavior guidance techniques commonly used and taught in advanced pediatric dental training programs include protective stabilization, sedation, and general anesthesia.[8] They are extensions of the overall behavior guidance continuum with the intent to facilitate the goals of communication, cooperation, and delivery of quality oral health care in the difficult patient. Skillful diagnosis of behavior and safe and effective implementation of these techniques necessitate

knowledge and experience that are generally beyond the core knowledge students receive during predoctoral dental education. While most predoctoral programs provide didactic exposure to treatment of very young children (ie, aged birth – 2 years), patients with special health care needs, and advanced behavior guidance techniques, hands-on experience is lacking.[84] A minority of programs provides educational experiences with these patient populations, while few provide hands-on exposure to advanced behavior guidance techniques.[84] "On average, predoctoral pediatric dentistry programs teach students to treat children four years of age and older, who are generally well behaved and have low levels of caries."[84] Dentists considering the use of these advanced behavior guidance techniques should seek additional training through a residency program, a graduate program, and/or an extensive continuing education course that involves both didactic and experiential mentored training.

Protective stabilization

• Description: The use of any type of protective stabilization in the treatment of infants, children, adolescents, or patients with special health care needs is a topic that concerns health care providers, care givers, and the public.[28,76,84-91] The broad definition of protective stabilization is the restriction of patient's freedom of movement, with or without the patient's permission, to decrease risk of injury while allowing safe completion of treatment. The restriction may involve another human(s), a patient stabilization device, or a combination thereof. The use of protective stabilization has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, and violation of a patient's rights. Stabilization devices placed around the chest may restrict respirations; they must be used with caution, especially for patients with respiratory compromise (eg, asthma) and/or who will receive medications (ie, local anesthetics, sedatives) that can depress respirations. Because of the associated risks and possible consequences of use, the dentist is encouraged to evaluate thoroughly its use on each patient and possible alternatives.[76,92] Careful, continuous monitoring of the patient is mandatory during protective stabilization.[76,92]

Partial or complete stabilization of the patient sometimes is necessary to protect the patient, practitioner, staff, or the parent from injury while providing dental care. Protective stabilization can be performed by the dentist, staff, or parent with or without the aid of a restrictive device.[76,92] The dentist always should use the least restrictive, but safe and effective, protective stabilization.[76,92] The use of a mouth prop in a compliant child is not considered protective stabilization.

The need to diagnose, treat, and protect the safety of the patient, practitioner, staff, and parent should be considered prior to the use of protective stabilization. The decision to use protective stabilization must take into consideration:

1. alternative behavior guidance modalities;
2. dental needs of the patient;
3. the effect on the quality of dental care;
4. the patient's emotional development;
5. the patient's medical and physical considerations.

Protective stabilization, with or without a restrictive device, performed by the dental team requires informed consent from a parent. Informed consent must be obtained and documented in the patient's record prior to use of protective stabilization. Due to the possible aversive nature of the technique, informed consent also should be obtained prior to a parent's performing protective stabilization during dental procedures. Furthermore, when appropriate, an explanation to the patient regarding the need for restraint, with an opportunity for the patient to respond, should occur.[76,79,93]

In the event of an unanticipated reaction to dental treatment, it is incumbent upon the practitioner to protect the patient and staff from harm. Following immediate intervention to assure safety, if techniques must be altered to continue delivery of care, the dentist must have informed consent for the alternative methods.[75]

The patient's record must include:

1. informed consent for stabilization;
2. indication for stabilization;
3. type of stabilization;
4. the duration of application of stabilization;
5. behavior evaluation/rating during stabilization.

• Objectives: The objectives of patient stabilization are to:

1. reduce or eliminate untoward movement;
2. protect patient, staff, dentist, or parent from injury;
3. facilitate delivery of quality dental treatment.

• Indications: Patient stabilization is indicated when:

1. patients require immediate diagnosis and/or limited treatment and cannot cooperate due to lack of maturity or mental or physical disability;
2. the safety of the patient, staff, dentist, or parent would be at risk without the use of protective stabilization;
3. sedated patients require limited stabilization to help reduce untoward movement.

• Contraindications: Patient stabilization is contraindicated for:

1. cooperative non-sedated patients;
2. patients who cannot be immobilized safely due to associated medical or physical conditions;
3. patients who have experienced previous physical or psychological trauma from protective stabilization (unless no other alternatives are available);
4. non-sedated patients with non-emergent treatment requiring lengthy appointments.

• Precautions: The following precautions should be taken:

1. the patient's medical history must be reviewed carefully to ascertain if there are any medical conditions (eg, asthma) which may compromise respiratory function;
2. tightness and duration of the stabilization must be monitored and reassessed at regular intervals;
3. stabilization around extremities or the chest must not actively restrict circulation or respiration;

4. stabilization should be terminated as soon as possible in a patient who is experiencing severe stress or hysterics to prevent possible physical or psychological trauma.

Sedation

• Description: Sedation can be used safely and effectively with patients unable to receive dental care for reasons of age or mental, physical, or medical condition. Background information and documentation for the use of sedation is detailed in the Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.[2]

The need to diagnose and treat, as well as the safety of the patient, practitioner, and staff, should be considered for the use of sedation. The decision to use sedation must take into consideration:

1. alternative behavioral guidance modalities;
2. dental needs of the patient;
3. the effect on the quality of dental care;
4. the patient's emotional development;
5. the patient's medical and physical considerations.

Documentation shall include[2]:

1. informed consent. Informed consent must be obtained from the parent and documented prior to the use of sedation;
2. instructions and information provided to the parent;
3. health evaluation;
4. a time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs;
5. the patient's level of consciousness, responsiveness, heart rate, blood pressure, respiratory rate, and oxygen saturation at the time of treatment and until predetermined discharge criteria have been attained;
6. adverse events (if any) and their treatment;
7. time and condition of the patient at discharge.

• Objectives: The goals of sedation are to:

1. guard the patient's safety and welfare;
2. minimize physical discomfort and pain;
3. control anxiety, minimize psychological trauma, and maximize the potential for amnesia;
4. control behavior and/or movement so as to allow the safe completion of the procedure;
5. return the patient to a state in which safe discharge from medical supervision, as determined by recognized criteria, is possible.

• Indications: Sedation is indicated for:

1. fearful, anxious patients for whom basic behavior guidance techniques have not been successful;
2. patients who cannot cooperate due to a lack of psychological or emotional maturity and/or mental, physical, or medical disability;
3. patients for whom the use of sedation may protect the developing psyche and/or reduce medical risk.

• Contraindications: The use of sedation is contraindicated for:

1. the cooperative patient with minimal dental needs;
2. predisposing medical and/or physical conditions which would make sedation inadvisable.

General anesthesia

• Description: General anesthesia is a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. The use of general anesthesia sometimes is necessary to provide quality dental care for the child. Depending on the patient, this can be done in a hospital or an ambulatory setting, including the dental office. Additional background information may be found in the Guideline on Use of Anesthesia Care Personnel in the Administration of Office-based Deep Sedation/General Anesthesia to the Pediatric Dental Patient.[3]

The need to diagnose and treat, as well as the safety of the patient, practitioner, and staff, should be considered for the use of general anesthesia. The decision to use general anesthesia must take into consideration:

1. alternative behavioral guidance modalities;
2. dental needs of the patient;
3. the effect on the quality of dental care;
4. the patient's emotional development;
5. the patient's medical status.

Prior to the delivery of general anesthesia, appropriate documentation shall address the rationale for use of general anesthesia, informed consent, instructions provided to the parent, dietary precautions, and preoperative health evaluation. Because laws and codes vary from state to state, minimal requirements for a time-based anesthesia record should include:

1. the patient's heart rate, blood pressure, respiratory rate, and oxygen saturation at specific intervals throughout the procedure and until predetermined discharge criteria have been attained;
2. the name, route, site, time, dosage, and patient effect of administered drugs, including local anesthesia;
3. adverse events (if any) and their treatment;
4. that discharge criteria have been met, the time and condition of the patient at discharge, and into whose care the discharge occurred.

• Objectives: The goals of general anesthesia are to:

1. provide safe, efficient, and effective dental care;
2. eliminate anxiety;
3. reduce untoward movement and reaction to dental treatment;
4. aid in treatment of the mentally, physically, or medically compromised patient;
5. eliminate the patient's pain response.

• Indications: General anesthesia is indicated for:

1. patients who cannot cooperate due to a lack of psychological or emotional maturity and/or mental, physical, or medical disability;
2. patients for whom local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;

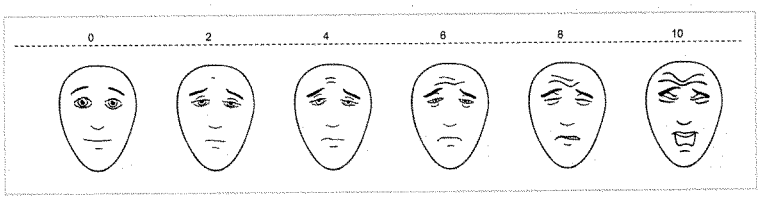
3. the extremely uncooperative, fearful, anxious, or uncommunicative child or adolescent;
4. patients requiring significant surgical procedures;
5. patients for whom the use of general anesthesia may protect the developing psyche and/or reduce medical risk;
6. patients requiring immediate, comprehensive oral/dental care.

• Contraindications: The use of general anesthesia is contraindicated for:

1. a healthy, cooperative patient with minimal dental needs;
2. predisposing medical conditions which would make general anesthesia inadvisable.

APPENDIX 1. PAIN SCALES FOR USE WITH CHILDREN

Faces Pain Scale – Revised (FPS-R)

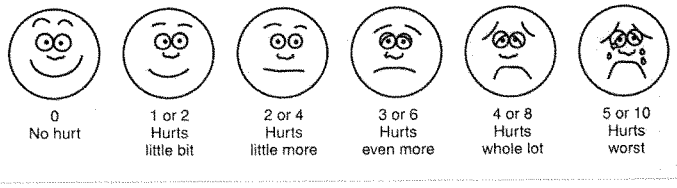


In the following instructions, say "hurt" or "pain", whichever seems right for a particular child.

"**These faces show how much something can hurt. This face** [point to left-most face] **shows no pain. The faces show more and more pain** [point to each from left to right] **up to this one** [point to right-most face] – **it shows very much pain. Point to the face that shows how much you hurt** [right now]."

Score the chosen face 0,2,4,6,8, or 10, counting left to right, so '0'= 'no pain' and '10'= very much pain.' Do not use words like 'happy' and 'sad'. This scale is intended to measure how children feel inside, not how their face looks.

Wong-Baker FACES Pain Scale



Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the child to choose face that best describes own pain and record the appropriate number.

Original instructions: Explain to the child that each face is for a child who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can image, although you don't have to be crying to feel this bad. Ask the child to choose the face that best describes how he is feeling. Rating scale is recommended for persons age 3 years and older.

APPENDIX 2. PATIENT ASSESSMENT TOOLS

Tool	Format	Application	Reference
Toddler temperament scale	Parent questionnaire	Behavior of 12 to 36 months	59, 66
Behavioral style questionnaire (BSQ)	Parent questionnaire	Child temperament of 3 to 7 years	58, 69
Eyberg Child Behavior Inventory (ECBI)	Parent questionnaire	Frequency and intensity of 36 common problem behaviors	68
Facial Image Scale (FIS)	Drawings of faces, child chooses	Anxiety indicator suitable for young preliterate children	69
Children's Dental Fear Picture Test (CDFP)	3 picture subtests, child chooses	Dental fear assessment for children >5 years old	70
Child Fear Survey Schedule-Dental Subscale (CFSS-DS)	Parent questionnaire	Dental fear assessment	41, 71, 72
Parent-Child Relationship Inventory (PCRI)	Parent questionnaire	Parent attitudes and behavior that may result in child behavior problems	56, 72
Corah's dental anxiety scale (DAS)	Parent questionnaire	Dental anxiety of parent	41, 65, 73

APPENDIX 3. FRANKL BEHAVIORAL RATING SCALE

1	– –	Definitely negative. Refusal of treatment, forceful crying, fearfulness, or any other overt evidence of extreme negativism.
2	–	Negative. Reluctance to accept treatment, uncooperative, some evidence of negative attitude but not pronounced (sullen, withdrawn).
3	+	Positive. Acceptance of treatment; cautious behavior at times; willingness to comply with the dentist, at times with reservation, but patient follows the dentist's directions cooperatively.
4	++	Definitely positive. Good rapport with the dentist, interest in the dental procedures, laughter and enjoyment.

References

1. American Academy of Pediatric Dentistry. Guideline on use of nitrous oxide for pediatric dental patients. Pediatr Dent 2011;33(special issue):181-4.
2. American Academy of Pedatrics, American Academy of Pediatric Dentistry. Guideline for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. Pediatr Dent 2011;33(special issue):185-201.
3. American Academy of Pediatric Dentistry. Guideline on use of anesthesia personnel in the administration of office-based deep sedation/general anesthesia to the pediatric dental patient. Pediatr Dent 2011;33(special issue):202-4.
4. American Academy of Pediatric Dentistry. Proceedings of the consensus conference: Behavior management for the pediatric dental patient. American Academy of Pediatric Dentistry. Chicago, Ill. 1989.
5. American Academy of Pediatric Dentistry. Special issue: Proceedings of the conference on behavior management for the pediatric dental patient. Pediatr Dent 2004;26(2): 110-83.
6. American Dental Association Commission on Dental Accreditation. Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry. American Dental Association. Chicago, Ill; 1998.
7. Adair SM, Schafer TE, Rockman RA, Waller JL. Survey of behavior management teaching in predoctoral pediatric dentistry programs. Pediatr Dent 2004:26(2):143-50.
8. Adair SM, Rockman RA, Schafer TE, Waller JL. Survey of behavior management teaching in pediatric dentistry advanced education programs. Pediatr Dent 2004:26(2): 151-8.
9. Adair SM, Waller JL, Schafer TE, Rockman RA. A survey of members of the American Academy of Pediatric Dentistry on their use of behavior management techniques. Pediatr Dent 2004:26(2):159-66.
10. Pinkham JR. Patient management. In: Pinkham JR, Casamassimo PS, Fields HW Jr, McTigue DJ, Nowak AJ, eds. Pediatric Dentistry - Infancy through Adolescence. 4th ed. St Louis, Mo. Elsevier-Saunders Co: 2005;394-413.
11. Wright GZ, Stigers JI. Nonpharmacologic management of children's behaviors. In: Dean JA, Avery DR, McDonald RE, eds. McDonald and Avery's Dentistry for the Child and Adolescent. 9th ed. Maryland Heights, Mo: Mosby-Elsevier; 2011:27-40.
12. Nutter DP. Good clinical pain practice for pediatric procedure pain: Iatrogenic considerations. J Calif Dent Assoc 2009;37(10):713-8.
13. Nutter DP. Good clinical pain practice for pediatric procedure pain: Target considerations. J Calif Dent Assoc 2009;37(10):719-22.
14. Nutter DP. Good clinical pain practice for pediatric procedure pain: Neurobiologic considerations. J Calif Dent Assoc 2009;37(10):705-10.
15. Nakai Y, Milgrom P, Mancl L, Coldwell SE, Domoto PK, Ramsay DS. Effectiveness of local anesthesia in pediatric dental practice. J Am Dent Assoc 2000;131(12):1699-705.

16. American Academy of Pediatric Dentistry. Use of local anesthesia for pediatric dental patients. Pediatr Dent 2010;32(special issue):141-7.
17. Versloot J, Veerkamp J SJ, Hoogstraten J. Children's self-reported pain at the dentist. Pain 2008;137(2):389-94.
18. Klingberg G. Dental anxiety and behaviour management problems in paediatric dentistry: A review of background factors and diagnostics. Eur Arch Paediatr Dent 2007;8(4):11-5.
19. Versloot J, Craig KD. The communication of pain in paediatric dentistry. Eur Arch Paediatr Dent 2009;10(2); 61-6.
20. Stinson JN, Kavanagh T, Yamada J, Gill N, Stevens B. Systematic review of the psychometric properties, interpretability and feasibility of self-reporting pain intensity measures for use in clinical trials in children and adolescents. Pain 2006;125(1):143-57.
21. Rasmussen JK, Fredeniksen JA, Hallonsten AL, Poulsen S. Danish dentists' knowledge, attitudes and management of procedural dental pain in children: Association with demographic characteristics, structural factors, perceived stress during the administration of local analgesia and their tolerance towards pain. Int J Paediatr Dent 2005;15 (3):159-68.
22. Wondimu B, Dahllöf G. Attitudes of Swedish dentists to pain and pain management during dental treatment of children and adolescents. Euro J Paediatr Dent 2005;6 (2):66-72.
23. Murtomaa H, Milgrom P, Weinstein P, Vuopio T. Dentists' perceptions and management of pain experienced by children during treatment: A survey of groups of dentists in the USA and Finland. Int J Paediatr Dent 1966;6(1): 25-30.
24. Versloot J, Veerkamp JSJ, Hoogstraten J. Assessment of pain by the child, dentist, and independent observers. Pediatr Dent 2004;26(5):445-9.
25. Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. The Faces Pain Scale-Revised: Toward a common metric in pediatric pain measurement. Pain 2001; 93(2):173-83.
26. Hockenberry MJ, Wilson D. Wong's Essentials of Pediatric Nursing. 8th ed. St. Louis, Mo: Mosby, Inc; 2009: 162.
27. Sheller B. Challenges of managing child behavior in the 21st century dental setting. Pediatr Dent 2004;26(2): 111-3.
28. Law CS, Blain S. Approaching the pediatric dental patient: A review of nonpharmacologic behavior management strategies. J Calif Dent Assoc 2003;31(9):703-13.
29. Feigal RJ. Guiding and managing the child dental patient: A fresh look at old pedagogy. J Dent Educ 2001;65 (12):1369-77.
30. Hall JA, Roter DL, Katz NR. Task versus socio-emotional behaviors in physicians. Med Care 1987;25(5): 399-412.
31. Gale EN, Carlsson SG, Eriksson A, Jontell M. Effects of dentists' behavior on patients' attitudes. J Am Dent Assoc 1984;109(3):444-6.
32. Schouten BC, Eijkman MA, Hoogstraten J. Dentists' and patients' communicative behavior and their satisfaction with the dental encounter. Community Dent Health 2003;20(1):11-5.
33. Lepper HS, Martin LR, DiMatteo MR. A model of nonverbal exchange in physician-patient expectations for patient involvement. J Nonverb Behav 1995;19(4):207-22.
34. Reichard A, Turnbull HR, Turnbull AP. Perspectives of dentists, families, and case managers on dental care for individuals with developmental disabilities in Kansas. Ment Retard 2001;39(4):268-85.
35. Lester GW, Smith SG. Listening and talking to patients: A remedy for malpractice suits. West J Med 1993;158 (3):268-72.
36. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. Arch Intern Med 1994;154 (12):1365-70.
37. Weinstein P, Getz T, Raetener P, Domoto P. The effect of dentists' behavior on fear-related behaviors in children. J Am Dent Assoc 1982;104(1):32-8.
38. ten Berge M, Veerkamp J, Hoogstraten J. Dentists' behavior in response to child dental fear. ASDC J Dent Child 1999;66(1):36-40.
39. Sarnat H, Arad P, Hanauer D, Shohami E. Communication strategies used during pediatric dental treatment: A pilot study. Pediatr Dent 2001;23(4):337-42.
40. Klingberg G, Berggren U. Dental problem behaviors in children of parents with severe dental fear. Swed Dent J 1992;16(1-2):27-32, 39.
41. Baier K, Milgrom P, Russell S, Mancl L, Yoshida T. Children's fear and behavior in private pediatric dentistry practices. Pediatr Dent 2004;26(4):316-21.
42. Long N. The changing nature of parenting in America. Pediatr Dent 2004;26(2):121-4.
43. Freeman R. Communicating with children and parents: Recommendations for a child-parent-centred approach for paediatric dentistry. Eur Arch Paediatr Dent 2008;9 (1):16-22.
44. Peretz B, Zadik D. Attitudes of parents toward their presence in the operatory during dental treatments to their children. J. Clin Pediatr Dent 1998;23(1):27-30.
45. Pinkham JR. An analysis of the phenomenon of increased parental participation during the child's dental experience. J Dent Child 1991;58(6):458-63.
46. Pfefferle JC, Machen JB, Fields HW Jr, Posnick WR. Child behavior in the dental setting relative to parental presence. Pediatr Dent 1982;4(4):311-6.
47. Chambers DW. Communicating with the young dental patient. J Am Dent Assoc 1976;93(4):793-9.
48. Pinkham JR. The roles of requests and promises in child patient management. J Dent Child 1993;60(3):169-74.

49. Abushal MS, Adenubi JO. Attitudes of Saudi parents toward behavior management techniques in pediatric dentistry. J Dent Child 2003;70(2):104-10.
50. Eaton JJ, McTigue DJ, Fields HW Jr, Beck M. Attitudes of contemporary parents toward behavior management techniques used in pediatric dentistry. Pediatr Dent 2005;27(2):107-13.
51. Chambers DW. Behavior management techniques for pediatric dentists: An embarrassment of riches. ASDC J Dent Child 1977;44(1):30-4, 12.
52. Klingberg G, Broberg AG. Temperament and child dental fear. Pediatr Dent 1998;20(4):237-43.
53. Arnup K, Broberg AG, Berggren U, Bodin L. Lack of cooperation in pediatric dentistry: The role of child personality characteristics. Pediatr Dent 2002;24(2):119-28.
54. Rud B, Kisling E. The influence of mental development on children's acceptance of dental treatment. Scand J Dent Res 1973;81(5):343-52.
55. Brill WA. The effect of restorative treatment on children's behavior at the first recall visit in a private pediatric dental practice. J Clin Pediatr Dent 2002;26(4):389-94.
56. Allen KD, Hutfless S, Larzelere R. Evaluation of two predictors of child disruptive behavior during restorative dental treatment. J Dent Child 2003;70(3):221-5.
57. Cunha RF, Delbem ACB, Percinoto C, Melhado FL. Behavioral evaluation during dental care in children ages 0 to 3 years. J Dent Child 2003;70(2):100-3.
58. Radis FG, Wilson S, Griffen AL, Coury DL. Temperament as a predictor of behavior during initial dental examination in children. Pediatr Dent 1994;16(2):121-7.
59. Lochary ME, Wilson S, Griffen AL, Coury DL. Temperament as a predictor of behavior for conscious sedation in dentistry. Pediatr Dent 1993;15(5):348-52.
60. Jensen B, Stjernqvist K. Temperament and acceptance of dental treatment under sedation in preschool children. Acta Odontol Scand 2002;60(4):231-6.
61. Arnup K, Broberg AG, Berggren U, Bodin L. Treatment outcome in subgroups of uncooperative child dental patients: An exploratory study. Int J Paediatr Dent 2003; 13(5):304-19.
62. Holst A, Hallonsten AL, Schroder U, Ek L, Edlund K. Prediction of behavior-management problems in 3-year-old children. Scand J Dent Res 1993;101(2):110-4.
63. Klingberg G, Berggen U, Carlsson SG, Noren JG. Child dental fear: Cause related factors and clinical effects. Eur J Oral Sci 1995;103(6):405-12.
64. Johnson R, Baldwin DC. Maternal anxiety and child behavior. J Dent Child 1969;36(2):87-92.
65. Peretz B, Nazarian Y, Bimstein E. Dental anxiety in a students' pediatric dental clinic: Children, parents and students. Int J Paediatr Dent 2004;14(3):192-8.
66. Fullard W, McDevitt SC, Carey WB. Assessing temperament in one- to three-year-old children. J Pediatr Psychol 1984;9(2):205-17.
67. McDevitt SC, Carey WB. The measurement of temperament in 3- to 7-year-old children. J Child Psychol Psychiatry 1978;19(3):245-53.
68. Eyberg S, Pincus D. Child Behavior Inventory. Odessa, Fla: Professional Manual Psychological Assessment Resources, Inc; 1999.
69. Buchanan H, Niven N. Validation of a facial image scale to assess child dental anxiety. Int J Paediatr Dent 2002; 12(1):47-52.
70. Klingberg G, Vannas Löfqvist L, Hwang CP. Validity of the children's dental fear picture test (CDFP). Eur J Oral Sci 1995;103(1):55-60.
71. Cuthbert MI, Melamed BG. A screening device: Children at risk for dental fears and management problems. ASDC J Dent Child 1982;49(6):432-6.
72. Gerard AB. Parent-Child Relationship Inventory (PCRI) Manual. Los Angeles, Calif: Western Psychological Services;1994.
73. Corah NL. Development of a dental anxiety scale. J Dent Res 1969;48(4):596.
74. American Academy of Pediatric Dentistry. Policy on the dental home. Pediatr Dent 2010;32(special issue):25-6.
75. Seale NS. Behavior management conference panel III report: Legal issues associated with managing children's behavior in the dental office. Pediatr Dent 2004;26(2): 175-9.
76. Nunn J, Foster M, Master S, Greening S. British Society of Paediatric Dentistry: A policy document on consent and the use of physical intervention in the dental care of children. J Paediatr Dent 2008;18(suppl 1):39-46.
77. American Academy of Pediatric Dentistry. Guideline on pediatric restorative dentistry. Pediatr Dent 2010;32 (special issue):187-93.
78. American Academy of Pediatric Dentistry. Policy on interim therapeutic restoration (ITR). Pediatr Dent 2010; 32(special issue):39-40.
79. American Academy of Pediatric Dentistry. Guideline on informed consent. Pediatr Dent 2010;32(special issue): 268-71.
80. American Academy of Pediatric Dentistry. Guideline on caries-risk assessment and management for infants, children, and adolescents. Pediatr Dent 2011:33(special issue):110-7.
81. American Academy of Pediatric Dentistry. Guideline on fluoride therapy. Pediatr Dent 2011;33(special issue): 153-6.
82. La Rosa-Nash PA, Murphy JM. A clinical case study: Parent-present Induction of anesthesia In children. Pediatr Nursing 1996;22(2):109-11.
83. Seale NS, Casamassimo PS. US predoctoral education in pediatric dentistry: Its impact on access to dental care. J Dent Educ 2003;67(1):23-30.
84. Connick C, Palat M, Puagliese S. The appropriate use of physical restraint: Considerations. ASDC J Dent Child 2000;67(4):231, 256-62.

85. Crossley ML, Joshi G. An investigation of pediatric dentists' attitudes towards parent accompaniment and behavioral management techniques in the UK. Br Dent J 2002;192(9):517-21.
86. Peretz B, Zadik D. Parents' attitudes toward behavior management techniques during dental treatment. Pediatr Dent 1999;2(3):201-4.
87. Peretz B, Gluck GM. The use of restraint in the treatment of pediatric dental patients: Old and new insights. Int J Paediatr Dent 2002;12(6):392-7.
88. Brill WA. Parents' assessment and children's reactions to a passive restraint device used for behavior control in a private pediatric dental practice. ASDC J Dent Child 2002;69(3):236, 310-3.
89. Kupietzky A. Strap him down or knock him out: Is conscious sedation with restraint an alternative to general anesthesia? Br Dent J 2004;196(3):133-8.
90. Manley MCG. A UK perspective. Br Dent J 2004;196 (3):138-9.
91. Morris CDN. A commentary on the legal issues. Br Dent J 2004;196(3):139-40.
92. Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Comprehensive Accreditation Manual for Hospitals 2011. Oakbrook Terrace, Ill: Joint Commission on Accreditation of Healthcare Organizations; 2011:pc30-pc66.
93. American Academy of Pediatrics Committee on Pediatric Emergency Medicine. The use of physical restraint interventions for children and adolescents in the acute care setting. Pediatrics 1997;99(3):497-8.

EXHIBIT 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

JUN 2 2 2012

VIA OVERNIGHT MAIL

[redacted]
Chief Compliance Officer
Church Street Health Management
618 Church Street
Suite 520
Nashville, TN 37219

RE: Demand for Stipulated Penalties and Notice of Material Breach and Intent to Exclude

Dear Ms[redacted]

On January 15, 2010, Church Street Health Management, formerly known as FORBA Holdings, LLC (hereinafter, "CSHM"), entered into a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services. In addition to other obligations, the CIA requires CSHM to: (1) develop, implement, and distribute written standards; and (2) address to the OIG's satisfaction any written recommendation made by the Independent Monitor.

This letter serves as notification that the OIG finds CSHM to be in breach of these specific obligations. As a result, the OIG is exercising its contractual right to demand payment of a Stipulated Penalty in the amount of $100,000 under section X.B of the CIA for the time period in which CSHM has been in breach of the CIA. Section X.D.2 of the CIA requires CSHM to submit payment of the penalty amount or notify the OIG of CSHM's request for an ALJ hearing **within 10 days** of CSHM's receipt of this letter.

In addition, this letter serves as a Notice of Material Breach and Intent to Exclude under section X.E.2 of the CIA. As a result of the material breaches described below, the OIG intends to exclude Small Smiles Dental Centers of Youngstown (Youngstown Clinic). Pursuant to section X.E.3 of the CIA, CSHM has **30 days** from the date of receipt of this Notice to demonstrate to the OIG's satisfaction that: (a) CSHM is in compliance with the obligations of the CIA cited by the OIG as being the basis for the material breach; (b) the alleged material breach has been cured; or (c) the alleged material breach cannot be cured within the 30-day period, but that: (i) CSHM has begun to take action to cure the material

breach; (ii) CSHM is pursuing such action with due diligence; and (iii) CSHM has provided to the OIG a reasonable timetable for curing the material breach.

As you are aware, on May 13, 2011, the OIG assessed a $230,000 Stipulated Penalty for CSHM's failure to comply with certain CIA provisions. On March 8, 2012, the OIG issued a Notice of Material Breach and Intent to Exclude to CSHM for CSHM's continued failure to comply with those CIA provisions. In addition, we understand that on June 1, 2012, CSHM underwent a substantial ownership and management change. We have taken CSHM's past history of noncompliance and its new ownership and management into consideration as we address CSHM's present breach of CIA requirements.

Policies and Procedures Requirements

section III.B.2 of the CIA requires that within 90 days after the Effective Date of the CIA, CSHM shall implement written Policies and Procedures regarding the operation of CSHM's compliance program and its compliance with Federal health care program requirements. Section III.B.2 further requires that within 90 days after the Effective Date, CSHM shall distribute "the relevant portions of the Policies and Procedures ... to all individuals whose job functions relate to those Policies and Procedures."

Section III.B.2.b of the CIA requires CSHM's CIA-related Policies and Procedures to address the following:

> Measures designed to ensure that [CSHM] fully complies with Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395hhh and 1396-1396v, and all regulations, directives, and guidelines promulgated pursuant to these statutes, including, but not limited to 42 C.F.R. Part 440 and any other state or local statutes, regulations, directives, or guidelines, and any that address quality of care in dental practices, such as state dental board requirements and the AAPD guidelines.

Section III.B.2.c of the CIA requires CSHM's CIA-related Policies and Procedures to address the following:

> [CSHM's] commitment to ensuring that [CSHM] facilities provide services and items to their patients that meet professionally recognized standards of health care, including but not limited to Federal health care program requirements, state dental board requirements, and the AAPD guidelines.

Section III.B.2.d of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, the following:

> Measures designed to promote the delivery of patient items or services at [CSHM] and [CSHM] facilities that meet professionally recognized standards of health care…

This provision of the CIA requires that the measures include, but not be limited to, the following issues: appropriate documentation of dental records, including radiographs or digital photos consistent with professionally recognized standards of care, appropriate anesthesia guidelines for pediatric dental patients, appropriate behavior guidance approaches for the pediatric dental patient, including dental team behavior, dentist behavior, communications, patient assessment, barriers, and deferred treatment, advanced behavior guidance techniques for the pediatric dental patient, including protective stabilization, sedation, general anesthesia, and contraindications for each technique, informed consent, and infection control.

Section III.B.2.g of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, the following:

> Measures designed to ensure that compliance issues are identified internally, are promptly and appropriately investigated and, that if the investigation substantiates compliance issues, [CSHM] implements effective and timely corrective action plans and monitors compliance with such plans.

Section III.B.2.k of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, the following:

> Nonretaliation policies and methods for Covered Persons to make disclosures or otherwise report on compliance issues through the Disclosure Program required by section III.F of the CIA.

Section III.B.2.m of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, the following:

> Measures designed to ensure that [CSHM] has a system to require and centrally collect reports relating to patient care incidents, injuries, abuse, and neglect. The reports required under this system shall be of a nature to allow the Compliance Committee meaningful information to be able to determine: (1) whether a quality of care problem exists; and (2) the scope and severity of the problem. The measures should ensure that patients, parents, and guardians are provided with

> CSHM's Parent Compliance Hotline number, state dental board complaint numbers, and the OIG Hotline number. The measures should also develop a mechanism for informing all current patients, parents, and guardians who received care from a CSHM facility when a substantiated incident of patient harm occurs at that facility.

Section III.B.2.n of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, the following:

> Measures designed to ensure that [CSHM] and [CSHM] facilities comply with Federal health care program requirements on billing and reimbursement…

This provision of the CIA requires that the measures include, but not be limited to, the following issues: ensuring proper and accurate preparation and submission of claims to Federal health care programs, ensuring the proper and accurate documentation of dental records, conducting periodic billing and coding reviews of CSHM facilities, and reporting and repayment of all identified Overpayments to Federal health care programs and other payors.

Independent Monitor Report

On May 25, 2012, the Independent Monitor (Monitor) issued to CSHM its Clinic Report of its onsite visit to Youngstown Clinic during April 25 – April 27, 2012 (Youngstown Report). This onsite visit was a follow-up to the Monitor's previous onsite visit to Youngstown Clinic during July 27-29, 2011, which resulted in an expanded desk review based upon significant quality of care issues identified during the onsite visit. The primary scope of the Monitor's review during April 25 – April 27, 2012 was to determine whether the recommendations contained in the Monitor's reports from the previous visit and expanded desk review had been implemented.

In the Youngstown Report, the Monitor identified significant findings with respect to the quality of care that was rendered at Youngstown Clinic. It also included additional findings discovered during this review.

Specifically, the Monitor identified, among other issues, the following:

1. Provision of services that were not medically necessary and billing, reimbursement, and documentation issues

    a. Of 15 records reviewed by the Monitor, seven records did not provide documentation or radiographic evidence to support the medical necessity

for the treatment provided. Six of the seven records showed pulpotomies were performed without medical necessity. One additional record showed no X-rays or photographs were taken to support the medical necessity for treatment provided.

b. Pulpotomies performed by the dentists in the facility were poorly performed and/or failing, demonstrating that such care fell below professionally recognized standards of care.

c. Significant quality of care concerns were identified in the fillings performed by the expanded functions dental assistant.

d. The results of medical record reviews demonstrated additional quality of care concerns such as radiographic evidence of residual cement, poorly performed fillings and stainless steel crowns, undiagnosed recurrent decay or faulty restorations, lack of rationale for extractions, no use of local anesthetic for placement of fillings in teeth with deep decay, use of multiple surface fillings without any substantiation as to why stainless steel crowns were not used, stainless steel crowns placed on non-restorable teeth, and billing for a space maintainer that was not radiographically evident six months later.

2. Provision of services that fell below professionally recognized standards of care

a. CSHM has failed to conduct a root cause analysis to determine why CSHM has not identified or addressed quality of care issues related to pulpotomies at Youngstown Clinic.

b. The Lead Dentist demonstrated no efforts to mitigate pain during the administration of anesthesia.

c. None of the dentists calculated the maximum dose of local anesthetic for the patient's weight prior to administering the agent.

d. The Monitor observed a patient encounter in which a "happy, communicative seven-year-old patient began to cry and became combative during administration of local anesthetic with no efforts by the dentist to ameliorate the painful sensation. The mother and grandmother restrained the child". The Operative Procedures form dated April 25, 2012, recorded "no active stabilization" and the written summary of the appointment recorded "pt on N20 for anxiety and pt. vocal but cooperative." Neither

was true. The Monitor directly observed a combative, uncooperative child actively restrained by her mother and grandmother and the Clinic's medical record documentation contradicted that observation.

3. Documentation issues

    a. Medical record documentation was incomplete, inaccurate, contained evidence of undiagnosed conditions, and lack of accurate interpretation of radiographs.

4. Failure to report

    a. Adverse events went unreported to the Compliance Department by staff members at the facility.

5. Unimplemented Corrective Action Plans

    a. A corrective action plan was not implemented to address the Clinic Coordinator's lack of oversight of the infection control practices of the dental hygienists in the Clinic.

6. Fear of retaliation

    a. Employees' fear of retaliation by CSHM hinders the appropriate and comprehensive reporting of compliance and quality of care-related matters at this facility.

The Monitor's findings relating to the provision of services that were not medically necessary demonstrate that CSHM has failed to comply with the obligations of sections III.B.2.b, III.B.2.c, and III.B.2.d of the CIA. The Monitor's findings relating to billing, reimbursement, and documentation issues demonstrate that CSHM has failed to comply with the obligations of section III.B.2.n of the CIA. The Monitor's findings relating to the failure to report adverse events demonstrate that CSHM has failed to comply with the obligation of sections III.B.2.g and III.B.2.m of the CIA. The Monitor's findings relating to the failure to implement corrective action plans demonstrate that CSHM has failed to comply with the obligation of section III.B.2.g of the CIA. The Monitor's findings relating to fear of retaliation in the reporting of quality and compliance issues demonstrate that CSHM has failed to comply with the obligation of section III.B.2.k of the CIA.

Independent Monitor Requirements

Section III.E.3.b of the CIA requires CSHM to address any written recommendation made by the Monitor within 15 business days, either by substantially implementing the Monitor's recommendations or by explaining in writing why CSHM has elected not to do so and thereafter timely addressing the Monitor's concerns to the OIG's satisfaction.

CSHM received the Monitor's initial Clinic Report and Desk Audit Report on the Youngstown Clinic on October 14, 2011. Therefore, CSHM was required to have substantially implemented the Monitor's recommendations in those reports no later than October 29, 2011. The Youngstown Report indicated that CSHM had failed to substantially implement a significant number of the Monitor's recommendations from its previously submitted reports of that facility.

Stipulated Penalties

Section X.B.1.i provides the OIG with the right to assess a Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CSHM fails to establish and implement written policies and procedures. Based upon CSHM's failure to comply with sections III.B.2.b, III.B.2.c, III.B.2.d, III.B.2.g, III.B.2.k, III.B.2.m, III.B.2.n, III.B.2.k, the OIG has the contractual right to assess a Stipulated Penalty for this infraction.

Based on the violations identified in this letter, the OIG has decided to exercise its contractual right to demand payment of Stipulated Penalties. Under the CIA, the OIG could seek $1.85 million based upon CSHM's failure to comply with the policies and procedures provisions of section III.B.2. CSHM was required to have established and implemented written policies and procedures within 90 days after the Effective Date, or by April 15, 2010. Accordingly, the OIG could assess a Stipulated Penalty of $2,500 for each day for the time period of April 16, 2010 through at least the date of the Monitor's visit, April 25, 2012 – a period of 740 days.

However, in its discretion, the OIG has decided not to assess the full amount of Stipulated Penalties authorized by the CIA, but rather to impose a single Stipulated Penalty in the amount of $100,000.

As indicated in section X.D of the CIA, you are required to respond to this Demand Letter in one of two manners. Within 10 days after the receipt of this Demand Letter, CSHM shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon

provisions set forth in section X.F of the CIA. In the event CSHM elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until CSHM cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period may be considered a material breach of the CIA and may be grounds for exclusion under section X.E.1.d of the CIA.

Please note that payment of the Stipulated Penalties shall be made by electronic funds transfer in accordance with the instructions that are enclosed with this Demand Letter, pursuant to section X.D.3 of the CIA.

Within 10 days of CSHM's receipt of this letter, please submit payment of the penalty amount or notify us of CSHM's request for an ALJ hearing.

Material Breach and Intent to Exclude

Section X.E.1.c of the CIA defines a material breach of the CIA as a repeated or flagrant violation of any obligation under the CIA. Additionally, section X.E.1.f of the CIA defines a material breach of the CIA as a failure to retain, pay, utilize, or respond to OIG's satisfaction to the recommendations of the Monitor in accordance with section III.E of the CIA. Finally, section X.E.1.h of the CIA defines a material breach of the CIA as a failure to meet an obligation under the CIA that has a material impact on the quality of care rendered to any patients of CSHM facilities.

With respect to CSHM's repeated and flagrant violations of the obligations of the CIA, these issues are well documented by the OIG. We cite to our May 13, 2011 Stipulated Penalties Demand Letter, and our March 8, 2012 Notice of Material Breach and Intent to Exclude to substantiate our findings relating to CSHM's material breach of the CIA for repeated and flagrant CIA violations. The breaches identified in the Youngstown Report demonstrate that CSHM has continued to repeatedly and flagrantly violate the terms of the CIA by failing to comply with the policies and procedures requirements of the CIA.

With respect to CSHM's failure to respond to the OIG's satisfaction to the recommendations of the Monitor in accordance with section III.E of the CIA, the Youngstown Report identified numerous failures on the part of CSHM to substantially implement the Monitor's recommendations as stated in previous reports of that facility.

With respect to CSHM's failure to meet an obligation under the CIA that has a material impact on the quality of care rendered to any patients of CSHM facilities, CSHM's failure to establish and implement the policies and procedures as discussed in this letter

has materially impacted the quality of care that has been rendered to patients in the Youngstown Clinic. In addition, CSHM's failure to substantially implement the

Monitor's recommendations in its reports on the Youngstown Clinic has materially impacted the quality of care that has been rendered to patients in that facility.

Section X.E.2 of the CIA provides that:

> [A] material breach of this CIA by [CSHM] constitutes an independent basis for [CSHM's] exclusion from participation in the Federal health care programs. Upon a determination by the OIG that [CSHM] has materially breached this CIA and that exclusion is the appropriate remedy, the OIG shall notify CSHM of (a) [CSHM]'s material breach; and (b) the OIG's intent to exercise its contractual right to impose exclusion . . . . The exclusion may be directed at . . . any [CSHM] facility . . . depending upon the facts of the breach.

Consequently, the OIG finds CSHM to be in material breach under section X.E of the CIA. As such, the OIG intends to exercise its contractual right to exclude Youngstown Clinic from further participation in the Federal health care programs.

Conclusion

The OIG is exercising its contractual right to demand payment of a Stipulated Penalty in the amount of $100,000 under section X.B of the CIA for the time period in which CSHM has been in breach of the CIA. As stated above, section X.D.2 of the CIA requires CSHM to submit payment of the penalty amount or notify the OIG of CSHM's request for an ALJ hearing **within 10 days** of CSHM's receipt of this letter.

The OIG intends to exclude Youngstown Clinic. Pursuant to section X.E.3 of the CIA, CSHM has **30 days** from the date of receipt of this Notice to demonstrate to the OIG's satisfaction that: (a) CSHM is in compliance with the obligations of the CIA cited by the OIG as being the basis for the material breach; (b) the alleged material breach has been cured; or (c) the alleged material breach cannot be cured within the 30-day period, but that: (i) CSHM has begun to take action to cure the material breach; (ii) CSHM is pursuing such action with due diligence; and (iii) CSHM has provided to the OIG a reasonable timetable for curing the material breach. Pursuant to section X.E.4 of the CIA, if CSHM fails to satisfy the requirements of section X.E.3 of the CIA at the conclusion of the 30-day period, the OIG may exclude CSHM from participation in the Federal health care programs.

If you have any questions regarding this letter or CSHM's obligations under its CIA, please contact [redacted] at [redacted]

Sincerely,

[redacted]

Chief Counsel to the Inspector General

Enclosure –Wire Transfer Payment Instructions for Stipulated Penalties

Wire Transfer Instructions for CMS

Subtype/Type Code: 10 00

Amount: $100,000

Sending Bank Routing Number: (insert the individual's or entity's bank routing number)

ABA Number of Receiving Institution: [redacted]

Receiving Institution Name: [redacted]

Beneficiary (Agency Location Code): [redacted]

Federal Reserve Assistance Number: [redacted]

Originator to Beneficiary Info: Stipulated Penalty payment under the Corporate Integrity Agreement with Church Street Health Management.

Please email confirmation that the wire transfer has been made to [redacted] at [redacted]

EXHIBIT 27

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Attorney
Church Street Health Management, LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Clinic Report
Youngstown, Ohio

Deliverable #1-59

May 25, 2012

Executive Summary

Introduction

The Office of Inspector General (OIG) and Church Street Health Management, LLC (CSHM) (f/k/a FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted]) to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Youngstown, LLC, 3353 Mahoning Ave., Youngstown, OH 44509 (Clinic).

Overall Clinic Impression

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were timely provided. The Monitor observed patient care was delivered with a caring and compassionate team approach.

Overall Summary of Critical Findings and Observations

Set forth below is a summary of the Monitor's critical findings and observations:

The Monitor's assessment of CSHM's implementation of the Monitor's recommendations found CSHM had successfully met and implemented 29 of the 45 recommendations. After careful analysis of documentation and data collected, the Monitor determined 3 of the 45 recommendations were not met, 12 were partially met, and 1 remains under evaluation by the Monitor.

Two of five records from the December 2011 CSHM chart audit results were reviewed by the Monitor and revealed quality of care findings that were not clearly communicated to the Clinic. In addition, the documentation provided to the Monitor did not show the Chief Dental Officer's (CDO) recommendations and Corrective Action Plan (CAP) were completed.

CSHM has made improvements in tracking billing errors and refunds. There have also been noticeable improvements in the communication efforts related to billing errors and significant chart audit findings.

Staff members interviewed were able to define the different types of adverse events and how they could be prevented. Five incidents were reported as potential adverse events since the Monitor's visit in July 2011; however, the Monitor was notified during an interview with a staff member that a recent "nick" to a patient's tongue went unreported, and she did not feel comfortable reporting the event to the Compliance Liaison or the hotline. Only one of the five incidents reported to CHSM was substantiated as an adverse event.

CSHM has made a substantial effort in the training of staff members with respect to identification and reporting of adverse events; however, there still appears to be an underlying issue of fear to report an incident that involves particular staff members.

Three employee complaints have been investigated since the Monitor's visit. One complaint indicated an issue with reporting incidents and the hotline, and another investigation showed the clinic's management team did not enforce a CAP issued by CSHM's Director of Clinic Coordinators for the Clinic Coordinator's lack of oversight of the infection control practices of the dental hygienists in the Clinic. This may further contribute to staff members' lack of confidence and fear when reporting incidents to the Clinic's management team.

Two employees (a staff dentist and an assistant) reported quality of care concerns related to fillings performed by the expanded functions dental assistant (EFDA). These complaints were substantiated during the record review process.

The Monitor's main concern regarding communication is that fear of retaliation may still hinder employees from reporting quality of care issues or adverse events. CSHM's Comprehensive Compliance Disclosure Log and the documentation provided to the Monitor did not show any quality of care issues have been reported by staff members. Although CSHM has extensively trained and discussed reporting issues, the Monitor finds the recommendations with respect to reporting incidents and comfort using the hotline as partially unmet.

Although many site visits were conducted, the dentists indicated the X-rays from the Monitor's report, which showed poorly performed and failing pulpotomies, were not reviewed with the dentists; however, the dentists reported there was discussion related to making sure all pulp tissue was removed and firmly packing the pulp paste.

Although specific training was provided by CSHM related to Tooth Chart documentation, five records showed errors in documentation of decay on the upper odontogram of the Tooth Chart. In three records, radiographically demonstrable decay went undiagnosed. Six records did not document existing conditions on the upper odontogram of the Tooth Chart.

Three records contained non-diagnostic X-rays or photographs. Three records did not document interpretation of X-rays. X-rays were not taken when indicated in three records.

Seven records did not provide documentation or radiographic evidence to support the medical necessity for the treatment provided. Six of the seven records showed pulpotomies were performed without medical necessity. An additional record did not have X-rays or photographs to support the medical necessity for treatment provided.

Four records did not address radiographic pathology in the Treatment Plan and one of the four records did not contain consent for the pulpotomy and stainless steel crown (SSC) performed on tooth #B.

Five records did not document the rationale for placement of multiple surface fillings instead of SSCs as directed by the *Intracoronal Restorations Documentation* policy.

Post-operative X-rays were reviewed when available to evaluate the quality of pulpotomies performed. Twelve records showed incomplete removal of pulpal tissues or failing pulpotomies with no recognition or documentation of these findings. The dates of service for 11 of the 12 records were prior to the Monitor's initial visit; however, this was a result of CSHM responding to the Monitor's request to provide data analysis that allows the Monitor to identify records that allows for a retrospective analysis of the quality of care provided. This additional review gave the Monitor a better perspective of the magnitude of the issues related to the pulpotomies performed in the Clinic. The Monitor was also able to confirm all three dentists had performed pulpotomies without complete removal of pulpal tissue.

Fourteen records revealed other quality of care issues, including radiographic evidence of residual cement, poorly performed fillings and SSCs, undiagnosed recurrent decay or faulty restorations, lack of rationale for extractions, no use of local anesthetic for placement of fillings in teeth with deep decay, use of multiple surface fillings without rationale about why SSCs were not used, SSCs placed on non-restorable teeth, and billing for a space maintainer that was not radiographically evident six months later.

Responses from the dentists indicated knowledge of the indications and contraindications for performing a pulpotomy and the radiographic and clinical findings associated with follow-up of pulpotomies for success over time, but they demonstrated an uneven level of knowledge about the technique of performing a pulpotomy.

A five-year-old patient received a pulpotomy and SSC on tooth #K with no attempt to obtain or maintain isolation from oral secretions during the pulpotomy.

All three dentists could describe the proper use of topical anesthetic and techniques to mitigate the pain associated with administering local anesthetic.

All three dentists demonstrated proper techniques for applying topical anesthetic before administering local anesthetic.

During patient observations of dentists for techniques to mitigate the sensations of discomfort during the administration of local anesthetic, one Staff Dentist demonstrated good technique, one Staff Dentist demonstrated some efforts to mitigate pain, and the Lead Dentist demonstrated no efforts to mitigate pain.

A happy, communicative seven-year-old patient began to cry and became combative during administration of local anesthetic with no efforts by the dentist to ameliorate the painful sensation. The mother and grandmother restrained the child. This was an excellent example of a good patient, old enough to communicate, becoming combative and noncompliant as a result of poor techniques of administering local anesthesia. The Operative Procedures form (Op Sheet) dated April 25, 2012, recorded "no active stabilization" and the written summary of the appointment recorded "pt on N20 for anxiety and pt. vocal but cooperative." Neither was true. The Monitor observed a combative, uncooperative child actively restrained by her mother and grandmother.

None of the dentists calculated the maximum dose of local anesthetic for the patient's weight prior to administering the agent.

All three dentists reported they had been told by "other dentists" in the company to perform pulpotomies on all primary teeth restored with SSCs. Two of the dentists said they were now only doing pulpotomies when they were necessary. Two of the dentists said they had not been taught to perform pulpotomies on all crowned primary teeth in dental school. When asked why they thought it was acceptable to do so now, they explained the dentists who instructed them to do so were older and more experienced, and they believed they should follow their directions.

A staff dentist expressed a reluctance to report poor quality dental treatment other dentists had done and expressed no ownership to record problems she identified on recall examinations if she had not done the procedure in question.

A three-year-old patient was treated by a staff dentist for extraction of teeth #E and #F. The chief complaint on the Health History form read "two front teeth" in response to the question about perceived dental problems. There was a history of pain recorded on the Hygiene form under clinical findings and a later note about trauma to these same teeth. However, there was no documentation of follow-up about when or how the reported trauma occurred or whether it could have been the reason for the visit on this date or the reason for the reported pain. In addition, there was no documentation of follow-up concerning the report of pain to determine the nature of the pain, whether it was associated with the trauma mentioned, or the cause for the visit on the date of service. In the absence of expanded documentation concerning the reported trauma and pain and the presence of a normal X-ray, it is unclear to the Monitor why these teeth were extracted.

Overall Summary of Recommendations

Set forth below is a summary of the Monitor's recommendations:

- Ensure the December 2011 chart audit recommendations from the CDO and CAP requirements were completed.
- Ensure the CDO receives and evaluates the totality of care when reviewing potential adverse events and not just whether the definition of an adverse event has been met.
- Perform a root cause analysis as to why the failure to follow a physician's directives related to the administration of local anesthetic was not considered an adverse event.
- Provide the Monitor with analysis as to why extracting the wrong tooth was not considered an adverse event.
- Evaluate the process to obtain informed consent to ensure the parent understands the basis for treatment, especially when teeth are being removed.
- Perform a root cause analysis to determine why some employees are still uncomfortable with reporting quality of care concerns to the Clinic's management team and CSHM.

- Perform a retrospective review to determine quality of fillings performed by EFDAs to determine whether the re-treatment of teeth was related to quality of care provided.
- While training was provided and monitoring is being conducted, there are still significant findings that suggest CSHM needs to evaluate the effectiveness of their training and monitoring processes.
- Conduct a root cause analysis to determine why CSHM has not identified or addressed quality of care issues related to pulpotomies.
- Ensure staff members are properly reviewing the Health History form and documenting findings related to missing information or explanations to "yes" responses.
- Ensure staff members are correctly documenting decay, existing conditions, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure staff members provide X-rays of diagnostic quality and duplicate X-rays which are properly mounted and labeled.
- Ensure staff members take appropriate diagnostic X-rays and/or photographs when indicated to support the medical necessity for treatment provided.
- Ensure staff members document the interpretation of all X-rays taken.
- Ensure pulpotomies are performed only when medically necessary and teeth with radiographic pathology are treated appropriately.
- Ensure dentists are able to recognize and properly document treatment plans for all radiographic conditions and obtain proper consent for treatment.
- Ensure staff members provide documentation to support the rationale for placement of multiple surface fillings instead of SSCs.
- Ensure staff members are recording the appropriate method of delivery, location, and the dose of local anesthesia administered in the local anesthesia section of the Op Sheet.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of restorative procedures.
- Ensure services performed by an EFDA are clearly documented in the patient's record to allow for clinician identification related to quality of care issues.
- Ensure EFDAs are well-trained and the services they provide are monitored with proper oversight to ensure restorative services are completed within professionally recognized standards of care.
- Conduct a root cause analysis as to why the previous corrective action was not effective in implementing the Monitor's recommendation to ensure dentists understand techniques to mitigate pain with the administration of local anesthetic injections, especially inferior alveolar block injections and palatal anesthesia.

- Ensure dentists are calculating and recording on the Op Sheet the maximum dose of local anesthetic for the patient's weight that can be administered to the patient before administering the agent.
- Conduct a root cause analysis as to why the previous corrective action was not effective in implementing the Monitor's recommendation to ensure dentists employ proper techniques for pulpotomies and understand indications of failed pulpotomies.
- Conduct a root cause analysis to determine why all three dentists reported having been told by other more senior dentists in the Center clinics to perform a pulpotomy for every tooth they restored with an SSC.
- Conduct a root cause analysis as to why the previous corrective action was not effective in implementing the Monitor's recommendation to ensure X-rays are medically necessary even though documentation supports they have been read and interpreted. Ensure dentists are taking panoramic X-rays when recommended by *AAPD Guidelines*, interpreting the X-rays and recording their findings.
- Ensure dentists and staff understand the importance of identifying and reporting quality of care issues in the Clinic and feel comfortable doing so.
- Ensure dentists understand the proper work-up and documentation for teeth that have experienced trauma before initiating treatment.
- Ensure dentists use behavior management techniques before attempting PSD on apparently cooperative patients. Also ensure the Op Sheet and doctor's notes accurately record the use of patient stabilization when used.
- Ensure patient records accurately document failure of treatment over time and that re-treatment and rebilling are justified.

Clinic On-site Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management, LLC (CSHM) (f/k/a FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted]) to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Center of Youngstown, LLC, 3353 Mahoning Avenue, Youngstown, OH 44509 (Clinic). This is a follow-up visit to an on-site conducted July 27-29, 2011, which resulted in an expanded desk review. The primary scope of this review is to determine whether the recommendations contained in the Monitor's reports from the previous visit and expanded desk review have been implemented. It will also include any additional findings discovered during this review.

Implementation

The OIG approved an unannounced on-site visit to be conducted April 25-27, 2012, at the Clinic. The Monitor notified [redacted], Compliance Officer, immediately prior to arriving on April 25, 2012.

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were timely provided. The Monitor observed patient care was delivered with a caring and compassionate team approach.

Entrance Conference

An entrance conference was held on April 25, 2012. The Monitor Team of [redacted] RDH, [redacted], RDH, and [redacted], DDS, attended. Clinic staff members [redacted], DDS, Lead Dentist, [redacted], Office Manager and Compliance Liaison, and [redacted], Clinic Coordinator, also attended. Discussion included an overview of the process, point of contact information, intent to conduct treatment observations, and the need to interview individuals employed by the Clinic. The Monitor explained this visit was a follow-up to the previous visit in July 2011 and would represent a more focused review related to findings and recommendations stemming from that visit.

General

There were no findings or recommendations in the previous report that required follow up during this visit.

Review of Quality Control System

Policies and Procedures

A list of five randomly selected active employees was supplied to the Compliance Liaison with a request for the 2012 Code of Conduct Acknowledgements. All five covered persons signed the initial acknowledgment and certification related to CSHM's *Code of Ethics and Business Conduct* within the time frames required; however, the 2012 Acknowledgement and Certification forms were not provided to the Monitor.

Interviews and documentation provided to the Monitor revealed infection-control training was conducted on September 21, 2011. A signature sheet showing each employee had reviewed the *Infection Control Manual* was completed in December 2011, and the Clinic Coordinator gave an instrument sterilization demonstration on April 13, 2012. Staff members stated the Regional Director discussed where to store the *Infection Control Manual*; however, there was confusion about where it was located in the sterilization area. Instead of being stored with other manuals, as some staff members had expected, it was located in another cabinet on the other side of the room.

Interviews indicated the Chief Dental Officer (CDO) reviewed CSHM's policies regarding parents who refuse X-rays for their children as well as policies on how to manage intoxicated adult patients and four-minute topical gel/foam fluoride application. Documentation through the record review process also supported compliance with CSHM's policy regarding fluoride application.

Training

A list of five randomly selected active, clinical employees was supplied to the Compliance Liaison with a request for CE Tracking and signature sheets for all training requirements from July 2011 to present. The documentation provided was well organized and showed all five employees had received the required training within the designated time frame. Additional training documentation, including training materials and signature sheets, was provided to show CSHM's efforts in addressing the Monitor's recommendations.

Internal Audits

CSHM's December 2011 chart audit results show that two of the three dentists failed the chart audit. In addition to the review of CSHM's chart audit results, the Monitor completed a quality of care review of the records selected for the December 2011 chart audit. Upon completion of this review, the Monitor had the following findings:

- Two of the five records (patients #048 and #049) reviewed by the Monitor revealed quality of care findings.
  - Upon review of the audited date of service for patient #048, the Monitor noticed radiographic evidence of fillings with significant overhangs on teeth #19, #21, and #28. The record also indicates an EFDA may have been responsible for the placement of these fillings. These overhangs were not recorded on the Tooth Chart or addressed by the Lead Dentist in the

Treatment Plan. After review of CSHM's chart audit results spreadsheet, the Monitor noticed the record was sent to the CDO for his review. The CDO's comments recorded in the December 2011 chart audit spreadsheet state: "I see an amalgam overhang or loose piece of amalgam between #18,19. The center should include treatment of this area to remove the overhang even if replacement of the fillings in 18,19 are required. I'm disappointed that this overhang has been in place for two (2) years. #14 contains an amalgam restoration with a radiopaque base. I see a radiolucency beneath the base in the distal area of the restoration. This could represent a calcium hydroxide liner or secondary caries. The center should be asked to ensure that this area is re-evaluated or carefully followed for possible necessary retreatment." Although there are clear findings and recommendations mentioned by the CDO in the chart audit spreadsheet, the Corrective Action Plan (CAP) does not clearly identify or address this specific issue. In addition, there was no evidence to show follow up with the patient related to the CDO's findings. During the Monitor's visit to the Clinic, these X-rays were reviewed with the Lead Dentist and he seemed surprised and unaware of these findings.

- CSHM's chart audit spreadsheet indicates the CDO was consulted during the review of patient #049; however, the following findings were not identified by CSHM. CSHM had no findings related to the medical necessity for the treatment provided to teeth #B and #I or interpretation of the panoramic X-ray. The bitewing X-rays dated November 11, 2011, show teeth #B and #I had severe decay into the pulp and beyond the cementoenamel junction (CEJ), which had resulted in loss of tooth space. Both teeth appeared non-restorable, and there were no periapical X-rays taken to support the medical necessity for the pulpotomies and stainless steel crowns (SSCs) performed on the audited date of service. In addition, the panoramic X-ray showed teeth #20 and #29 were congenitally missing, and there was no documentation of these findings on the Tooth Chart or Hygiene Procedures form.

- CSHM's chart audit results e-mail and the CAP for the December 2011 chart audit failure do not clearly state the findings from the chart audit spreadsheet.
- The CAP states the Regional Senior Vice President (SVP) "will ensure that all dentists and staff review chart documentation guidelines and understand the following 10 items that were the most frequently missed audit areas." In addition, the Regional SVP was to review 15 records and monitor them for improvements in the identified areas. There was no documentation provided to the Monitor to show the CAP was completed.
- The CAP also included the correction of all billing errors per the e-mail from CSHM's auditor; however, this e-mail was not provided to the Monitor. Upon review of CSHM's overpayment log and the chart audit spreadsheet, it appears one billing issue remains under dispute and has not been corrected or resolved. The chart audit finding indicated there was no medical necessity for a panoramic X-ray and a refund was warranted.

A re-audit was conducted in February 2012 for the two dentists who failed the December 2011 chart audit. Both dentists passed the re-audit and there was noticeable improvement in the communication of billing issues found in the February 2012 re-audit. Documentation was provided to show all billing errors were corrected within 15 days.

The March 2012 chart audit results were sent to the Clinic during the Monitor's visit. The results showed the Clinic and all dentists passed the chart audit. There were no billing errors reported; however, there was a CAP for a staff dentist because a critical item was missed on the health history of a patient who was taking the blood-thinner warfarin, and was treated without medical consultation or clearance. The CAP instructed the Lead Dentist to review the management of patients taking blood thinners while under the care of the treating dentist. The Lead Dentist was also to ensure the staff dentist reviews the webinar given in November 2011, which was a Mandatory Quality Assurance Training for all clinically covered staff regarding the health history.

CSHM has made improvements in tracking billing errors and refunds. There have also been noticeable improvements in the communication efforts related to billing errors and significant chart audit findings.

Complaints

Staff members interviewed were able to define the different types of adverse events and how they can be prevented. Five incidents were reported as potential adverse events since the Monitor's visit in July 2011; however, the Monitor was notified during an interview with a staff member that a recent "nick" to a patient's tongue went unreported and she did not feel comfortable reporting the event to the Compliance Liaison or the hotline.

Only one of the five incidents reported to the Patient Advocate was substantiated as an adverse event. The incident was found by CSHM's clinical auditor during a review of the patient's record. The incident involved lack of consent for a filling performed on a permanent molar (tooth #18) by the Lead Dentist on September 20, 2011. The incident was reported on January 25, 2012. Documentation provided to the Monitor shows the Lead Dentist was counseled by the CDO and the CAP was completed on March 6, 2012.

The following is a summary of the four incidents that were reported by the Compliance Liaison but were not considered adverse events by CSHM's CDO. Three of the four complaints are discussed below:

- Case CD-433 reported a combative four-year-old child received a cut to the tongue while three teeth were treated with fillings, a pulpotomy, and an SSC. The date of the incident was August 17, 2011, and the record indicated a digital photo was taken; however, the photo was not provided to the Monitor. The documentation in the patient's record did not record the size of the cut and reported the patient was "very strong and vocal." Four people were required to help manage the patient. Documentation also showed a protective stabilization device (PSD) was used and the patient was "double wrapped" in order to provide

treatment. In addition, the Operative Procedures Form (Op Sheet) showed insufficient time was allowed for the onset of local anesthesia, with only a three-minute time difference between anesthetic and treatment start times. The record showed the patient was in the PSD for 39 minutes. The documentation provided by CSHM to the Monitor did not include the digital photo or X-rays related to the date of service. The e-mail communication related to this case did not show X-rays were requested; therefore, it appeared there was no evaluation to determine whether the treatment rendered was medically necessary. An e-mail dated August 18, 2011, indicated the CDO reviewed the photo and chart information and determined the cut was not an adverse event. There was no indication the CDO evaluated the need for the stabilization measures that included "double wrapping" and four people to manage the patient.

- Case CD-560 reported a 24-year-old pregnant female was given four carpules of lidocaine with epinephrine with apparent disregard to a physician's orders. The incident occurred on September 26, 2011. The e-mail communication from the Compliance Liaison and the documentation in the patient's record indicated the patient's prenatal care provider approved dental treatment with the use of lidocaine without epinephrine. The dental assistant reported reviewing the physician's orders, loading the anesthetic syringe with mepivicaine without epinephrine, and leaving the release form on the counter for the dentist to read. The dental assistant switched treatment rooms with another assistant but discussed the issue with the new assistant. When the staff dentist entered the room, the assistant told her that mepivicaine was being used because the patient was pregnant. The incident report stated: "The Dr proceeded to read the release from the OBGYN and then replaced the anesthetic with lido with epi. She then told the assistant that she wasn't sure why she thought we had to use the mepiviaine that just because she is pregnant the lido with epi would be fine. She then gave 4 carps of anesthetic. The pt was jittery and felt "not right" her blood pressure was 106/59 so [the staff dentist] had her sit and relax." The patient's blood pressure was taken again and was within normal limits. The notes indicate the patient wanted to leave without receiving treatment and wanted to return after the pregnancy. An e-mail dated September 28, 2011, includes the following comments from the CDO: "Lidocaine with epinephrine is generally considered safe for pregnant women, though some authorities suggest using a local anesthetic without epinephrine. However, in this case the patient's physician recommended a local anesthetic without epinephrine. In addition, 4 carpules of lidocaine is a large dose. It may have been within the limits of the DCPW, but the DCPW should be adjusted downward. Local anesthetics should be minimized in pregnant women. In this case the patient's anxiety was managed properly. I don't consider it an adverse event, but another one to put in our 'near miss' collection." Although this was not considered an adverse event, the CDO had the Lead Dentist complete a CAP with the staff dentist, which included "counseling regarding ignoring a physician's advice without consulting the physician further" and minimizing treatment, appointment time, and amount of local anesthetic

when treating a patient who is pregnant. An e-mail dated October 25, 2011, from the Lead Dentist states: "The counseling has been completed."

- Case CD-788 reports an incident where an initial orthodontic referral dated July 13, 2011, was sent to the Clinic requesting the extraction of teeth #4 and #29; however, the Clinic received another extraction request from a different orthodontist dated October 18, 2011, requesting extraction of teeth #5, #12, #20, and #29. On October 31, 2011, the Lead Dentist reviewed the July 2011 referral and extracted teeth #4 and #29. The treating orthodontist called the Clinic later that day to determine why teeth #4 and #29 were extracted instead of teeth #5, #12, #20, and #29. The Lead Dentist informed the orthodontist that he went with the referral he had and was not informed there were two different orthodontists involved. He then indicated the treating orthodontist stated it would not be a problem. The Clinic received a subsequent referral dated November 10, 2011, with the following recommendation: "Since the upper right second premolar has been extracted instead of the upper right first premolar, at this time it would be best to extract the following teeth for orthodontic purposes: upper left second premolar (#13); lower left second premolar (#20)." After review of all the facts from this case, the CDO retracted his initial judgment and determined that this incident was not an adverse event; however, a CAP was implemented. The CAP instructed the Lead Dentist to caution front office staff to check for pre-existing referral requests whenever they place a new one into the chart and to caution clinical staff to search the record for additional referral requests when removing one for the dentist to assess prior to treatment.

CSHM has made a substantial effort in the training of staff members with respect to identification and reporting of adverse events; however, there still appears to be an underlying issue of fear to report an incident that involves particular staff members.

There have been three employee complaints since the Monitor's visit in July 2011. The following is a summary of the employee complaints:

- CD-486 reports a possible Health Insurance Portability and Accountability Act (HIPAA) violation by an expanded functions dental assistant (EFDA). The Compliance Liaison reported the EFDA was keeping a personal list of patient names and services that she had provided and stated she had recorded this information for "personal gain." The investigative report indicates there was a notebook with procedures recorded but no patient names listed. The report also states: "Staff keep a dry erase board in the Center to document how many patients each assistant sees as a informal competition to have a fun environment in the office." CSHM did not perform an evaluation to determine whether this "competition" affected the quality of patient care and treatment. There was no compliance issue found and the employee was counseled about HIPAA and advised to cease any further recording or tracking of patient information that was not necessary to perform her job. This information was reported on August 31, 2011, and the employee was terminated from employment on unrelated grounds.

Her final date of employment was September 19, 2011. The case was closed in November 2011.

- CD-761 documents complaints from a previous Assistant Office Manager through an exit interview. The internal investigation report is dated November 14, 2011. The exit interview indicates the employee was aware of the Hotline poster and phone number but did not feel confident talking to anyone and chose instead to terminate her employment. The most significant reason for leaving the dental center was reported as "100% management." The investigation shows no compliance or quality of care issue was found and no CAP was needed.
- CD-1263 shows the Compliance Liaison reported a complaint on April 11, 2011. The Compliance Liaison noticed the "nose cones" were "just wiped down and used again" and not sterilized by the hygienists. An e-mail from the Director of Clinic Coordinators states she spoke with the Compliance Liaison and confirmed the hygienists in the Clinic were "defiantly not following the CSHM policy on proper infection control for handpieces." The Director of Clinical Coordinators addressed the compliance issue and performed corrective action with all five dental hygienists on the day the incident was reported. In addition, she requested corrective action for the Clinic Coordinator "for not overseeing proper infection control in the center as the infection control coordinator." An e-mail from the Director of Clinic Coordinators to the Compliance Attorney dated April 13, 2012, states: "The CC in the center did not receive a corrective action due to the Lead Doctor and Office Manager not agreeing that she should be held accountable because she was in an operative assisting another doctor. I strongly disagree with this decision and feel the CC should have been written up as she is the Infection Control Coordinator in the center and is responsible for insuring all staff follows the policies and procedures we have in place for infection control." No further correspondence was provided and it appears the CAP was only completed by the dental hygienists involved.

The Monitor's main concern with respect to the above complaint is the disagreement expressed by the Clinic's Compliance Liaison and Lead Dentist with the CAP issued by CSHM's Director of Clinical Coordinators. Because it appears the Clinical Coordinator was not held accountable for her oversight, this may further contribute to staff members' lack of confidence and fear when reporting incidents to the Clinic's management team.

There were only two patient/parent complaints received since the Monitor's last visit. Both complaints were investigated and neither required corrective action.

Recommendations

- Ensure the December 2011 chart audit recommendations from the CDO and CAP requirements were completed.
- Ensure the CDO receives and evaluates the totality of care when reviewing potential adverse events and not just whether the definition of an adverse event has been met.

- Perform a root cause analysis as to why the failure to follow a physician's directives related to the administration of local anesthetic was not considered an adverse event.
- Provide the Monitor with analysis as to why extracting the wrong tooth was not considered an adverse event.
- Evaluate the process to obtain informed consent to ensure the parent understands the basis for treatment, especially when teeth are being removed.

Review of Communication System

Educational materials are now available in English and Spanish and staff members report awareness of CSHM's translation service.

CSHM's Compliance Attorney and Human Resource Specialist conducted a site visit and training at the Youngstown office on November 30, 2011. The purpose of the visit was to educate management about how to encourage reporting of any concerns, educate staff about use of the hotline and to interview staff to investigate any potential concerns, including quality of care. Six staff members were interviewed, including three dental assistants, a hygienist, a front office staff member, and a dentist. Findings from interviews were not included in the report provided to the Monitor.

The Monitor conducted interviews with seven staff members. One of the seven, who was not interviewed by CSHM during the November 2011 visit, stated she was still uncomfortable reporting incidents to the Clinic's management team and would not use the hotline because of fear of retaliation. This staff member reported a recent incident where a patient received a nick to the tongue; however, the incident was not recorded in the patient's record or reported to CSHM. Although she said she felt the incident should have been reported, she did not feel comfortable reporting it to the Compliance Liaison or the hotline. When asked why, she stated she feared retaliation from the Clinic's management team. Although the report provided by CSHM records discussions with the management team "asking them to be mindful of recognizing and being open to concerns, ensuring there is no retribution (directly or subtly) for the employee having raised a concern, being familiar with the appropriate channels to assist with or escalate the issue, and understanding that they are not to perform their own investigation as issues may be raised," it appears there may be issues that still remain.

Two employees (a staff dentist and an assistant) reported quality of care concerns related to fillings performed by the EFDA. These complaints were substantiated during the record review process and the related findings are specified in the record review section of this report.

- A staff dentist reported fillings performed by the EFDA are often too high or have overhanging margins. When asked whether she evaluates the quality of the fillings performed by the EFDA, she said she does not check the quality or occlusion of the fillings prior to the patient's departure. This Clinic Coordinator confirmed the lack of supervision and quality evaluation and reported the patient is escorted to the front once the EFDA has completed her treatment. The staff

dentist stated she had three records on her desk to discuss the quality of restorations performed by the EFDA with the Lead Dentist.

- A dental assistant expressed concern about the quality of care provided in the Clinic, specifically for lost restorations and recurrent caries. She said she would not feel comfortable using the hotline for fear that Clinic management would retaliate.

The Monitor's main concern regarding communication is that fear of retaliation may still hinder employees from reporting quality of care issues or adverse events. CSHM's Comprehensive Compliance Disclosure Log and the documentation provided to the Monitor did not show any quality of care issues have been reported by staff members. Although CSHM has extensively trained and discussed reporting issues, the Monitor finds the recommendations with respect to reporting incidents and comfort using the hotline as partially unmet.

Recommendations

- Perform a root cause analysis to determine why some employees are still uncomfortable with reporting quality of care concerns to the Clinic's management team and CSHM.
- Perform a retrospective review to determine quality of fillings performed by EFDAs to determine whether the re-treatment of teeth was related to quality of care provided.

Analysis of CSHM Corrective Action

The Monitor performed a site visit at the Clinic July 26-28, 2011. As a result of significant quality of care findings, the Monitor expanded the review to include an evaluation of CSHM's chart audit process for the Clinic. Both the Clinic and the desk review reports were issued on October 14, 2011.

Attachment A shows the Monitor's assessment of CSHM's implementation of the Monitor's recommendations. Through interviews, documentation review, treatment observations, and record review, the Monitor was able to determine that CSHM had successfully met and implemented 29 of the 45 recommendations. After careful analysis of documentation and data collected, the Monitor determined 3 of the 45 recommendation were not met, 12 were partially met, and 1 is still under evaluation by the Monitor.

Staff members reported many changes since the previous visit. The Lead Dentist and two staff dentists articulated understanding of the Monitor's findings and recommendations and actions taken in response. Interviews with the Compliance Liaison and clinical staff members revealed mixed levels of knowledge of the Monitor's findings and recommendations. For example, the Clinic Coordinator and dental assistants that were interviewed were not aware of any quality of care issues or treatment related findings from the Monitor's report. The Compliance Liaison was aware

of the high pulp to crown ratio, but was not aware of any quality of care issues with respect to pulpotomies. All staff members articulated changes that have occurred, including policies and procedures and training.

Staff members reported multiple visits by CSHM representatives to address the findings and recommendations in the Monitor's report. The Regional Director of Operations met with staff members at the Clinic on October 20, 2011, to discuss the hotline, Infection Control Manual, the CDO's Best Practice Memo on fluoride application, the translation service, and completion of the Health History form. The Clinic Coordinator from Small Smiles Dental Center of Akron was also present and reviewed how to best duplicate X-rays.

The Compliance Attorney and Human Resources Specialist conducted a site visit on November 30, 2011. The main purpose of their visit was to address the issues related to the hotline and investigate any potential concerns, including quality of care. The site visit included a presentation titled "HR and Compliance Roadshow" and interviews with six randomly selected staff members including three dental assistants, one hygienist, one front office staff and one dentist.

The Director of Clinical Quality Initiatives and Training visited the Clinic on February 2, 2012. He conducted chart reviews, discussed his findings with the Clinic dentists, and recommended the following corrective actions. The Lead Dentist was to: "review radiographic procedures with the staff, including examples of non-diagnostic bitewings and the removal of the patient's jewelry/piercings prior to taking panoramic films, review proper health history follow up with staff who review medical histories, reinforce with staff that all existing conditions, including the presence of teeth, restoration, pulpotomies, etc, are to be charted on the upper odontogram, and reinforce use of 'CT' on odontogram when charting caries discovered during treatment."

He also observed care and interviewed staff in which he had no findings. He met with all three dentists and reviewed the findings and recommendations from the Monitor's report. His report indicates there were no quality of care findings during the record review, patient observations, or interview process.

In sum, he states: "This staff in this center appeared to work well as a team. The atmosphere was positive and upbeat. Parents and children were treated politely. The clinic operated efficiently, though I cannot comment on front office procedures, as I did not observe activities there. [The Lead Dentist] is, in my opinion, one of our best Lead Dentists. He has already implemented changes in response to the monitor's recommendations. My comments and suggestions were well received by the dentists."

Dentists also reported a recent site visit by the CDO and stated he reviewed records but did not observe treatment. There was no documentation provided to the Monitor to show the CDO's findings from this visit.

Although many site visits were conducted, the dentists indicated the X-rays from the Monitor's report which showed poorly performed and failing pulpotomies were not

reviewed with the dentists; however, the dentists reported there was discussion related to making sure all pulp tissue was removed and firmly packing the pulp paste.

Recommendations

- While training was provided and monitoring is being conducted, there are still significant findings that suggest CSHM needs to evaluate the effectiveness of their training and monitoring processes.
- Conduct a root cause analysis to determine why CSHM has not identified or addressed quality of care issues related to pulpotomies.

Review of Dental Record Documentation

The testing attributes related to the dental record documentation were designed to determine whether the documentation was complete and accurate, including HIPAA-related forms, medical necessity, and consent forms. A random sample of 15 visits representing 15 separate patients and records was identified from the patient listing provided by CSHM. The sample is based on all Medicaid patients seen for operatory visits from February 17, 2012, through April 16, 2012. The Monitor's pediatric dentist provided consultation on 15 of the 15 visit records reviewed. In addition to the review of 15 visit records, the Monitor selected additional records, which contained post-operative X-rays to evaluate quality of care with respect to pulpotomies and fillings. This process involved a re-review of the records reviewed during the July 2011 site visit and a random selection from a query provided by CSHM. Findings related to patients #030 and above are associated with the Monitor's pediatric dentist's treatment observations and findings from the quality of care review. The relevant findings from the record review and treatment observations are as follows:

Health History

The Health History form was not completed correctly in 2 (patients #001and #003) of the 15 reviewed records.

The table below provides a summary of each finding.

Health History		
Patient	**Date**	**Finding**
#001	April 10, 2012	The Health History form recorded a "yes" response to allergies with the explanation "allergy to antibiotics don't remember name"; however, there were no details regarding the type of allergic reaction.
#003	March 28, 2012	The Health History form did not document a "yes/no" response for the question related to allergies.

Tooth Chart

Five records (patients #001, #005, #011, #014, and #015) showed errors in documentation of decay on the upper odontogram of the Tooth Chart. In three of the six patients (#005, #011, and #014), radiographically demonstrable decay went undiagnosed.

Six records (patients #001, #002, #005, #008, #014, and #015) did not document existing conditions on the upper odontogram of the Tooth Chart.

In one record (patient #014), the lower odontogram did not document completed treatment for tooth #B, which received a pulpotomy and an SSC.

The following findings are related to documentation on the Tooth Chart.

Decay on the Upper Odontogram		
Patient	**Date**	**Finding**
#001	April 13, 2012	The upper odontogram recorded mesial occlusal decay on tooth #T; however, the X-rays showed tooth #T was missing.
#005	March 8, 2012	The radiographically demonstrable mesial decay on teeth #A and #T was not recorded on the Tooth Chart.
#011	March 23, 2012	The radiographically demonstrable distal decay on tooth #S and mesial decay on tooth #T were not recorded on the Tooth Chart.
#014	February 6, 2012	The radiographically demonstrable distal decay on tooth #S was not recorded on the Tooth Chart.
#015	April 12, 2012	The mesial occlusal buccal decay on tooth #K was not recorded on the Tooth Chart.

Existing Conditions on the Upper Odontogram		
Patient	**Date**	**Finding**
#001	April 13, 2012	Permanent teeth were documented as present by circling the entire tooth instead of the tooth number. Missing primary teeth also were incorrectly documented with a line marked through them.
#002	November 8, 2011	The Tooth Chart did not document the radiographically demonstrable internal root resorption on tooth #L, the pulpotomies on teeth #S and #L, or the incomplete removal of pulpal tissue in teeth #S and #L.
#005	March 8, 2012	The left bitewing X-ray revealed an ectopic eruption of tooth #14, which was not documented on the Tooth Chart.

Existing Conditions on the Upper Odontogram		
Patient	**Date**	**Finding**
#008	March 15, 2012	The Tooth Chart did not document the pulpotomies and crowns on teeth #J, #K, and #L; the fillings on teeth #19, #I and #S; or the sealants on teeth #14 and #30. There also was no documentation of the furcation radiolucency on tooth #I.
#014	February 6, 2012	The Tooth Chart did not document the furcation radiolucency on teeth #I and #B or the pulpotomy on tooth #I.
#015	April 12, 2012	The Tooth Chart did not document the existing primary teeth.

X-rays and Digital Photographs

Exposure of radiographs generally followed recognized guidelines and X-rays were of good quality.

Three records (patients #007, #012, and #014) contained non-diagnostic X-rays or photographs.

Three records (patients #003, #004, and #049) did not document interpretation of X-rays.

X-rays were not taken when indicated in three records (patients #002, #003, and #031).

In one record (patient #014), the X-ray was labeled incorrectly. The Op Sheet recorded a periapical X-ray was exposed on March 5, 2012; however, the periapical X-ray was dated March 3, 2012.

The tables below provide a summary of each finding.

Non-diagnostic X-rays or Photographs		
Patient	**Date**	**Finding**
#007	March 14, 2012	The right bitewing X-ray was non-diagnostic for tooth #T because of interproximal overlapping contacts.
#012	March 20, 2012	The left bitewing X-ray was non-diagnostic because of interproximal overlapping contacts between teeth #I and #J and lack of visibility.
#014	February 6, 2012	The left bitewing X-ray was non-diagnostic for teeth #I and #L because of overlapping contacts. The duplicate periapical X-ray of tooth #B was flipped and labeled with an incorrect date of service.

No Interpretation of X-rays		
Patient	**Date**	**Finding**
#003	March 28, 2012	There was no documentation on the Tooth Chart or Hygiene Procedures form to show the panoramic X-ray was read or interpreted.
#004	March 15, 2012	There was no documentation on the Tooth Chart or Hygiene Procedures form to show the panoramic X-ray was read or interpreted.
#049	November 11, 2011	A panoramic X-ray dated November 11, 2011, showed congenital absence of teeth #21 and #29, but there was no recording of this finding or that the X-ray had been interpreted on the Tooth Chart. "Caries" was checked as the only finding under Radiographic Findings.

X-rays Not Taken When Indicated		
Patient	**Date**	**Finding**
#002	November 8, 2011	Tooth #L was treated with a pulpotomy and an SSC on April 22, 2011. The bitewing X-rays dated November 8, 2011, showed internal root resorption on the distal root of tooth #L. A periapical X-ray was indicated to determine appropriate treatment.
#003	March 28, 2012	The bitewing X-ray showed significant distal decay on tooth #I, which appeared near the pulp; however, the furcation was not visible. A periapical X-ray was indicated to determine appropriate treatment.
#031	April 3, 3012	X-rays dated April 3, 2012, did not show evidence of a premolar bud for teeth #20 and #29, and the upper left periapical X-ray showed no evidence of tooth #13. The account history did not show a panoramic X-ray was taken. A panoramic X-ray was needed to confirm the presence or absence of these permanent teeth, because planning is necessary to determine the best long term outcome for the stability of the dental arch.

Medical Necessity

Seven records (patients #013, #014, #050, #056, #063, #064, and #076) did not provide documentation or radiographic evidence to support the medical necessity for the treatment provided. Six of the seven records (patients #013, #014, 050, #056, #063, and #076) showed pulpotomies were performed without medical necessity. One

additional record (patient #064) showed no X-rays or photographs were taken to support the medical necessity for treatment provided.

The following table provides details related to each finding:

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
#013	March 19, 2012	There was no medical necessity for the pulpotomy and SSC performed on Tooth #B. The X-ray dated March 12, 2012, showed furcation radiolucency, indicating extraction was the appropriate treatment.
#014	March 5, 2012	The Account History Report showed the Lead Dentist performed a pulpotomy and SSC on tooth #B on September 28, 2010; however, the X-rays dated February 6, 2012, and March 5, 2012, did not show evidence a pulpotomy was performed on tooth #B. The X-rays taken on February 6, 2012, and March 5, 2012, showed a large furcation radiolucency that extended to the apices of the roots of tooth #B. Therefore, there was no medical necessity for the re-treatment of tooth #B with a pulpotomy and an SSC.
#050	December 6, 2011	There was lack of radiographic evidence to support the medical necessity for the pulpotomy performed on tooth #B. The X-ray dated November 15, 2011, showed decay was not halfway to the pulp.
#056	June 22, 2011	There was lack of radiographic evidence to support the medical necessity for the pulpotomies performed on teeth #A, #B, #I, and #J. The X-rays dated June 22, 2011, showed decay was not halfway to the pulp.
#063	June 20, 2011	There was lack of radiographic evidence to support the medical necessity for the pulpotomy performed on tooth #T. The X-rays dated June 20, 2011, showed decay was not halfway to the pulp.
#064	January 16, 2012	There were no X-rays or photographs taken to support the medical necessity for the fillings performed on teeth #A, #I, #S, and #T.
#076	January 6, 2012	There was lack of radiographic evidence to support the medical necessity for the pulpotomy performed on tooth #J. The X-rays dated June 6, 2011,showed decay was not halfway to the pulp.

Treatment Plan

Four records (patients #005, #008, #011, and #014) did not address radiographic pathology in the Treatment Plan and one of the four records (patient #014) did not contain consent for the pulpotomy and SSC on tooth #B.

The table below provides a summary of each finding.

Treatment Plan and Consent for Treatment		
Patient	**Date**	**Finding**
#005	March 8, 2012	The Treatment Plan did not include treatment for the radiographically demonstrable mesial decay on teeth #A and #T or the ectopic eruption of tooth #014.
#008	March 15, 2012	The Treatment Plan did not include treatment for the radiographically demonstrable furcation radiolucency on tooth #I.
#011	March 23, 2012	The Treatment Plan did not include treatment for the radiographically demonstrable distal decay on tooth #S or mesial decay on tooth #T.
#014	February 6, 2012	The Treatment Plan did not include consent for the pulpotomy and SSC performed on tooth #B. The Treatment plan also did not include treatment for the furcation radiolucency on tooth #I.

Multiple Surface Fillings

Five records (patients #004, #007, #008, #009, and #013) did not document the rationale for placement of multiple surface fillings instead of SSCs as directed by the *Intracoronal Restorations Documentation* policy.

The table below provides a summary of each finding.

No Rationale for Multiple Surface Fillings		
Patient	**Date**	**Finding**
#004	March 21, 2012	The Op Sheet did not document the rationale for the placement of a three-surface filling on tooth #S.
#007	March 28, 2012	The Op Sheet did not document the rationale for the placement of a two-surface filling on tooth #T or a three-surface filling on tooth #K.
#008	March 19, 2012	The Op Sheet did not document the rationale for re-treating teeth #A and #S with multiple surface fillings instead of SSCs. Both teeth had existing fillings.
#009	March 16, 2012	The Op Sheet did not document the rationale for restoring teeth #I and #S with multiple-surface fillings instead of SSCs.
#013	March 19, 2012	The Op Sheet did not document the rationale for restoring teeth #C, #H, and #M with multiple surface restorations instead of SSCs.

Local Anesthesia and Patient Management

The Op Sheet dated February 28, 2012, for patient #010 did not document the dose, location, or type of local anesthesia administered for the extraction of tooth #I and the pulpotomy and SSC performed on tooth #L.

Necrotic Teeth

Two records (patients #013 and #014) did not follow American Academy of Pediatric Dentistry Guidelines (*AAPD Guidelines)* with regard to treatment of necrotic teeth or teeth with radiographic pathology.

The table below provides a summary of each finding.

Necrotic Teeth Treated Outside AAPD Guidelines		
Patient	**Date**	**Finding**
#013	March 19, 2012	Review of X-rays by the Monitor's pediatric dentist determined the radiographic pathology visible on tooth #B contraindicated the pulpotomy and SSC that were performed.
#014	March 5, 2012	Review of X-rays by the Monitor's pediatric dentist determined the radiographic pathology visible on tooth #B contraindicated the pulpotomy and SSC that were performed.

Pulpotomies

Post operative X-rays were reviewed when available to evaluate the quality of pulpotomies performed. Twelve records (patients #001, #002, #008, #014, #039, #041, #051, #055, #056, #057, #063, and #076) showed incomplete removal of pulpal tissues or failing pulpotomies with no recognition or documentation of these findings. The dates of service for 11 of the 12 records were prior to the Monitor's initial visit; however, this was a result of CSHM responding to the Monitor's request to provide data analysis that allows the Monitor to identify records that allows for a retrospective analysis of the quality of care provided. This additional review gave the Monitor a better perspective of the magnitude of the issues related to the pulpotomies performed in the Clinic. The Monitor was also able to confirm all three dentists had performed pulpotomies without complete removal of pulpal tissue.

One record (patient #001) contained a post operative X-ray of a recently performed pulpotomy. These findings show CSHM has not adequately addressed the quality of care issue related to pulpotomies in this Clinic; therefore, the Monitor's recommendation was unmet.

Additionally, 14 records (patients #001, #008, #009, #031, #040, #041, #047, #048, #049, #057, #063, #064, #076, and #078) revealed other quality of care issues, including radiographic evidence of residual cement, poorly performed fillings and SSCs, undiagnosed recurrent decay or faulty restorations, lack of rationale for extractions, no use of local anesthetic for placement of fillings in teeth with deep decay, use of multiple

surface fillings without rationale about why SSCs were not used, SSCs placed on non-restorable teeth, and billing for a space maintainer that was not radiographically evident six months later.

The tables below provide a summary of each finding.

Quality of Pulpotomies Performed		
Patient	**Date of X-ray**	**Finding**
#001	April 20, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomy performed on tooth #J on April 16, 2012.
#002	November 8, 2011	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #L and #S.
#008	March 15, 2011	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #J, #K, and #L.
#014	February 6, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #I and #B.
#039	April 9, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomy performed on tooth #S.
#041	March 15, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomy performed on tooth #L.
#051	December 2, 2011	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #A, #B, and #S. This record was included in the February 2012 re-audit for the Lead Dentist. The chart audit findings did not report any findings related to the quality of the pulpotomies performed by the Lead Dentist in March 2011. The Account History Report also showed the SSC on tooth #S was re-cemented in June 2011.
#055	January 16, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #K, #L, #S, and #T.
#056	January 20, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #A, #B, #S, #I, and #J. Tooth #S abscessed and was extracted.
#057	January 25, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #I and #K. The pulpotomy on tooth #K was failing.

Quality of Pulpotomies Performed		
Patient	**Date of X-ray**	**Finding**
#063	December 29, 2011	Pulp tissue appeared to have been incompletely removed in the pulpotomy performed on tooth #K. X-rays dated June 20, 2011, show large mesial lesion in tooth #K with otherwise normal two-thirds of the roots visible. X-rays dated December 29, 2011, show total resorption of the mesial root and a small amount of distal root and bud ready to erupt. The tooth is barely attached to the bone. X-ray shows only a small portion of mesial pulp tissue removed. It appears the pulpotomy has abscessed and accelerated the eruption of the premolar compared with the contra-lateral tooth.
#076	January 6, 2012	Pulp tissue appeared to have been incompletely removed in the pulpotomies performed on teeth #L and #S. This record was included in the February 2012 re-audit. The audited date of service was February 17, 2012, which would have included the review of the X-rays dated January 6, 2012. The only findings reported in the chart audit results were related to an upper occlusal X-ray taken without medical necessity. There were no findings regarding the quality of the pulpotomies performed by the audited dentist at an earlier date of service.

Other Quality of Care Findings		
Patient	**Date of Service**	**Finding**
#001	April 16, 2011	The post operative X-ray dated April 20, 2012, showed cement was left on the mesial and distal of the SSC placed on tooth #J.
#008	March 15, 2011	The X-rays dated March 15, 2012, showed oversized SSCs on teeth #J and #K.
#009	March 13, 2012	According to the Monitor's pediatric dentist, there was a radiolucency beneath the distal occlusal restoration of tooth #C indicative of either recurrent decay or a faulty restoration.

Other Quality of Care Findings		
Patient	**Date of Service**	**Finding**
#031	April 3, 2012	Teeth #I and #L were extracted on April 25, 2012. X-rays dated April 3, 2012, showed a large distal lesion impinging on the pulp for tooth #L and no furcation pathology. The tooth chart dated April 3, 2012, records no justification for extraction instead of treatment with a pulpotomy and an SSC. Tooth #S was extracted on April 3, 2012, with no documented justification. There was no furcation pathology and bone was visible between the permanent tooth bud and the furcation, indicating this tooth could have been treated with a pulpotomy and an SSC.
#040	April 18, 2012	Poorly performed composites were found on teeth #D, #E, #F, and #G. Composites on #D mesial facial lingual (MFL), #E mesial distal lingual facial (MDLF), #F (MFL), and #G (MFL) were performed on October 19, 2011, with no local anesthesia administered by the Lead Dentist. X-rays dated October 10, 2011, show deep caries nearly to the pulp on teeth #E and #F. The Treatment Plan dated April 18, 2012, showed all fillings need to be redone with possible pulpotomies and SSCs on teeth #D, #E, and #F and a redo filling on tooth #G.
#041	March 15, 2012	The X-rays dated March 15, 2012, showed a poorly fitted SSC on tooth #L. Multiple surface fillings also were performed on teeth #F and #G on September 12, 2011, with no rational for fillings versus SSCs. The maxillary occlusal X-ray dated September 8, 2011, showed decay on tooth #F in close proximity to the pulp. The fillings on teeth #G and #K were not evident on X-rays or recorded on the Tooth Chart. Decay was charted where the filling should be on tooth #G. The missing filling on tooth #K was not addressed.
#047	April 17, 2012	Tooth #L indicated a poorly performed amalgam filling. X-rays dated April 17, 2012, show band and loop space maintainers on teeth #A and #J with teeth about to exfoliate. Space maintainers were done after October 27, 2011, when space was already lost for tooth #B.

Other Quality of Care Findings		
Patient	**Date of Service**	**Finding**
#048	December 7, 2011	The patient received multiple fillings; however, radiographic evidence of significant overhangs on teeth #19, #21, and #28 were not recorded on the Tooth Chart or addressed in the Treatment Plan. The Op Sheets related to these services showed an EFDA may have placed these fillings.
#049	December 2, 2011	Pulpotomies and SSCs were performed on teeth #B and #I. X-rays dated November 11, 2011, do not show the furcation, but massive lesions into the pulp and teeth do not appear to be restorable and are probably abscessed.
#057	January 25, 2012	Records indicated billing for a unilateral fixed space maintainer on Tooth #T occurred July 22, 2011. No space maintainer was visible on X-rays dated January 25, 2012.
#063	January 23, 2012	The X-rays dated December 29, 2011, showed the SSC on tooth #T was missing. The Op Sheet dated January 23, 2012, shows the SSC on tooth #T was redone but the redo crown was not recorded on the Account History Report.
#076	February 17, 2012	The X-rays showed residual cement at the mesial margin of the SSC on tooth #T. In addition, the pulpotomies performed on teeth #B and #I were completed without the ability to view the furcation to rule out furcation radiolucency. The lesions in both teeth were very large and the teeth may not have been vital.
#078	January 26, 2012	The Lead Dentist performed pulpotomies and SSCs on teeth #E and #F on March 24, 2011. This two-year-old patient returned for a limited oral exam on January 26, 2012, with a chief complaint of "tooth loose." The X-ray dated January 26, 2012, showed tooth #E with abscess and resorption of the root, which indicate extraction. Documentation in the record states: "Mobility #E; x-ray shows root resorption no infection; allow to exfoliate; no pain."

Recommendations

- Ensure staff members are properly reviewing the Health History form and documenting findings related to missing information or explanations to "yes" responses.

- Ensure staff members are correctly documenting decay, existing conditions, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure staff members provide X-rays of diagnostic quality and duplicate X-rays which are properly mounted and labeled.
- Ensure staff members take appropriate diagnostic X-rays and/or photographs when indicated to support the medical necessity for treatment provided.
- Ensure staff members document the interpretation of all X-rays taken.
- Ensure pulpotomies are performed only when medically necessary and teeth with radiographic pathology are treated appropriately.
- Ensure dentists are able to recognize and properly document treatment plans for all radiographic conditions and obtain proper consent for treatment.
- Ensure staff members provide documentation to support the rationale for placement of multiple surface fillings instead of SSCs.
- Ensure staff members are recording the appropriate method of delivery, location, and the dose of local anesthesia administered in the local anesthesia section of the Op Sheet.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of restorative procedures.
- Ensure services performed by an EFDA are clearly documented in the patient's record to allow for clinician identification related to quality of care issues.
- Ensure EFDAs are well-trained and the services they provide are monitored with proper oversight to ensure restorative services are completed within professionally recognized standards of care.

Treatment Observations, Findings, and Staff Interviews Related to Care

The treatment observation testing attributes were designed to determine whether care is performed in accordance with CSHM's policies and procedures, the *AAPD Guidelines*, and professionally recognized standards of care.

The on-site review included observations of treatments and interactions with patients, review of workspace, and review of dental records. Observation of treatment and patient interactions included observation of treatment on three patients who were receiving invasive dental treatment. The review of workspace included observation of activities in the dental hygiene and sterilization areas. Seven individuals were interviewed, including the Lead Dentist, two Staff Dentists, the Compliance Liaison, the Clinical Coordinator, and two dental assistants.

The CIA, Section III.A.2, specifies the CDO is "responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by CSHM and CSHM facilities meet the professionally recognized standards

of health care." Such language directs that possessing knowledge of and following these policies are not at the discretion of the Clinic dentists and staff. The Monitor interviewed the dentists about their familiarity with the recent Best Practice E-mails, and Internal Memoranda that modify, clarify, and add to *Clinical Policies and Guidelines for CSHM Associated Clinics*.

Questions asked during the interviews were targeted at the areas of concern identified in the Monitor's October 2011 report and queried for pulp therapy, local anesthetic, and use of stainless steel crowns (SSCs).

- Responses from the dentists indicated knowledge of the indications and contraindications for performing a pulpotomy and the radiographic and clinical findings associated with follow up of pulpotomies over time for success, but they demonstrated an uneven level of knowledge about the technique to perform a pulpotomy.
- All three dentists could describe the proper use of topical anesthetic and techniques to mitigate the pain associated with administering local anesthetic.
- All three dentists demonstrated knowledge of appropriate use of SSCs.

The Monitor also had the following relevant findings:

- All three dentists demonstrated proper techniques for applying topical anesthetic before administering local anesthetic.
- During patient observations of dentists for techniques to mitigate the sensations of discomfort during the administration of local anesthetic, one Staff Dentist demonstrated good technique, one Staff Dentist demonstrated some efforts to mitigate pain, and the Lead Dentist demonstrated no efforts to mitigate pain.
- A happy, communicative seven-year-old patient (patient #031) began to cry and became combative during administration of local anesthetic with no efforts by the dentist to ameliorate the painful sensation. The dentist placed a very large mouth prop into the child's mouth before administering local anesthesia, which prevented the dentist from using physical distraction to mask the sensation of the local anesthesia. He made no attempt to distract except verbal reinforcement. The patient began to cry, which escalated to screaming when he gave palatal anesthesia without any attempt to mask the very painful sensation associated with this injection. The child was fighting, crying, and became combative. The mother and grandmother restrained the child. This is an excellent example of a good patient who is old enough to communicate but become combative and noncompliant because of poor techniques to administer local anesthesia. The Op Sheet dated April 25, 2012, recorded "no active stabilization," but the written summary of the appointment records "pt on N20 for anxiety and pt. vocal but cooperative." Neither was true. The Monitor observed the combative, uncooperative child actively restrained by her mother and grandmother.
- None of the dentists calculated the maximum dose of local anesthetic for the patient's weight prior to administering the agent.

- A staff dentist reported they were told to reduce the number of pulpotomies when asked about her understanding of the findings and recommendations from the Monitor's site visit in 2011. Her responses sounded hesitant to the Monitor's clinical scenarios about the technique used to perform a pulpotomy; however, with guidance, she could describe the steps when performing a pulpotomy. "I remove the decay, and if it is not needed I don't do it," she said. The staff dentist reported Dr. [redacted] had reviewed the technique to perform pulpotomies with the three dentists. When the Monitor asked her if she knew what was wrong with the pulpotomies observed in the Monitor's record review, she could not answer. However, when shown examples of poorly performed pulpotomies on the view box, she was able to identify that all the pulp tissue had not been removed. She also recognized furcation radiolucency.
- A five-year-old patient (patient #033) received a pulpotomy and an SSC on tooth #K with no attempt made to obtain or maintain isolation from oral secretions during the pulpotomy. The Monitor's pediatric dentist observed the pulpotomy technique. The staff dentist asked several questions related to the Monitor's pediatric dentist's technique during the procedure. As a result, the chamber was adequately opened and the tissue removed to the pulp stumps.
- One staff dentist was aware of a quality of care issue with pulpotomies noted in the Monitor's report, specifically incomplete removal of tissue from the pulp chamber. She said they were told to pack zinc oxide eugenol (ZOE) farther down into the chamber. She seemed to believe the problem was not using enough ZOE to fill the chamber rather than incomplete removal of pulp tissue. She was able to describe the technique to perform a pulpotomy and knew the indications and contraindications. However, when the Monitor later showed her two records in which she had performed pulpotomies on teeth with furcal radiolucencies, she proclaimed it was acceptable. She believed as long as the teeth were not clinically symptomatic, they could be left alone. She did not document the radiolucencies or her decision to watch the teeth rather than treat them.
- All three dentists reported they had been told by "other dentists" in the company to perform pulpotomies on all primary teeth that were restored with SSCs. One of the dentists reported the "other dentists" rationalized this action as legitimate treatment because it eliminated the possibility of any sensitivity if a crown came off. The "other dentists" also said if they were close to the pulp, they should "make it a pulpotomy." Two of the dentists said they now only do pulpotomies when necessary. Two of the dentists said they were taught in dental school not to perform pulpotomies on all crowned primary teeth. When asked why they believed that was acceptable now, they explained the dentists who instructed them to do so were older and more experienced. The younger dentists believed they needed to follow the more experienced dentists' directions.
- A staff dentist expressed reluctance to report poor quality dental treatment provided by other dentists. She also expressed no ownership to record problems she identified on recall examinations if she had not done the procedure in question.

- A three-year-old patient (patient #032) was treated by a staff dentist for extraction of teeth #E and #F. The chief complaint on the health history read "two front teeth" in response to the question about perceived dental problems. The Hygiene Procedures form dated April 26, 2012, recorded internal resorption associated with teeth #E and #F. There was also a history of pain recorded on the Hygiene Procedures form under clinical findings and a later note about trauma to these same teeth. The tooth chart dated April 26, 2012, recorded trauma to teeth #E and #F and "#E and #F internal resorption due to injury and decay." The X-ray dated April 26, 2012, was negative for pathology or internal resorption; however, it did show what appeared to be an incisal fracture of tooth #F. There was no follow-up about when or how the reported trauma occurred or whether it could have been the reason for the visit on this date or the reason for the reported pain. There also was no follow-up concerning the report of pain to determine the nature of the pain, whether it was associated with the trauma mentioned, or the cause for the visit on the date of service. In the absence of expanded documentation concerning the reported trauma and pain and the presence of a normal X-ray, it is unclear to the Monitor why these teeth were extracted.
- A three-year-old patient (patient #032) was very active, yet cooperative, but did not respond to the dentist's initial attempts to communicate with him. The dentist decided to use a PSD without further behavior management or attempting nitrous oxide. The child willingly submitted to being placed in the PSD. The dentist administered nitrous oxide and the dental assistant placed a large mouth prop into the child's mouth. The dentist applied topical anesthesia appropriately but the upper lip was stretched too tightly because of the mouth prop. The dentist could not wiggle the upper lip as a distraction to mask the sensation of local anesthetic. She administered maxillary infiltration to teeth #E and #F. Her main distraction tool was to raise her voice and talking loudly to the child, who did fairly well during the injection. The dentist provided some palatal anesthesia but did not use local anesthesia when she prepared and filled tooth #B. The child did not appear to be in pain and did well during the extractions, which were uneventful. The dentist did not sign the Op Sheet for the extractions or amalgams. It is unclear from the documentation whether this was a procedure that warranted use of the PSD.

Recommendations

- Conduct a root cause analysis as to why the previous corrective action was not effective in implementing the Monitor's recommendation to ensure dentists understand techniques to mitigate pain with the administration of local anesthetic injections, especially inferior alveolar block injections and palatal anesthesia.
- Ensure dentists are calculating and recording on the Op Sheet the maximum dose of local anesthetic for the patient's weight that can be administered to the patient before administering the agent.
- Conduct a root cause analysis as to why the previous corrective action was not effective in implementing the Monitor's recommendation to ensure dentists

employ proper techniques for pulpotomies and understand indications of failed pulpotomies.

- Conduct a root cause analysis to determine why all three dentists reported having been told by other more senior dentists in the Center clinics to perform a pulpotomy for every tooth they restored with an SSC.
- Conduct a root cause analysis as to why the previous corrective action was not effective in implementing the Monitor's recommendation to ensure X-rays are medically necessary even though documentation supports they have been read and interpreted. Ensure dentists are taking panoramic X-rays when recommended by *AAPD Guidelines*, interpreting the X-rays and recording their findings.
- Ensure dentists and staff understand the importance of identifying and reporting quality of care issues in the Clinic and feel comfortable doing so.
- Ensure dentists understand the proper work-up and documentation for teeth that have experienced trauma before initiating treatment.
- Ensure dentists use behavior management techniques before attempting PSD on apparently cooperative patients. Also ensure the Op Sheet and doctor's notes accurately record the use of patient stabilization when used.
- Ensure patient records accurately document failure of treatment over time and that re-treatment and rebilling are justified.

Exit Conference

The exit conference was held on April 27, 2012, at 9:30 a.m. Present at the conference were the Monitor Team of [redacted], RDH, [redacted], RDH, and [redacted], DDS. [redacted] Chief Compliance Officer, and [redacted], Compliance Attorney, attended the conference via telephone. Clinic staff members [redacted] Office Manager and Compliance Liaison [redacted], Clinic Coordinator, and [redacted], DDS, Lead Dentist, also attended. The preliminary findings discussed at the exit conference included the following:

- We can verify that training has taken place, but our patient observations, record reviews, and interviews indicate quality of care issues remain.
- Each dentist was able to articulate techniques to mitigate pain during injections; however, observations showed inconsistent use of these techniques.
- Dentists demonstrated awareness of the Monitor's previous findings related to pulpotomies that were medically unnecessary and were able to articulate when pulpotomies are indicated. The Monitor noted fewer medically unnecessary pulpotomies were being performed.
- Interviews with all dentists indicated they are only performing pulpotomies now when they are medically necessary.
- While the record review process is incomplete, the Monitor's pediatric dentist found evidence of pulpotomies performed on teeth with radiographic furcation radiolucency and pulpotomies with incomplete removal of pulp tissue.

- The quality of X-rays has generally improved with occasional non-diagnostic X-rays.
- One of the staff dentists is expected to be credentialed within the next few months to provide full-mouth dental rehabilitation under general anesthesia at a local hospital.
- Staff members interviewed supported and welcomed the new changes in the patient stabilization policy.
- Interviews with staff members revealed an incomplete understanding of findings from the Monitor's reports, such as the Clinic Coordinator was unaware of quality of care concerns.
- Two staff members expressed quality of care concerns.

Attachment A

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
1	Ensure all staff members have signed the Code of Conduct.	CSHM believes that it has adequately and appropriately addressed this.	The training department is working with each Compliance Liaison in the CSHM network individually to ensure their Compliance Binders have all Code of Conduct and Training signatures. The employees in question did sign the Code of Conduct timely as required under the CIA (See Attachment A). Going forward, CSHM will remind Compliance Liaisons to verify with CSHM that they have all signatures on file in the Center before providing documentation to the Monitor. Additionally, as part of the exit conference for each visit, the Monitor will provide to the Compliance Liaison any missing signatures. CSHM will seek to provide any on site at CSHM prior to the Monitor's issuance of their reports.	Met
2	Ensure staff members are familiar with the content of the Infection Control Manual.	CSHM believes that it has adequately and appropriately addressed this.	The Regional Director presented the Infection Control Manual to the center staff during his visit on October 20, 2011. The Compliance Liaison will also establish a sign-off sheet to ensure each employee had an opportunity to review it and is familiar with its content.	Met
3	Ensure staff members understand the policies concerning length of time topical fluoride should be applied and how to manage parents who refuse X-rays for their children.	In Process.	The Regional Director reviewed Dr. [redacted] Best Practice Memorandum regarding fluoride application with particular emphasis on the four minute application time during his visit on October 20, 2011. He also distributed copies of the Memo to staff. Dr. [redacted] has opined that this Best Practice memo is a recommendation and should not be considered a policy statement. The Center was also encourage to use Dr. [redacted] Best Practice Memos as a "Policy of the Day" so that staff are familiar with the content of all memos. Dr. [redacted] will also review how to manage parents who refuse x-rays with center staff during his visit to the center.	Met
4	Address staff members concerns about treating intoxicated adults.	In Process.	Dr. [redacted] will survey a focus group of CSHM dentists whose Centers are treating adults to begin developing guidance on this recommendation. Based upon the extent of the issue identified from the focus group, CSHM will include this topic in either a future policy or a Best Practice memorandum.	Met
5	Ensure all staff members received the required	CSHM believes	The Monitor's report references missing training for staff	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
	training.	that it has adequately and appropriately addressed this.	relative to the May 2010 training. The report also acknowledges that staff received make-up training in May 2011. CSHM acknowledges this omission and identified the missing trainings as part of its retrospective review completed in July 2011. CSHM believes the missing trainings are a legacy issue that have now been corrected with additional controls implemented to ensure all staff members receive the required training.	
6	Ensure training is labeled consistently to allow for proper tracking.	CSHM believes that it has adequately and appropriately addressed this.	CSHM instructed all centers to use the CE tracking software system exclusively to track all training related certifications as of September 1, 2011. CSHM recognized that acceptance and use of the system was moderate during September; therefore, the training department required signature sheets from those centers struggling to accept the software. Prior to CSHM's transition to the CE tracking software, sign-in sheets have been standardized to include the name of the training course taken and the date of the training for system wide training. As center wide training is offered, the sign in sheets are distributed by CSHM to each Center and include an up-to-date employee roster. As of October 1, 2011, all new hire training is validated in the CE Tracking System which provides for consistent labeling of training. The training department continues to work with all Compliance Liaisons as described more fully in recommendation #1 to ensure that they have all required training completed, proper course titles, and signatures in place on an ongoing basis.	Met
7	Ensure billing issues are corrected within the required time frame.	In Process.	As billing issues are discovered, each item is logged by either the Clinical Audit Manager or clinical auditors. The Center is notified and required to provide email confirmation within 15 days that steps have been taken to correct the billing and/or re-bill. Once the corrected billing has been issued by the payer, the Center is required to provide a copy of the remittance and Account History reflecting the correction. The Log provides the date the Center was notified as an additional tracking mechanism to	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			ensure corrections are addressed within 15 days. CSHM is retrospectively reviewing this log to ensure all billing errors identified since March 2011 have been corrected.	
8	Ensure staff members understand the definition of an adverse event.	In Process.	CSHM began an adverse event education initiative in September 2011. The Patient Advocate began sending weekly emails to all Centers on September 9, 2011 to share with the staff during morning huddles. Each weekly email has focused on one specific adverse event and provided examples. Each of the 12 adverse events will be highlighted in a weekly email. The SVP will review the Parent Notification and Adverse Event policy with all Youngstown staff to reinforce what constitutes an adverse event during her site visit. Dr. [redacted] will review this topic during his site visit as well.	Met
9	Ensure staff members are reporting all nicks or cuts to the Compliance Liaison.	In Process.	CSHM began an adverse event education initiative in September 2011. The Patient Advocate began sending weekly emails to all Centers on September 9, 2011 to share with the staff during morning huddles. Each weekly email has focused on one specific adverse event and provided examples. Each of the 12 adverse events will be highlighted in a weekly email. "Cuts" was highlighted as the Adverse Event of the Week for Week 3 (September 22). The SVP will review this recommendation during her visit to the center. Dr [redacted] will review this topic during his site visit as well.	Partially Met
10	Ensure staff members are comfortable using the hotline.	In Process.	• CSHM's Chief Operating Officer held a conference call with all leadership teams in all CSHM Associated Dental Centers in April 2011 with the express purpose of educating leadership on the importance of CSHM's Hotline and CSHM's non-retaliation policy. • CSHM provided wallet cards to each employee in May 2011 that included the phone number for CSHM's Hotline. • CSHM included the Disclosure Program or CSHM's non-retaliation policy in monthly Compliance Liaison webinars in April, May, June, August, and October	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			2011. • CSHM requires each Compliance Liaison to share the Power Point presentation used in the monthly Compliance Liaison webinar with all of the staff each month. • CSHM also emphasized the use of the hotline and the non-retaliation policy during the summer Policy and Procedure training and the July Gifts and Referral trainings. • The Disclosure Program was also the topic emphasized by the Chief Compliance Officer in CSHM's 3rd quarter 2011 "Word of Mouth" newsletter which is provided to all employees. • CSHM will continue its efforts to promote hotline use and emphasize confidentiality along with non-retaliation and non-retribution policies. • In an additional effort to brand the hotline as "comfortable", CSHM has added a sign under the Resources page of the Compliance tab on the intranet for optional posting in the Center with a picture of a couch, the hotline number, and a reminder that: The Ethics & Compliance Hotline is a Comfy Place! Employees should feel comfortable to call anytime to share any concerns. You may remain anonymous.	
11	Determine why employees are reluctant to report quality of care concerns and evaluate whether there is a pressure to produce that is affecting quality of care.	In Process.	To ensure we respond to any concerns at a local level, CSHM will also pilot a program in the Youngstown Center to respond to the Monitor's recommendations. The program will include an onsite visit by a member of the Compliance Department as well as member of Human Resources. • The visit will include meeting with Center leadership (Lead Dentist, Office Manager, and Clinical Coordinator) to discuss communication techniques and the importance of their role in ensuring staff feel comfortable reporting concerns.	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			A "lunch and learn" format will be utilized to review the methods of reporting concerns and encouragement of staff to use the hotline for any concerns. An example hotline report (a vendor template with no CSHM specific information) will be presented to provide evidence that the hotline is managed by a third party vendor and support the ability to remain anonymous. CSHM will also interview individual staff to explore any current concerns, including: pressure to produce, suggestions for improvement, and staff comfort levels with reporting issues. Anonymous survey cards will be provided to the Center post-visit to provide additional feedback on any concerns and effectiveness of the program. • CSHM shared the Monitor's Report and discussed the critical observations and recommendations with the Lead Dentist on October 21, 2011. The Lead Dentist indicated that he stresses efficiency and meeting the needs of the patient. The Monitor's report cites an example of six crowns being performed on one day. CSHM also reviewed data for the Youngstown Center to determine if practice patterns reveal a pressure to produce. There has been one patient who received six or more crowns in the Center this year. CSHM will continue to monitor treatment outliers to detect whether there is pressure to produce that is affecting quality of care.	
12	Ensure investigations of adverse events address the quality of care provided and not just the documentation of the care provided.		As part of CSHM's retrospective review, CSHM emphasized the importance of documenting assessments of the quality of care provided in the investigative report. Additionally, CSHM is revising the Investigation Report to clearly identify the CDO's conclusion regarding the quality of care provided. Finally, the example in the Monitor's report was used as a teaching opportunity for the Patient	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			Advocate.	
13	Ensure educational materials are readily available in English and Spanish.	CSHM believes that it has adequately and appropriately addressed this.	This item was reviewed with the Marketing Department and the Office Manager. The Office Manager placed an order for the brushing and flossing brochure and a pregnancy brochure on October 19, 2011. The Patient Advocate counseled the Office Manager to ensure she is aware that are education materials are available in both English and Spanish.	Met
14	Ensure staff members understand how to access the translation service, if it is needed.	CSHM believes that it has adequately and appropriately addressed this.	The Regional Director reviewed the Translation Services Policy with all center staff and made sure staff are aware of the Propio service during his visit to the Center on October 20, 2011. He also distributed copies of the policy to staff. A review of the translation service was included in the August Compliance Liaison webinar. Compliance Liaisons were required to review the service with all staff members.	Met
15	Ensure staff members are exploring unanswered "yes/no" conditions or questions on the Health History form and providing adequate explanations for "yes" answers.	In Process.	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the Voice Over Power Points (VOPP's) specific to the Health History form by December 7, 2011. A quiz covering the Health History will be administered to the staff to ensure understanding of the materials. Dr [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director reinforced this during his visit on October 20, 2011. This topic was also discussed with the Lead Dentist during a conference all with Dr [redacted] to reivew the Monitor's report on October 21, 2011. The Health History form is also monitored through CSHM's chart audit process. The Guidelines for CSHM's revised audit process were provided to the Lead Dentist, Office Manager, and Clinical Coordinator of each team in early October 2011. The Guidelines provide detailed guidance with respect to requirements for the Health History. The Leadership Teams were encouraged	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			to share the Chart Audit Tool and Guidelines with all staff members. The Health History was also emphasized in CSHM's Chart Audit Process training held on October 25 and 26, 2011 for all staff. Additionally, CSHM's training department is working with Dr[redacted] to implement a training program on the Health History completion. This training will include each of the health issue concerns along with a basic definition and the dental contraindications that should be considered, what questions to ask and why it is so important in regards to the overall well-being of the patient during dental treatment. This total dental center team training will take place on November 22 and 23, 2011.	
16	Ensure staff members are reviewing the previous Health History form and clearly documenting any changes.	CSHM believes that it has adequately and appropriately addressed this.	The Regional Director reviewed this recommendation during his visit on October 20, 2011, reminding staff to review the previous Health History form as well as the most current one. Dr[redacted] addressed this topic with the Lead Dentist by conference call on October 21, 2011, and will review this recommendation during his follow-up visit to discuss its importance with the staff. The SVP will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates.	Met
17	Ensure staff members are trained to use the Tooth Chart and that such use is monitored. This includes properly recording decay, existing conditions, pathology, new findings, and/or additional decayed surfaces on the upper odontogram and/or in the notes section of the Tooth Chart, according to the Patient Care Manual and the Chart Documentation Guide.	In Process.	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Tooth Chart by December 7, 2011. A quiz covering the Tooth Chart will also be administered to the staff to ensure understanding of the materials. Dr. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The SVP will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Documentation on	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			the Tooth Chart is also monitored through CSHM's chart audit process. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool will be used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor the documentation of existing conditions, restorations and decay on the upper odontogram as well as the completed treatment on the lower odontogram.	
18	Ensure staff members are properly documenting completed treatment on the lower odontogram of the Tooth Chart.	In Process.	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Tooth Chart by December 7, 2011. A quiz covering the Tooth Chart will also be administered to the staff to ensure understanding of the materials. Dr. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Documentation on the Tooth Chart is also monitored through CSHM's chart audit process. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool will be used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor the documentation of completed treatment on the lower odontogram.	Partially Met
19	Ensure staff members are verifying and recording the correct date and the patient's correct age on all forms.	In Process.	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Op Sheet, Health History form and Hygiene Sheet by December 7, 2011. A quiz covering these training modules will be administered to the staff to	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			ensure understanding of the materials. Dr [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The SVP will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates.	
20	Ensure staff members are documenting the medical necessity of services rendered.	In Process.	Documenting medical necessity was a featured topic in the September 2011 Compliance Liaison webinar and a featured topic in the Compliance Liaison sub-region conference calls. The Compliance Liaisons were required to share the Power Point used during the monthly webinar with all staff. Documentation of medical necessity was also the focus of the Q3 2011 Compliance Liaison Quarterly report. The importance of documenting medical necessity on the Tooth Chart was also heavily stressed during the training for the revised Chart Audit Process held on October 25 and 26, 2011. Documentation of medical necessity was also addressed by the Chief Dental Officer with the Lead Dentist on October 21, 2011. The Lead Dentist advised he would immediately review the Monitor's findings and recommendations with the Associate Dentists and stress the importance of documenting medical necessity on the odontogram. For additional training at the local level, the center will be required to view voice over Power Points (VOPPs) specific to the Tooth Chart by December 7, 2011. A quiz covering the Tooth Chart will be administered to the staff to ensure understanding of the materials. Additionally, Dr. [redacted] will review the records identified by the Monitor as not properly documenting medical necessity with the dentists during his visit to the Center. Finally, the SVP will further reinforce this finding during her site visit and review records since October 21, 2011 to evaluate error rates and assess the need for additional training.	Met
21	Ensure staff members are complying with CSHM's Intracoronal Restorations Documentation policy.	In Process.	The Chief Dental Officer reminded the Lead Dentist on October 21, 2011 of CSHM's Intracoronal Restorations	Not Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			Policy. More specifically, Dr [redacted] reminded the Lead Dentist to document the rationale for a multiple surface restoration rather than a stainless steel crown. The Lead Dentist advised he would immediately review the Monitor's findings and recommendations with the Associate Dentists. Dr [redacted] will review these records and the Intracoronal Restorations Documentation policy with the Associate Dentists as well during his visit to the Center. The SVP will further reinforce this finding during her site visit and review records since October 21, 2011 to evaluate error rates and assess the need for additional training. CSHM will monitor compliance with the Intracoronal Restorations Policy in the Youngstown Center's next chart audit.	
22	Evaluate training needs to address quality of care concerns, including the administering local anesthesia when indicated.	In Process.	To evaluate training needs with respect to administering local anesthesia when indicated, Dr. [redacted] instructed CSHM's clinical auditors to track all operative and restorative procedures provided without local anesthesia as identified in chart audits. This has been tracked since August 11, 2011. Dr. [redacted] is evaluating the results from this exercise and will incorporate findings into the local anesthesia webinar scheduled for December 14 and 15, 2011. This recommendation was also addressed by the CDO on a conference call with the Lead Dentist on October 21, 2011. Dr. [redacted] reiterated the importance of using local anesthesia when indicated for the comfort of the child and discussed examples of when local anesthesia would be indicated. The Lead Dentist committed to share this information with all dentists at the Youngstown Center. Dr. [redacted] will review this recommendation during his follow-up visit. The SVP, who is also a dentist, will also reinforce this during her visit and will review records during her time at the Center to ensure local anesthesia is administered when indicated.	Partially Met
23	Ensure X-rays are medically necessary and documentation supports they have been read and interpreted.	CSHM believes that it has adequately and	CSHM implemented a new Tooth Chart on October 1, 2011 that prompts providers to document the rationale for taking certain radiographs as well as the interpretation of	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
		appropriately addressed this.	findings. Additionally, CSHM stressed the importance of taking medically necessary x-rays during Chart Audit Process Training on October 25 and 26, 2011. Additionally, CSHM has increased the focus of documenting both the rationale for and the interpretation of radiographs as part of the revised chart audit process.	
24	Ensure X-rays are diagnostic.	CSHM believes that it has adequately and appropriately addressed this.	Dr. [redacted] will review these recommendations during his follow-up visit and discuss the importance with the staff. The SVP will also review these recommendations during her follow-up visit, discuss the importance with the staff, and review records during her time at the Center to ensure proper documentation and evaluate error rates. The Youngstown center also received radiography training on October 19, 2011. The comprehensive X-ray training covers topics including labeling of X-rays, mounting of X-rays, types of X-rays, proper angelation, proper placement, diagnostic quality, proper film size, bite tabs, processing, duplicating, and maintenance of the processors.	Partially Met
25	Ensure staff members are documenting required information related to the administration of local anesthesia.	In Process.	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Op Sheet by December 7, 2011. A quiz covering this training module will be administered to the staff to ensure understanding of the materials. Dr. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The SVP will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates.	Partially Met
26	Ensure all billing errors are corrected and the Account History Report reflects only the procedures performed on the date of service.	CSHM believes that it has adequately and appropriately addressed this.	The billing for patient #006 was corrected on November 1, 2011. Upon review, the Op Sheet dated July 1, 2011, for patient #018 was incorrectly dated as the correct date of treatment was July 6, 2011. The patient's chart has been noted to clearly reflect the proper dates. CSHM conducted	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			the first hour of year 2 billing training as required by the CIA the week of October 10, 2011. This training reinforced the importance of submitting accurate claims.	
27	Ensure patient names are present on Consent for Protective Stabilization forms and they are completed with all required information.	In Process.	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Consent for Protective Stabilization by December 7, 2011. Dr. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The SVP will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates.	Met
28	Ensure dentists employ proper techniques for pulpotomies and understand indications of failed pulpotomies.	In Process.	The Chief Dental Officer began addressing this recommendation with the Lead Dentist on October 21, 2011. The Lead Dentist indicated a dentist who is no longer with CSHM had difficulty with pulpotomies in the past and may be a driver for the failed pulpotomies. The Chief Dental Officer reviewed the indicators for pulpotomies and highlighted to the Lead Dentist the effectiveness of indirect pulp therapy. The Lead Dentist advised he would immediately review this guidance with the Associate Dentists. Dr. [redacted] will discuss techniques for pulpotomies and indicators of failed pulpotomies using the records identified in the Monitor's visit during his site visit. Dr. [redacted] will also review charts since October 21, 2011 to evaluate the quality and frequency of pulpotomies performed in the Center.	Still Evaluating
29	Ensure dentists understand techniques to mitigate pain with the administration of local anesthetic injections, especially inferior alveolar block injections.	In Process.	This recommendation was addressed by the CDO on a conference call with the Lead Dentist on October 21, 2011. Dr. [redacted] discussed techniques to minimize pain, such as conversing more with the patients, employing distraction techniques, gently vibrating the mucosa, and injecting slowly. The Lead Dentist committed to share this guidance	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			with all dentists in the Youngstown Center. The CDO and the Regional Director will both discuss techniques with the dentists and any staff who administer injections during their site visits as well. Techniques to mitigate pain during the administration of local anesthetic injections will also be included in a webinar on local anesthesia scheduled for December 14 and 15, 2011.	
30	Ensure staff dentists are aware of the Lead Dentist's effective techniques for managing the behavior of child patients.	In Process.	The Lead Dentist performed an in-service with the Associate Dentists in the Center on October 25, 2011 to review his techniques for behavior management. The Lead Dentist stressed the importance of communication with the patient and positive feedback. He shared with CSHM that the Associate Dentists were receptive to his suggestions and recommendations.	Met
31	Ensure staff members understand the policy for when consent should be obtained when children may need to be actively restrained.	In Process.	Both Dr. [redacted] and the SVP will address the policy for when consent should be obtained for active restraint by reviewing and discussing the March 2009 Protective Stabilization and Treatment Planning White Paper, the June 2011 Clinical Issues Webinar slide on consent for active stabilization, pages 50-54 of the Chart Documentation Guide and the August 23, 2010 Best Practice Memo. Dr. [redacted] will also address very short restraint (less than 1 minute) and when it is necessary to obtain consent in a future Best Practice memo.	Met
32	Ensure staff members understand the proper method to apply topical anesthetic prior to administering local anesthetic, with attention to preparation of mucosa.	In Process.	The CDO has reviewed this issue in previous Clinical Issues webinar as well as a Best Practice Memo dated April 27, 2011. The CDO and the Regional Director will both discuss this issue with the staff during their site visits.	Met
33	Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the Patient Care Manual.	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Tooth Chart by December 7, 2011.	Not Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			A quiz covering the Tooth Chart will also be administered to the staff to ensure understanding of the materials. Dr. [redacted] will review this recommendation during a follow-up visit and discuss its importance with the staff. The SVP will also reinforce this during a visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool will be used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor the documentation of existing conditions, restorations and decay on the upper odontogram as well as the completed treatment on the lower odontogram.	
34	Ensure staff members are taking diagnostic digital photos when X-rays cannot be obtained.	In Process	The Youngstown OM will discuss CSHM's Digital Photo policy and the importance of taking diagnostic digital photos when x-rays cannot be obtained during morning huddle on November 7, 2011. Dr. [redacted] will also review the Digital Photo policy during his follow up site visit.	Not Met
35	Ensure that staff members provide diagnostic radiographs that are duplicated and labeled properly.	CSHM believes it has adequately and appropriately addressed this.	The Youngstown center received radiography training on October 19, 2011. The diagnostic X-ray training covers topics including labeling of X-rays, mounting of X-rays, types of X-rays, proper angelation, proper placement, proper film size, bite tabs, processing, duplicating, and maintenance of the processors.	Met
36	Ensure staff members are trained and monitored in the proper completion of the Operative Procedures form (Op Sheet).	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Op Sheet by December 7, 2011. A quiz covering the Op Sheet will also be administered to the staff to ensure understanding of the materials. Dr. [redacted] will review this recommendation during a follow-up visit and discuss its importance with the staff. The SVP will also reinforce this during a visit and will review records during	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			her time at the Center to ensure proper documentation and evaluate error rates. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool will be used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor each section of the Op Sheet for proper completion.	
37	Ensure billing corrections are made for patients #009 and #010.	In Process	CSHM has instructed the Center's Office Manager to provide a remittance advice and account history supporting that refunds for patients #009 and #010 have occurred and corrections are made within the patient's accounts.	Met
38	Ensure staff members provide adequate documentation and/or radiographic evidence to support the medical necessity for all treatment provided.	In Process	In recent months CSHM has repeatedly stressed the importance of documenting decay, disease or pathology identified on radiographs, through visual/tactile means or during treatment on the Tooth Chart. Documenting medical necessity was a featured topic in the September 2011 Compliance Liaison webinar and a featured topic in the Compliance Liaison sub-region conference calls. The Compliance Liaisons were required to share the PowerPoint used during the monthly webinar with all staff. Documentation of medical necessity was also the focus of the Q3 2011 Compliance Liaison Quarterly Report. The importance of documenting medical necessity on the Tooth Chart was also heavily stressed during the training for the revised Chart Audit Process held on October 25 and 26, 2011. CSHM notes that the majority of the Monitor's findings with respect to medical necessity relate to pulpotomies. The Chief Dental Officer, Chief Operating Officer and Chief Compliance Officer spoke with the center's Lead Dentist on October 21, 2011 regarding the Monitor's report, including the medical necessity for pulpotomies. The Chief Dental Officer reminded the Lead Dentist of the use of indirect pulp therapy for smaller lesions as a superior alternative to pulpotomies. The Lead Dentist was receptive to this instruction and committed to share Dr. [redacted]	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			guidance with the other dentists in the Youngstown Center. CSHM will monitor the Youngstown Center's commitment to this instruction in upcoming CRAFT meetings by reviewing changes in the pulp-to-crown ratio. CSHM will also monitor the medical necessity of pulpotomies through CSHM's revised chart audit process, which includes improved guidelines for assessing medical necessity. For further reinforcement at this center, the Youngstown center will be required to view the voice over power points (VOPPs) specific to the Tooth Chart by December 7, 2011 with quizzes being administered to help ensure understanding of the material. The Regional SVP will also reinforce this during her visit and will review records at the center to ensure proper documentation and evaluate error rates.	
39	Ensure findings are only captured in one question in the chart audit tool.	CSHM believes it has adequately and appropriately addressed this.	CSHM believes that the revised audit tool to be used for November 2011 audits and thereafter ensures that findings are only captured in one question in the chart audit tool.	Met
40	Ensure all findings captured in the audit tool are clearly communicated to the Clinic.	CSHM believes it has adequately and appropriately addressed this.	CSHM's revisions to the chart audit process also include a revision in the manner of communicating findings. Each record audited has a field for comments immediately next to the scoring prompting the auditor to clearly capture and communicate all findings. Additionally, the auditors are reminded to review the audit template and ensure that every "no" score has a comment provided before placing their signature in the audit file to evidence completion of the audit.	Met
41	Ensure billing errors are properly identified and communicated to the Clinic.	CSHM believes it has adequately and appropriately addressed this.	The following process has been implemented to ensure billing errors identified in chart audits are corrected: Items are logged by CSHM's Clinical Audit team on the Overpayment and Rebill Log. These items are subsequently communicated to the Office Managers and Lead Dentists as part of their audit results. These audit result include instruction that all issues must be corrected within 15 days. An e-mail attesting that corrections have	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			occurred must also be sent to the Audit Manager by the Office Manager within 15 days. CSHM's Audit Manager, Compliance reviews the log to monitor items nearing the 15 day time limit and prompts Office Managers who have not yet responded to make corrections as necessary. After the correction has been made and processed, the Office Manager must provide copies of the remittance advice and account history as supporting documentation to CSHM's Audit Manager, who then closes the matter. CSHM is retrospectively reviewing this log to ensure that all billing corrections identified in chart audits since the inception of the log (March 2011) have been corrected.	
42	Ensure that Quality Assurance Protocol (QAP) and Quality Score items are clarified in the Guidelines, identified by CSHM's auditor, and modifications are made to capture all unaddressed findings in the Chart Audit Tool.	CSHM believes it has adequately and appropriately addressed this.	As you are aware, CSHM has invested considerable resources into the development of a risk based Chart Audit Tool with clear and instructive guidelines. The guidelines in the revised Chart Audit Tool reference Quality Assurance Protocol. Every CSHM Clinical Auditor has been part of each Chart Audit Tool development session, which also included CSHM's Chief Compliance Officer and CSHM's Chief Dental Officer. These development sessions have been designed to thoroughly equip each Clinical Auditor to identify quality of care issues, increase their knowledge of CSHM's QAP and provide the opportunity to learn from CSHM's Chief Dental Officer. CSHM's revisions to the chart audit process also include a revision in the manner of communicating findings. Each record audited has a field for comments immediately next to the scoring prompting the auditor to clearly capture and communicate all findings. Additionally, the auditors are reminded to review the audit template and ensure that every "no" score has a comment provided before placing their signature in the file to evidence completion of the audit. CSHM believes these measures adequately prevent unaddressed findings on a go forward basis	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
43	Ensure the CSHM audit tool used to conduct the chart audit is provided in a format that allows data entry and is provided with the requested materials.	CSHM believes it has adequately and appropriately addressed this.	CSHM will provide electronic versions of a blank audit template and the audit template used by CSHM's auditors via email for each Desk Audit request made by the Monitor going forward. Copies of records and radiographs will be shipped via FedEx as CSHM has historically provided.	Met
44	Ensure the CSHM audit tool is sufficient to capture underutilization and overutilization of procedures.	CSHM believes it has adequately and appropriately addressed this.	CSHM has included the following question with respect to underutilization and overutilization of procedures in the revised audit tool[1] ***Question:*** *Is it acceptable to NOT pass on results of this chart audit to the Patient Advocate and the CDO for a broader review as it relates to systemic overtreatment/undertreatment issues?* ***"Yes" Guideline:*** *Yes- the record does NOT have possible systemic overtreatment/undertreatment and it is acceptable to NOT pass this on for further review. Examples of systemic overtreatment/undertreatment include, but are not limited to: a very high pulp-to-crown ratio, routinely performing multiple surface restorations when crowns are indicated, routinely performing crowns when fillings are indicated, or a high number of teeth treated in 1 visit.* ***"No" Guideline:*** *No- the record has possible systemic overtreatment/undertreatment and should be passed on to the Patient Advocate and CDO for a broader review. Examples include, but are not limited to: a very high pulp-to-crown ratio, routinely performing multiple surface restorations when crowns are indicated, routinely performing crowns when fillings are indicated or a high number of teeth treated in 1 visit.* ***When to Present to Chief Dental Officer:*** *All records showing potential over/undertreatment should be provided to the CDO and the Patient Advocate. The Clinical Audit*	Met

[1] CSHM's Chart Audit Tool identifies all "No" scoring as adverse findings and all "Yes" scoring as positive findings.

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			Manager must also be notified to include this as an agenda item in upcoming CRAFT meeting. The Patient Advocate will log on CDL and coordinate a broader review with the CDO and CCO.	
45	Clarify scoring instructions for question number 23 in the Guidelines to specify documentation requirements for medical necessity when decay is not visible on X-rays.	CSHM believes it has adequately and appropriately addressed this.	CSHM's revised audit tool contains the following questions regarding medical necessity when decay is not visible on X-rays: ***Question:*** *Was the need to treat justified? (Medical Necessity Question - Automatic Failure if missed.)* ***"Yes" Guideline:*** *Yes - when any services provided on the audited DOS per the Operative Sheet are supported through either 1) documentation on the upper odontogram from x-rays, digital photos, or visual/tactile means or 2) decay supporting the chosen treatment is evident on radiographs or digital photos.* ***"No" Guideline:*** *No - when any service provided on the audited DOS per the Operative Sheet are not supported through either 1) documentation on the upper odontogram from x-rays, digital photos or visual/tactile means and 2) decay supporting the chosen treatment is not evident on radiographs or digital photos. NOTE: any item deemed to be a NO by Dr. [redacted] must be placed on the overpayment log and a refund initiated.* ***"N/A" Guideline:*** *N/A -when no operative procedures were performed on the DOS being audited.* ***When to Present to Chief Dental Officer:*** *All No's should be provided to Dr. [redacted] for review and decision with respect to scoring of this question. All no's are automatic failures.* ***Question:*** *If no x-rays or digital photos are present or decay is not visible on the radiograph, was the condition fully documented through visual/tactile means? (Also a DOCUMENTATION of medical necessity question)* ***"Yes" Guideline:*** *Yes-When the Doctor being audited has provided written documentation of visual/tactile means on the odontogram page (notes section) to justify treatment on*	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met
			specific teeth OR when a red mark is documented on the upper odontogram of the Tooth Chart. Additionally any conditions found during treatment related to the audited DOS must be notated with CT on the upper odontogram. ***"No" Guideline:*** *No - treatment was planned without the presence of x-rays, digital photos or narrative of visual/tactile means of discovery.* ***"N/A" Guideline:*** *N/A - x-rays or digital photos are present in the record or all decay per the tooth chart is visible on the radiograph.* ***When to Present to Chief Dental Officer:*** *All No's should be provided to Dr. [redacted] for review and decision with respect to scoring of this question*	

590

EXHIBIT 28

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

AUG 2 3 2012

VIA OVERNIGHT MAIL

[redacted]
Chief Compliance Officer
Church Street Health Management
618 Church Street
Suite 520
Nashville, TN 37219

RE: Resolution of the Stipulated Penalties and Notice of Material Breach and Intent to Exclude Matter

Dear [redacted]

On June 22, 2012, the Office of Inspector General (OIG) of the United States Department of Health and Human Services issued to Church Street Health Management, formerly known as FORBA Holdings, LLC (hereinafter, "CSHM") a Demand for Stipulated Penalties and Notice of Material Breach and Intent to Exclude (Notice) pursuant to the OIG's rights and authorities under the January 15, 2010 Corporate Integrity Agreement (CIA) executed between CSHM and the OIG. The OIG received CSHM's payment of the Stipulated Penalty on July 3, 2012, and reviewed CSHM's July 24, 2012 response to the Notice. As a result, the OIG has determined that CSHM cured the breaches identified in the OIG's Notice, and will not proceed with an exclusion action against CSHM's Small Smiles Dental Centers of Youngstown (Youngstown Center) at this time.

In its Notice, the OIG determined that CSHM was in material breach of its CIA for its failure to comply with the obligations of Sections III.B.2.b, III.B.2.c, III.B.2.d, III.B.2.g, III.B.2.k, III.B.2.m, and III.B.2.n of the CIA. In its July 24, 2012 response to the Notice, CSHM has advised the OIG of its effort to cure these specific breach through: (1) the temporary closure of Youngstown Center for two days for the purpose of conducting leadership and staff training, including clinical training, specialized training, and the review of the Independent Monitor's Reports of the facility; (2) the performance of multiple onsite reviews by the Chief Executive Officer, Chief Dental Officer, Chief Compliance Officer, and various other senior management team members; (3) the evaluation and termination of nine staff people at Youngstown Center, including the Associate Dentist and Expanded Functions Dental Assistant noted in the Independent

Monitor's Report; and (4) the development of an ongoing oversight and monitoring plan for the Youngstown Center by the Chief Compliance Officer, Chief Dental Officer, the Regional Director, and the Senior Vice President of Operations. The OIG considers CSHM's actions to be sufficient to cure its breach of Sections III.B.2.b, III.B.2.c, III.B.2.d, III.B.2.g, III.B.2.k, III.B.2.m, and III.B.2.n of the CIA.

In its Notice, the OIG further determined that CSHM was in material breach of its CIA for its failure to comply with the obligations of Section III.E.3.b of the CIA. In its July 24, 2012 response to the Notice, CSHM acknowledged that all prior Independent Monitor reports for Youngstown Center were never shared in their entirety with the dentists and staff persons at that facility. CSHM indicated in its response that it has now shared all Independent Monitor reports with the center's staff, and implemented retraining and monitoring efforts and described above. The OIG considers CSHM's actions to be sufficient to cure its breach of Section III.E.3.b of the CIA.

Finally, in its Notice, the OIG exercised its rights under the CIA to assess Stipulated Penalties for CSHM's breach of Sections III.B.2.b, III.B.2.c, III.B.2.d, III.B.2.g, III.B.2.k, III.B.2.m, and III.B.2.n of the CIA. As indicated above, the OIG received CSHM's timely payment of the Stipulated Penalty of $100,000 on July 3, 2012. Accordingly, CSHM has satisfied its obligations under Section X.D of the CIA by paying the Stipulated Penalty and curing the breaches to the OIG's satisfaction. The OIG will not pursue an exclusion of Youngstown Center at this time, as CSHM has responded to the Notice to the OIG's satisfaction.

The OIG has relied upon the representations of CSHM in its July 24, 2012 letter in making the determination that CSHM has cured the breaches identified in the Notice. In the event that the OIG determines CSHM's representations were inaccurate, the OIG may reinstate its Notice and pursue an exclusion of Youngstown Center.

If you have any questions regarding this letter or CSHM's obligations under its CIA, please contact [redacted] at [redacted]

Sincerely,

[redacted]

Chief Counsel to the Inspector General

EXHIBIT 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

VIA OVERNIGHT MAIL

MAR 8 2012

[redacted]
Chief Compliance Officer
Church Street Health Management
618 Church Street
Suite 520
Nashville, TN 37219

RE: Notice of Material Breach and Intent to Exclude

Dear [redacted]

On January 15, 2010, Church Street Health Management, formerly known as FORBA Holdings, LLC (hereinafter, "CSHM"), entered into a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services. In addition to other obligations, the CIA requires CSHM to: (1) provide annual certifications from Certifying Employees attesting to compliance with the obligations of the CIA, Federal health care program requirements, state dental board requirements, and professionally recognized standards of care within the Certifying Employees' areas of authority; (2) develop, distribute, and implement policies and procedures; and (3) notify the OIG of Reportable Events that involve a violation of the obligation to provide items or services of a quality that meets professionally recognized standards of heath care.

This letter serves as official notification that the OIG finds CSHM to be in material breach of the CIA based on CSHM's repeated and flagrant violation of certain provisions of the CIA. This letter also serves as notice of the OIG's intent to exercise its right under the CIA to exclude CSHM from participation in the Federal health care programs. We set forth below the specific provisions and grounds for the OIG's Notice of Material Breach and Intent to Exclude, as well as the steps that must be taken by CSHM to respond and cure the breach to the OIG's satisfaction.

As you are aware, on May 13, 2011, the OIG assessed a $230,000 Stipulated Penalty for CSHM's failure to comply with CIA provisions. Several bases for this Stipulated Penalty assessment were CSHM's submission of two false certifications in its first Annual Report from the Chief Compliance Officer and Chief Dental Officer, CSHM's failure to comply

with the Policies and Procedures requirements of the CIA, and CSHM's failure to comply with its reporting obligations under the CIA. We have taken CSHM's past history of noncompliance into consideration as we address CSHM's present noncompliance with CIA requirements.

Management Certifications and Accountability

Section III.A.7 requires CSHM's "Certifying Employees" to "monitor and oversee activities within their areas of authority and . . . annually certify in writing or electronically, that the applicable area of authority is compliant with the obligations of [the CIA], Federal health care program requirements, state dental board requirements, and professionally recognized standards of care." The term "Certifying Employees" includes the Lead Dentists of CSHM facilities.

Each Certifying Employee's annual certification must state that the Certifying Employee has been "trained on and understand[s] the compliance requirements and responsibilities as they relate to ... [the] area under [his/her] supervision." The certification requires the Certifying Employee to attest that his/her job responsibilities include ensuring compliance with regard to the area under his/her supervision, and that CSHM or the specific CSHM-facility at which the Certifying Employee works is in "compliance with all applicable Federal health care program requirements, state dental board requirements, and the obligations of the CIA."

On March 15, 2011, CSHM submitted with its first Annual Report to the OIG a Certifying Employee Certification for [redacted], D.D.S (Dr. [redacted]), the Lead Dentist (and a Certifying Employee) at the Small Smiles Dental Center of Manassas (Manassas Center). The certification, signed and dated on March 3, 2011, read as follows:

> I, [redacted] hereby certify that I have been trained on and understand the compliance requirements and responsibilities as they relate to Small Smiles of Manassas, LLC ("the Center"). My job responsibilities include ensuring compliance with regard to the Center. To the best of my knowledge, except as otherwise described herein, the Center, a Church Street Health Management associated facility, is in compliance with all applicable Federal health care program requirements, state dental board requirements, and the obligations of the Corporate Integrity Agreement. This certification does not include matters of compliance relating to front office responsibilities such as billing by the Center, as that is primarily the responsibility of the Office Manager and is outside my area of training and expertise.

On November 16, 2011, the OIG conducted a site visit to Manassas Center to determine the extent to which that facility was in compliance with the obligations of the CIA. During that site visit, the OIG interviewed Dr. [redacted] to discuss her oversight role and responsibility for compliance at Manassas Center. Dr. [redacted] was unable to address any compliance-related obligations that she oversaw at Manassas Center. Dr. [redacted] could not recall signing an annual certification or any specific steps that she took to evaluate compliance at Manassas Center for purposes of signing that certification. Accordingly, the OIG finds CSHM's Certifying Employee certification by Dr. [redacted] to be a false certification.

Section X.E.1.c of the CIA defines a material breach of the CIA as a repeated or flagrant violation of any obligation under the CIA. In addition, Section X.E.1.g of the CIA defines a material breach of the CIA as a submission of a false certification submitted by or on behalf of CSHM as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by OIG), or otherwise required by the CIA. Based upon CSHM's submission of a false certification under Section III.A.7 of the CIA, and CSHM's previous submissions of false certifications, the OIG finds CSHM to be in material breach of the CIA for this conduct.

Policies and Procedures Requirements

Section III.B.2 of the CIA requires that within 90 days after the Effective Date of the CIA, CSHM "shall implement written Policies and Procedures regarding the operation of [CSHM's] compliance program and its compliance with Federal health care program requirements." Section III.B.2 further requires that within 90 days after the Effective Date, CSHM shall distribute "the relevant portions of the Policies and Procedures ... to all individuals whose job functions relate to those Policies and Procedures."

CSHM's Review of the Monitor's Findings at Manassas Center

Section III.B.2.d of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, measures designed to promote the delivery of patient items or services at CSHM and CSHM facilities that meet professionally recognized standards of health care, including but not limited to the following areas: (1) patient safety, (2) appropriate patient assessment and treatment planning; (3) appropriate documentation of dental records consistent with professionally recognized standards of health care; (4) appropriate anesthesia guidelines for pediatric dental patients; (5) advanced behavior guidance techniques for the pediatric dental patient, including protective stabilization, sedation, general anesthesia, and contraindications for each technique; and (6) appropriate amount of treatment in an individual visit.

Section III.B.2.g of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, the following:

> Measures designed to ensure that compliance issues are identified internally (e.g., through reports to supervisors, complaints received through the Disclosure Program, internal audits, patient satisfaction surveys, quality indicators, facility-specific key indicators, clinical quality audits, or exit interviews) and that issues, whether identified internally or externally (e.g., through federal or state agency reports, consultants, or the Monitor's Reports) are promptly and appropriately investigated and, that if the investigation substantiates compliance issues, [CSHM] implements effective and timely corrective action plans and monitors compliance with such plans.

Section III.B.2.n of the CIA requires CSHM's CIA-related Policies and Procedures to address, among other issues, measures designed to ensure that CSHM and CSHM facilities comply with Federal health care program requirements on billing and reimbursement, including but not limited to, proper and accurate preparation and submission of claims to Federal health care programs, and proper and accurate documentation of dental records.

Section III.B.2.u of the CIA requires CSHM's CIA-related Policies and Procedures to address the requirement that CSHM terminate its relationship with any Covered Person that is found to have violated professionally recognized standards of health care.

On September 22, 2011, the Independent Monitor (Monitor) retained by CSHM as required by the CIA issued to CSHM its Desk Audit Report for Manassas Center. In the Desk Audit Report, the Monitor identified significant findings with respect to the quality of care that was rendered at Manassas Center. Specifically, the Monitor identified issues relating to billing for services not rendered, use of stabilization devices in a manner that deviated from CSHM and American Academy of Pediatric Dentistry (AAPD) guidelines, inadequate provision of anesthesia to provide proper pain control for the extent of treatment performed on patients, treatment on four quadrants during single visits, and provision of medically unnecessary services, in addition to other findings. In summary, the Monitor found that CSHM systems designed to detect quality of care issues were not effective at Manassas Center.

In its October 31, 2011 response to the Desk Audit Report, CSHM acknowledged the Monitor's "alarming findings" as detailed in the Desk Audit Report, and described its resulting internal investigation that was conducted by the Chief Compliance Officer, Chief Dental Officer and Chief Operating Officer. In the October 31, 2011 written

response, CSHM conceded its provision of and billing for medically unnecessary pulpotomies at Manassas Center, characterized this issue as a "significant quality of care matter," and acknowledged that its systems were "ineffective in identifying this issue" at Manassas Center. In a subsequent call with the OIG and the Monitor on November 3, 2011, CSHM conceded all other findings as identified in the Desk Audit Report.

Given the severity of issues identified in the Desk Audit Report, the OIG and the Monitor conducted an unannounced site visit to Manassas Center on November 16, 2011 to evaluate the extent to which CSHM: (1) implemented effective and timely corrective action plans to the Monitor's Desk Audit Report findings; and (2) monitored compliance with such plans. On December 23, 2011, the Monitor issued to CSHM its Site Visit Report for Manassas Center. In that Report, the Monitor identified more instances of treatment on four quadrants in a single visit, provision of medically unnecessary services, provision of medically unnecessary pulpotomies, administration of inadequate amounts of anesthesia, and improper restraining of patients, among other findings. In summary, the Monitor found that CSHM's corrective actions to address the Monitor's Desk Audit Report findings were ineffective.

In its January 13, 2012 response to the Site Visit Report, CSHM acknowledged that it "failed to take adequate steps to address and correct the quality of care issues that [the Monitor] identified in [the] September 22, 2011 report regarding [Manassas Center]." The January 13, 2012 response also acknowledged the "ineffectiveness of corrective actions taken to date" at Manassas Center. Finally, CSHM's January 13, 2012 response acknowledged CSHM's decision to "rehabilitate" the Lead Dentist at Manassas Center as opposed to terminating her and the Manassas Center.

By its own admission and as validated by the Monitor's December 23, 2011 Site Visit Report, CSHM has failed to comply with its obligations under Sections III.B.2.d, III.B.2.g, and III.B.2.n of the CIA to develop and implement policies and procedures to: (1) promptly and appropriately investigate serious compliance issues at Manassas Center; (2) implement effective and timely corrective actions plans; (3) monitor compliance with those plans; and (4) prevent further instances of provision and billing of medically unnecessary services, and provision of care that fell below professionally recognized standards. In addition, CSHM failed to comply with its obligations under Section III.B.2.u of the CIA to terminate its relationship with the dentists at Manassas Center as a result of the findings of the Monitor that the dentists violated professionally-recognized standards of health care.

Section X.E.1.c of the CIA defines a material breach of the CIA as a repeated or flagrant violation of any obligation under the CIA. Based upon CSHM's failure to comply with Sections III.B.2.d, III.B.2.g, III.B.2.n, and III.B.2.u of the CIA, and given the severity of

quality of care concerns identified by the Monitor at Manassas Center, the OIG finds CSHM's conduct to be a flagrant violation of the CIA.

CSHM's Change to Termination Policy and Procedure

As discussed above, Section III.B.2.u of the CIA requires CSHM's CIA related Policies and Procedures to address the requirement that CSHM terminate its relationship with any Covered Person that is found to have violated professionally-recognized standards of health care.

In January 2012, CSHM revised its policy "Adverse Events, Quality of Care Reportable Events, and OMIG Patient Care Matters," which provides as follows:

> Practitioners who have violated professionally recognized standards of healthcare, including the AAPD Guidelines, the CSHM Clinical Policies and Guidelines for CSHM Associated Dental Centers, and any applicable state or local standards or guidelines, and whose violation has been deemed by the Chief Dental Officer to be a Quality of Care reportable event *will be terminated or will undergo a remediation plan developed by the Chief Dental Officer with approval of the OIG.* (Emphasis added.)

This policy directly contradicts the requirements of Section III.B.2.u of the CIA which mandates CSHM to develop and implement a policy regarding termination of Covered Persons who are found to have violated professionally recognized standards of care. The CIA makes no provision for allowing CSHM's Chief Dental Officer to obviate the termination requirement with his/her own remediation plan.

Section X.E.1.c of the CIA defines a material breach of the CIA as a repeated or flagrant violation of any obligation under the CIA. Based upon CSHM's failure to comply with Section III.B.2.u of the CIA, and given the severity of quality of care concerns identified by the Monitor at Manassas Center, the OIG finds CSHM's conduct to be a flagrant violation of the CIA.

CSHM's Review of Pulp-to-Crown Ratios and Provision of Medically Unnecessary Services at Other CSHM Facilities

The Monitor's Desk Audit Report indicated that of 244 pulpotomies reviewed by the Monitor, 104 were medically unnecessary. Consequently, the Monitor's findings suggest that CSHM improperly billed the associated claims. In its October 31, 2011 response, CSHM stated that it "agrees that pulpotomies were performed that were not medically necessary…[and that] CSHM's systems were ineffective in identifying this issue."

Further, CSHM's response stated that CSHM acknowledged the "pulp-to-crown ratio" of the Lead Dentist at Manassas Center and its causal connection to the "medical necessity error rates" as reported by the Monitor, and used the error rates to identify CSHM's overpayment liability for the claims it submitted in error. As a result of the Monitor's Desk Audit Report, CSHM was required under the terms of the CIA to report to the OIG and refund to the Federal health care programs a significant overpayment resulting from its claims for medically unnecessary services.

In its October 31, 2011 response, CSHM further describes its review of "pulp-to-crown" ratios across CSHM facilities in response to the Monitor's Desk Audit Report. The response indicates that CSHM identified 13 dentists with high "pulp-to-crown" ratios similar to those at Manassas Clinic. In its description of its approach to address the Monitor's findings regarding provision of medically unnecessary services, CSHM provided the following information:

> Over the next month, [Dr. [redacted] the Chief Dental Officer] will discuss his philosophy with each of the remaining 13 dentists identified and determine the need to conduct a webinar presenting his training module on pulpotomies and indirect pulp therapy. The CRAFT Committee will monitor the pulp-to-crown ratio for each of these 13 individuals after Dr. [redacted] discussion and develop additional next steps as appropriate. In addition to the review of specific providers, Dr. [redacted] will include indirect pulp therapy as an alternative to pulpotomies in an upcoming Best Practice Memo to reinforce this philosophy among all providers.

CSHM later clarified that it had identified 12 dentists, not 13 dentists, with high "pulp-to-crown" ratios. Although CSHM acknowledged that it had potential quality of care-related concerns with respect to the 12 dentists with profiles similar to the Lead Dentist at Manassas Center, CSHM failed to indicate in its October 31, 2011 response whether it had performed or planned to perform a financial review of claims it submitted on behalf of the 12 identified dentists to determine whether CSHM had any overpayment or other liability for claims that were associated with high "pulp-to-crown" utilization. As such, the OIG has no indication as to whether CSHM has completed, or is in the process of completing, an investigation or financial analysis of the propriety of its claims to the Federal health care programs for the 12 dentists who have performed and billed services in a similar manner as Manassas Center.

As stated above, the OIG finds that CSHM has failed to comply with the requirements of Section III.B.2.g, in that CSHM has failed to develop and implement a policy to promptly and appropriately investigate compliance issues. In this circumstance, CSHM failed to promptly and appropriately investigate overpayment issues relating to medically

unnecessary services with respect to the 12 dentists it has identified and acknowledged as potentially at risk for this type of conduct.

Section X.E.1.c of the CIA defines a material breach of the CIA as a repeated or flagrant violation of any obligation under the CIA. Based upon CSHM's failure to comply with Section III.B.2.g of the CIA, the OIG finds CSHM's conduct to be a flagrant violation of the CIA.

Quality of Care Reportable Event Requirements

Section III.I.2.c of the CIA defines a Quality of Care Reportable Event as "anything that involves a violation of the obligation to provide items or services of a quality that meets professionally recognized standards of health care." Section III.I.2.d of the CIA further requires that:

> If [CSHM] receives a report that involves a potential violation of the obligation to provide items or services of a quality that meets professionally recognized standards of health care, [CSHM] shall initiate an investigation of the report within 5 days after receiving the report. Within 30 days after receiving the report, and, on finding a violation, [CSHM] shall provide written notice of [CSHM's] investigation and the actions taken to correct the violation to OIG, the Monitor, and the applicable state licensing board.

As detailed above, CSHM was provided with the Monitor's Desk Audit Report and Site Visit Report, which involved findings of Manassas Center's failure to provide items or services in accordance with professionally recognized standards of health care. To date, the OIG has no indication that CSHM provided a written notice of CSHM's investigation and actions taken to correct violations to the state licensing board in the state of Virginia.

Section X.E.1.b of the CIA defines the term material breach as CSHM's failure to report a Quality of Care Reportable Event, take corrective action to OIG's satisfaction, and make the appropriate notifications, as required in Sections III.I.2.c and III.I.2.d. Based upon the OIG's determination that CSHM has failed to comply with the obligations of Sections III.I.2.c and III.I.2.d of the CIA, the OIG finds CSHM to be in material breach of its CIA.

Notice of Material Breach and Intent to Exclude

The terms of Section X.E.2 of the CIA provide that a material breach of the CIA by CSHM constitutes an independent basis for CSHM's exclusion from participation in the Federal health care programs. Upon a determination by the OIG that CSHM has

materially breached the CIA and that exclusion is the appropriate remedy, the OIG shall notify CSHM of the material breach and the OIG's intent to impose exclusion.

By this letter, the OIG finds CSHM to be in material breach of the CIA as a result of CSHM's failure to comply with multiple provisions of the CSHM CIA as detailed in this letter. As such, the OIG intends to exercise its right to impose exclusion against CSHM from further participation in the Federal health care programs.

Opportunity to Cure

Pursuant to Section X.E.3, CSHM has 30 days from the date of receipt of this Notice of Material Breach and Intent to Exclude to demonstrate to the OIG's satisfaction that:

> (a) CSHM is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach; (b) the alleged material breach has been cured; or (c) the alleged material breach cannot be cured within the 30-day period, but that:
>
> i. CSHM has begun to take action to cure the material breach;
>
> ii. CSHM is pursuing such action with due diligence; and
>
> iii. CSHM has provided to OIG a reasonable timetable for curing the material breach.

Pursuant to Section X.E.4 of the CIA, if CSHM fails to satisfy the requirements of Section X.E.3 of the CIA at the conclusion of the 30-day period, the OIG may exclude CSHM from participation in the Federal health care programs.

The OIG is aware that CSHM is currently a chapter 11 debtor and debtor-in-possession under Title 11 of the United States Code having filed bankruptcy on or about February 20, 2012 in the United States Bankruptcy Court for the Middle District of Tennessee. The OIG understands that such a filing gave rise to the automatic stay under 11 U.S.C. 362; however, OIG believes that this notification is not subject to the automatic stay as it falls within the exceptions thereto set forth in 11 U.S.C. 362(b)(4) and (b)(28).

If you have any questions regarding this letter or CSHM's obligations under its CIA, please contact [redacted] at [redacted]

Sincerely,

[redacted]

Assistant Inspector General for Legal Affairs

EXHIBIT 30

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

March 13, 2012

VIA ELECTRONIC MAIL

[redacted], Esq.
General Counsel and Chief Administrative Officer
Church Street Health Management
618 Church Street
Suite 520
Nashville, TN 37219

[redacted]
Chief Compliance Officer
Church Street Health Management
618 Church Street
Suite 520
Nashville, TN 37219

RE: Notice of Material Breach and Intent to Exclude

Dear [redacted] and [redacted]:

The purpose of this letter is to formalize the terms of an agreement between Church Street Health Management, formerly known as FORBA Holdings, LLC (hereinafter, "CSHM") and the Office of Inspector General (OIG) of the United States Department of Health and Human Services. This letter agreement specifies the general terms discussed by the OIG during our meeting on March 13, 2012.

As you are aware, the purpose of this meeting was to discuss CSHM's March 12, 2012 response to the OIG's Notice of Material Breach and Intent to Exclude (Notice) which was issued to CSHM on March 8, 2012 pursuant to the OIG's rights and authorities under the Corporate Integrity Agreement (CIA) executed between CSHM and the OIG. As we discussed during our meeting this morning, the OIG has determined that: (1) CSHM has cured certain breaches identified in the OIG's Notice; (2) the OIG is satisfied with CSHM's response to certain breaches that may not necessarily be cured at this time; and (3) CSHM has failed to satisfy the OIG that certain breaches identified in the OIG's Notice can or will be cured by CSHM within the requisite timeframe under the CIA. The OIG agrees not to proceed with an exclusion action for the specific breaches of the CIA identified in our Notice in exchange for CSHM's agreement to: (1) a voluntary exclusion of Small Smiles Dental Center of Manassas (Manassas Center) if CSHM fails to divest, transfer, and/or sell Manassas Center within 90 days; and (2) assume additional integrity-related obligations incorporated as an amendment to the CIA by this letter.

OIG's Determination that Certain Breaches are Cured

In our Notice, the OIG determined that CSHM was in material breach of its CIA for its failure to comply with the obligations of Sections III.I.2.c and III.I.2.d of the CIA. In its response to the Notice, CSHM has advised the OIG of its effort to cure this specific breach through its provision of written notice to the Virginia state licensing board of CSHM's investigation of issues at the Manassas Center. The OIG considers CSHM's response to have cured its breach of Sections III.I.2.c and III.I.2.d of the CIA.

In our Notice, the OIG determined that CSHM was in material breach of its CIA for CSHM's failure to comply with Section III.B.2.u of the CIA. In its response to the Notice, CSHM has advised the OIG of its effort to cure this specific breach through: (1) the revision of CSHM's policy entitled "Adverse Events, Quality of Care Reportable Events, and OMIG Patient Care Matters," and (2) CSHM's termination of the Covered Person identified in CSHM's September 26, 2011 Quality of Care Reportable Event Notice to the OIG. The OIG considers CSHM's actions described in its response to have cured its breach of Section III.B.2.u of the CIA.

OIG's Determination that CSHM's Response is Satisfactory with Respect to Breaches that Could not be Cured

In our Notice, the OIG determined that CSHM was in material breach of its CIA for CSHM's submission of a false certification under Section III.A.7 of the CIA. In its response to the Notice, CSHM indicated that it could not cure the breach of having submitted a false certification, but that the Certifying Employee who signed the false certification is no longer employed by CSHM. CSHM also indicated in its response to the Notice that it has "implemented significant training and revamped our process for

certifications" under the CIA and described many such actions. The OIG considers CSHM's actions described in its response to be satisfactory with respect to the breach as cited under Section III.A.7 of the CIA.

OIG's Determination that Certain Breaches have not been Cured or Cannot be Cured within the Requisite Timeframe

In our Notice, the OIG determined that CSHM was in material breach of its CIA for CSHM's failure to comply with Sections III.B.2.d, III.B.2.g, and III.B.2.n of the CIA. The OIG has reviewed CSHM's March 12, 2012 response and determined that CSHM has failed to demonstrate to the OIG's satisfaction that the breaches under Sections III.B.2.d, III.B.2.g, and III.B.2.n of the CIA have been or will be cured within the requisite timeframe required by Section X.E.3 of CIA.

As we indicated in our meeting this morning, the OIG agrees not to pursue an exclusion action for CSHM's breach of Sections III.B.2.d, III.B.2.g, and III.B.2.n of the CIA, as specifically addressed in our Notice, in exchange for CSHM's agreement to: (1) a voluntary exclusion of Manassas Center within 90 days of the date of this letter; and (2) comply with additional integrity-related obligations that will be incorporated as an amendment to the CIA by this letter.

We understand that CSHM is in the process of closing or transferring the Manassas Center to an unrelated third party. In the event CSHM transfers the Manassas Center to an unrelated third party within 90 days of the date of this letter and CSHM has no affiliation or relationship with the new owner, the OIG would not pursue an exclusion of Manassas Center. In the event CSHM does not close or transfer the Manassas Center as described above, CSHM agrees that the Manassas Center shall be excluded from participation in the Federal health care programs.

The additional integrity-related obligations that the OIG will require are detailed as follows:

1. Compliance Program Onsite Reviews of CSHM Facilities. Within 30 days, CSHM shall develop and implement a process by which the Chief Dental Officer, the Compliance Officer, and Regional Dentists shall conduct at least one onsite review ("Onsite Review") each month to a CSHM facility for the purpose of evaluating and ensuring compliance with all applicable Federal health care program requirements, state dental board requirements, and the obligations of the CIA. The OIG will require CSHM to recruit Regional Dentists who will assist with the Onsite Reviews as well as assisting the Chief Dental Officer with the review of patient care mattes at CSHM and CSHM facilities, including but not limited to quality protocols, quality assessments, patient safety issues, utilization

review, performance improvement, and dental staff training. Regional Dentists will be required to maintain board-certification in pediatric dentistry and have experience treating pediatric Federal health care program beneficiaries. Within 30 days, CSHM shall prepare and submit to the OIG a plan to recruit Regional Dentists. The selection of CSHM facilities that will be subject to the Onsite Review should be based upon CSHM's evaluation of chart audit results, quality assurance indicators, CRAFT reports and complaints. Each Onsite Review shall include, at a minimum, the direct observation of patient care by the Chief Dental Officer and Regional Dentists, and an in-person review of CIA obligations by the Compliance Officer with the Lead Dentist and Compliance Liaison. Within 30 days after conducting an Onsite Review, the Chief Dental Officer and Compliance Officer shall prepare a written report of the onsite review ("Onsite Review Report") which shall provide details of the Onsite Review, and any findings, observations, and/or corrective action developed as a result of the Onsite Review. CSHM shall provide copies of all Onsite Review Reports to the OIG and the Independent Monitor.

2. Quality Improvement Initiatives. Within 30 days, CSHM shall develop and implement a process by which CSHM identifies specific risk areas and relevant quality benchmarks, taking into account the recommendations of the Independent Monitor, for the purpose of measuring and achieving quality improvement goals on an ongoing basis ("Quality Improvement Initiative"). The Quality Improvement Initiative shall be in addition to the current quality metrics maintained by CSHM. CSHM shall provide, on an ongoing basis, the identified risk areas and relevant quality benchmarks under the Quality Improvement Initiative to the OIG and the Independent Monitor.

3. Referral Process. Within 30 days, CSHM shall develop and implement guidance for each CSHM facility regarding patient referrals from CSHM facilities to other facilities better equipped to treat a patient in specific circumstances involving concerns for patient safety, including but not limited to anesthesia requirements, and behavior guidance techniques. Within 30 days, CSHM shall provide the OIG and the Independent Monitor with a listing of facilities to which referrals may be made for each CSHM facility. If no such referral-receiving facilities exist for any CSHM facility within the 30-day timeframe, CSHM shall provide the OIG and the Independent Monitor with an acceptable plan to identify or develop such facilities for those CSHM facilities.

4. Certifying Employee Certifications. Within 30 days, CSHM shall develop a specific process by which Certifying Employees shall perform a comprehensive assessment of the area under the Certifying Employee's supervision for purposes

of completing the Certifying Employee Certification process under Section III.A.7 of the CIA. The purpose of this requirement is to engage Certifying Employees in the process of evaluating and ensuring compliance with all applicable Federal health care program requirements, state dental board requirements, and the obligations of the CIA.

5. Pulp-to-Crown Medical Necessity Review. Within 120 days, CSHM will perform a review of claims documentation associated with CSHM dentists with high "pulp-to-crown" ratios to determine whether such documentation supports the medical necessity of the services ("Pulp-to-Crown Medical Necessity Review"). CSHM will adopt the appropriate ratio as determined by the Independent Monitor in order to identify all dentists who may be at risk for high "pulp-to-crown" utilization ("Reviewed Dentists"). CSHM will then perform the Pulp-to-Crown Medical Necessity Review for all claims submitted by or on behalf of the Reviewed Dentists from the Effective Date of the CIA to present. Within 150 days, CSHM shall prepare a Pulp-to-Crown Medical Necessity Review Report and provide copies to the OIG and the Independent Monitor. The Independent Monitor will perform a validation review of CSHM's Pulp-to-Crown Medical Necessity Review. CSHM shall report to the OIG all overpayments determined by the Pulp-to-Crown Medical Necessity Review; further, CSHM agrees to refund within 30 days all overpayments determined by the Pulp-to-Crown Medical Necessity Review to the appropriate payors. CSHM will also be required to comply with all relevant provisions of the CIA as a result of findings under the Pulp-to-Crown Medical Necessity Review.

As we discussed, the OIG will instruct the Independent Monitor to carefully evaluate the extent to which CSHM has complied with its obligations under the CIA and, in particular, the additional CIA obligations that we outline in this letter.

The parties agree that this letter shall serve as an amendment to the CIA and that CSHM's failure to implement the additional integrity obligations set forth in this letter shall be a Material Breach under Section X.E.1 and shall be subject to Stipulated Penalties under Section X.B.1 of the CIA. The parties agree that the OIG has relied upon the representations of CSHM in its March 12, 2012 letter. In the event that the OIG determines CSHM's representations were not accurate, the OIG may reinstate its Notice and pursue an exclusion of CSHM.

If CSHM agrees to the terms of this letter, please provide the countersignatures below and return this letter no later than Wednesday, March 14, 2012. If you have any questions regarding this letter or CSHM's obligations under its CIA, please contact [redacted] at [redacted].

Sincerely,

[redacted]

Assistant Inspector General for Legal Affairs

[redacted], Esq.
General Counsel, Chief Administrative Officer
Church Street Health Management

3/14/12
Date

[redacted]

[redacted]
Senior Vice President, Chief Compliance Officer
Church Street Health Management

3/14/12.
Date

EXHIBIT 31

WILMERHALE

Reginald J. Brown

+1 202 663 6430(t)
+1 202 663 6363(f)
reginald.brown@wilmerhale.com

February 23, 2012

BY HAND DELIVERY

The Honorable Max Baucus
Chairman, Committee on Finance
United States Senate
511 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Charles E. Grassley
Committee on Finance
United States Senate
135 Hart Senate Office Building
Washington, D.C. 20510

Re: Response to January 12, 2012 Letter To ReachOut Healthcare America from Senators Baucus and Grassley

Dear Senators Baucus and Grassley:

We are writing on behalf of ReachOut Healthcare America Ltd. ("RHA") in response to your January 12, 2012 letter. Thank you for the opportunity to address the issues you have raised and for the extra time we have received to provide an initial response.

ReachOut Healthcare America is an administrative services organization for pediatric mobile dentistry. Founded in 1997 and headquartered in Phoenix, Arizona, RHA provides administrative and business services to dental practices that are owned and controlled by licensed dentists. The practices RHA works with serve a diverse patient base, including children in our nation's Head Start programs, foster programs, and public schools. RHA's services are also available to our nation's National Guard and Reserve Forces.

RHA's initial response to your information request follows, and is based on readily accessible information in RHA's possession about RHA and the dental practices with whom RHA contracts. We will supplement and amend the response as appropriate.

Dentistry Ownership and Certifications

1) A detailed description of ownership of all ReachOut Healthcare America facilities and mobile units from January 1, 2010 to present.

RHA provides administrative and business services to dental practices and is not itself a provider of clinical dental services. RHA currently provides services to 23 dental practices that operate in 22 states (the "Dental Practices"). RHA does not own the Dental Practices, which are organized as professional corporations under state law and owned by licensed dentists, who do not have any ownership interest in RHA. Attached as Exhibit 1 is a list of the Dental Practices and the dentists who own them.

RHA provides services for the administration of the nonclinical aspects of the Dental Practices. These services include providing the necessary equipment and supplies and maintaining inventory for the provision of dental services; information systems; scheduling; customer service; financial planning; and reporting and analysis. The personnel who provide all clinical dental services and patient management are employed by the Dental Practices, not RHA. (See, e.g., Administrative Service Agreement with "Menu of Services" [Bates Nos. RHA_0000015 - 0000019]). RHA does not provide any services to the Dental Practices related to clinical matters or the practice of dentistry.

The Dental Practices provide mobile dentistry for various school districts in the states in which they operate, primarily to children covered by Medicaid. RHA owns 19 dental mobile vehicles, which RHA leases to certain Dental Practices for use by them as mobile dental units. RHA does not own or operate any fixed-site dental facilities.

In addition to providing business and administrative services to the Dental Practices, RHA also coordinates dental staffing for mobile dental programs that serve the National Guard. The clinical dental services for these programs are provided by dentists, who are independent contractors.

2) Dentistry certifications and names for any person with a partial or full ownership interest in each ReachOut Healthcare America facilities and mobile units.

As explained in response to Request 1 above, there are no RHA dental facilities or mobile units[1]; RHA provides administrative and business services to the Dental Practices. The names of the dentist-owners of the Dental Practices with whom RHA contracts are listed in Exhibit 1. In response to this request, RHA is producing the dentistry certifications held by the dentist-owners

[1] As explained above, RHA leases vehicles to certain Dental Practices for use by the Dental Practices as mobile dental units.

of the Dental Practices that are readily accessible in RHA's files [Bates Nos. RHA_0000497 - 0000548].

a. For each person with a partial or full ownership interest, the total number of procedures they have performed since January 2010, including subtotals of each type of procedure.

There are no persons with an ownership interest in RHA who currently provide clinical dental services. RHA is working to gather responsive data regarding the dentist-owners of the Dental Practices and will provide it as soon as possible.

b. For each person with a partial or full ownership interest, please provide their employment contract with ReachOut Healthcare America facilities and mobile units.

RHA does not employ, or have employment contracts with, the dentist-owners of the Dental Practices to run their practices. RHA is reviewing its files to determine whether it possesses other documents responsive to this request and will provide such documents, if any, as soon as possible.

c. All purchase agreements, professional services agreements, and attachments by and between ReachOut Healthcare America facilities, mobile units, and affiliates.

RHA has entered into an Administrative Service Agreement ("ASA") with each of the 23 Dental Practices. In response to this request, RHA is producing the ASAs and attachments thereto [Bates Nos. RHA_0000001 - 0000496]. RHA is reviewing its files to determine whether it possesses other documents responsive to this request and will provide such documents, if any, as soon as possible.

Patient Abuse and Medicaid Fraud

1) All documents related to production goals set out by ReachOut Healthcare America facilities and mobile units.

RHA is reviewing readily accessible documents in its possession and will provide any responsive documents as soon as possible.

2) **All policies and documents, including emails, regarding any contests or other bonus incentive structure for each dental procedure since January 2010.**

RHA's Chief Financial Officer, Chief Executive Officer, and former Chief Executive Officer do not recall being aware of any Dental Practice sponsoring contests or other bonus incentive structures for particular dental procedures, but we are reviewing readily accessible documents in RHA's possession for reference to any such contests or other bonus incentive structures and will provide any responsive information as soon as possible.

3) **The number of baby root canals and crowns each of your ReachOut Healthcare America facilities and mobile units facilities has performed on all Medicaid and non-Medicaid patients since January 2010.**

RHA is working to gather responsive data in its possession and will provide it as soon as possible.

4) **All policies, procedures, and documents regarding school personnel observation of all dental procedures being performed.**

and

5) **All policies, procedures, and documents regarding parental or guardian observation of dental procedures.**

Policies responsive to Requests 4 and 5 are established by the Dental Practices with the approval of their dentist-owners. In response to this request, RHA is producing, as an exemplar within its possession, a Clinical Manual developed by Dr. [redacted], in collaboration with UCLA Dental School, for use by the Dental Practices that he owns and oversees [Bates Nos. RHA_0000944 - 0001013]. Under the heading "Patient Accompaniment," the Clinical Manual states:

> When possible, school administrative staff should accompany patients to and from classrooms to treatment areas. In some states, for example, Texas, there are special rules for accompanying children. Parents, guardians, or school officials may also accompany children prior to, during, and after treatment, at the discretion of the parent or legal guardian. Otherwise, only the Practice personnel may accompany patients to and from classrooms.
>
> Two or more Practice personnel must be present in the room at all times during the treatment of any patient. Under no circumstance should any [of] the Practice personnel be alone in a room, building, or vehicle with a minor patient at any time. Any occurrence of such is grounds for immediate termination.

[Bates No. RHA_0000970]

6) **All policies, procedures, and documents regarding the use of the "papoose board" or other restraint devices during dental procedures.**

Policies responsive to Request 6 are established by the Dental Practices with the approval of their dentist-owners. In response to this request, RHA is producing readily accessible e-mails within its possession demonstrating the adoption of a "non-restraint" policy by the Dental Practices [Bates Nos. RHA_0000549 - 0000560]. This policy states, in pertinent part: "***NEVER PHYSICALLY RESTRAIN A PATIENT***, such as, using a papoose or other restraint device. You may contain a patient's hands only if patient presents imminent danger of harm to themselves." [Bates No. RHA_0000551 (bold, italics, and underline in original)] RHA is continuing to review its files for documents regarding the adoption of this policy by the Dental Practices and will produce any such documents in its next production.

In addition, we note that the Clinical Manual developed by Dr. [redacted] states: "Never physically restrain a patient. Appropriate referral is necessary when there are patient behavior management problems. Delivery of safe, quality patient-centered care is paramount." [Bates No. RHA_0000952 (emphasis in original)] The Clinical Manual also specifically states: "At no time should a child be physically restrained." [Bates No. RHA_0000954]

7) **All policies, training manuals, informational booklets, other classroom materials, and any other related documents provided to dentists or used during the training of any dentists employed by ReachOut Healthcare America facilities and mobile units.**

Policies and other materials responsive to Request 7 are established by the Dental Practices with the approval of their dentist-owners. In response to this request, RHA is producing, as an exemplar within its possession of the policies and manuals that are provided to dentists by the Dental Practices, the Clinical Manual developed by Dr. [redacted] [Bates Nos. RHA_0000944 - 0001013].

RHA is working to gather additional readily available documents in its possession that are responsive to this request, and will produce any such documents in its next production.

8) **The amount of revenue by ReachOut Healthcare America facilities and mobile units on Medicaid patients and reimbursement, by clinic, in each year since January 2010.**

RHA is working to gather responsive data in its possession and will provide it as soon as possible.

9) All policies related to non-retaliation policies.

RHA and the Dental Practices that it services have all adopted policies concerning retaliation toward employees who report fraud, waste, abuse, or other violations of the law. In response to this request, RHA is producing (1) the RHA Employee Manual, which applies to all RHA employees [Bates Nos. RHA_0000561-0000663]; (2) RHA's HIPAA HITECH Policies and Compliance Program documents [Bates Nos. RHA_0000664-0000764]; (3) an example of a Dental Practice's HIPAA HITECH Policies and Compliance Program documents for its officers and employees [Bates Nos. RHA_0000765-0000943]; and (4) the Clinical Manual developed by Dr. [redacted] which also includes a non-retaliation policy [Bates No. RHA_0000960].

The Dental Practices' HIPAA HITECH Policies and Compliance Program for employees include a "Code of Conduct," which provides in pertinent part:

> No reprisals, or other disciplinary action inconsistent with law, will be taken or permitted against personnel for good faith reporting of, or cooperating in the investigation of, suspected illegal acts or violations of this Code. It is a violation of this Code for personnel to punish or conduct reprisals in regard to personnel who have made a good faith report of, or cooperated in good faith in the investigation of, suspected illegal acts or violations of this Code.

[Bates No. RHA_0000863]. The Compliance Manuals further provide that at the request of the Dental Practice, employees are required to sign semi-annual certifications stating that they are not aware of any compliance issues, or that they have reported any such issues to the Compliance Officer. As part of this certification, employees are required to state that they are not aware of any unreported compliance issues, including but not limited to, overpayments, false bills or kickbacks.

We are determining whether RHA's records indicate that all of the Dental Practices have Compliance Manuals and will advise if any Dental Practices do not or if RHA's records do not answer this question. We are working to determine whether all of the Dental Practices' Compliance Manuals in RHA's possession contain the same non-retaliation provisions. If any of the Compliance Manuals in RHA's possession are different from the enclosed examples, RHA will provide them.

10) All emails and other documents used to promote the existence of the Disclosure Program to employees of ReachOut Healthcare America facilities and mobile units.

You have asked for documents used to promote the existence of "the Disclosure Program" to employees. We have interpreted your request as pertaining to documents related to a policy that encourages employees of RHA and the Dental Practices to disclose fraud, waste, abuse, or other illegal acts. In response to this request, we are producing: (1) the RHA Employee Manual [Bates Nos. RHA_0000561-0000663]; and (2) the Compliance Program documents [RHA_0000664-0000943], which require employees voluntarily to disclose all illegal acts or violations of the Code of Conduct. We are working to determine whether all of the Dental Practices' Compliance Manuals in RHA's possession contain the same pro-disclosure provisions. If any of the Compliance Manuals in RHA's possession are different from the enclosed examples, RHA will provide them.

* * *

Today's production contains confidential business information. RHA respectfully requests that these documents be maintained confidentially and that, if the Committee is considering releasing any of these documents, RHA be given an opportunity to be heard on that question.

If you have any questions, please feel free to contact us at the telephone number listed above.

Sincerely,

Reginald J. Brown
Robin L. Baker

Enclosures

EXHIBIT 1: Dental Practices Serviced by RHA

Dental Practice	State	Owner(s)
[redacted], D.M.D., P.C.	NV	[redacted] D.D.S.
Big Smiles Alabama, P.C.	AL	[redacted] D.D.S.
Big Smiles Colorado, P.C.	CO	[redacted] D.D.S.
Big Smiles Kentucky, P.S.C.	KY	[redacted] D.D.S.
Big Smiles Pennsylvania, P.C.	PA	[redacted] D.D.S.
Big Smiles Virginia, P.C.	VA	[redacted] D.D.S.
[redacted] D.D.S. Gateway, P.C.	MO	[redacted] D.D.S. [redacted] D.D.S.
[redacted], D.D.S. Texas, P.C.	TX	[redacted] D.D.S.
[redacted], DDS, Big Smiles Massachusetts, P.C.	MA	[redacted] D.D.S.
[redacted] DDS, Inc.	WV	[redacted] D.D.S.
[redacted], D.D.S., P.C.	IL	[redacted] D.D.S. [redacted] D.D.S. [redacted] D.D.S
[redacted] DDS, P.C.	CA	[redacted], D.D.S.
[redacted], D.D.S., Ltd., A Dental Corporation	LA	[redacted], D.D.S.
Little Smiles New Jersey P.C.	NJ	[redacted], D.D.S.
[redacted] Dental Group, D.D.S., P.C. (d/b/a Help a Child Smile)	GA	[redacted], D.D.S.
[redacted] D.D.S., P.A.	KS	[redacted] D.D.S.
[redacted] D.D.S., P.C.	MO	[redacted] D.D.S.
[redacted], D.D.S., P.C.	AZ	[redacted], D.D.S.
[redacted] D.D.S., Big Smiles Maryland, P.C.	MD	[redacted], D.D.S.

Dental Practice	State	Owner(s)
[redacted] Dental Group, P.C.	GA	[redacted] D.D.S.
Smile Care, L.L.C.	OH & IN	[redacted] D.D.S.
Smile Michigan, P.C.	MI	[redacted] D.D.S.
[redacted] DDS P.A.	NC	[redacted] D.D.S.

EXHIBIT 32

ADMINISTRATIVE AGREEMENT

This Administrative Agreement ("Agreement") by and between ReachOut Healthcare America LTD (RHA) and [redacted] DDS, PC an Arizona professional corporation, which is referred to as "PC" and the "Principal Shareholder" of the PC, [redacted] DDS.

WHEREAS, RHA is a corporation, which provides administrative and financial services to dental entities engaged in providing mobile dentistry; and

WHEREAS, PC desires to engage RHA, directly and through the sub-contractors of RHA, to provide administrative and financial services as set forth herein, so that the PC can focus on furnishing high-quality dental care directly and through third-party dentists to needy, primarily low income, children in schools and out-of-home placement agencies needing mobile dentistry through the services of the PC's dentist(s); and

WHEREAS, the PC, the Principal Shareholder and RHA mutually desire to enter into a relationship under the terms of this Agreement to assist the PC as set forth herein;

Definitions:

"Dentist" means an individual who is currently licensed by the State of Arizona who will be rendering services through the "PC".

"PC" is an Arizona professional corporation owned by [redacted], a licensed Massachusetts dentist.

The principal shareholder of the PC is [redacted] and is referred to as "Principal Shareholder".

"School" or "Schools" are defined as the schools and out-of-home placement agencies where the students, whose parents or guardians want the child to receive dental care, will be provided dental care.

"Dental Visit" is defined as a Dentist (and either a dental assistant and/or an x-ray technician) going to a School to see children to provide dental care on any given day.

"Formula" for those expenses that are incurred for multiple state activities by RHA for various other professional corporations and this PC shall be totaled and then those expenses shall be divided in the following manner: The total number of dental visits that take place in all the multiple states each month shall be divided by the number of dental visits undertaken in this PC's territory and that percentage shall be applied to the expenses as the PC's obligation. For example, in multiple states where there are three hundred total dental visits in a given month and one hundred of these dental visits took place in this given month in this PC's territory, then one-third of all the expenses incurred

by RHA (and its sub-contractors) for the PC and other professional corporations for common type of services would be charged to the PC as Direct Expenses (DE) as defined in Exhibit A of this Agreement.

NOW, THEREFORE, in consideration of the foregoing, and the mutual covenants and agreements herein contained, all the parties hereto agree as follows:

I. RESPONSIBILITIES AND OBLIGATIONS OF RHA

1.00 Responsibilities in General: RHA directly, or through it sub-contractors, is responsible for the duties and obligations set forth below and in Exhibit A which is attached hereto and incorporated herein by reference. RHA is authorized, in its sole discretion, to assign whatever duties it deems appropriate without specifying the duties herein to sub-contractors of RHA's choice. PC is responsible for the duties and obligations set forth below and in Exhibit B which is attached hereto and incorporated herein by reference.

1.01 Dental Equipment and Supplies: To the extent needed for PC to provide dental services to the patients in the Schools as directed by the PC, RHA shall supply the dental equipment and supplies.

1.02 Dental Staff, Dentists, Care Coordinators, Program Developers, and Payroll: PC shall exercise exclusive control over all standards relating to the hiring, training and possible termination of the dental staff, their professional conduct, their pay and hours of practice. The dental staff such as dental assistants and x-ray technicians shall be employees of the PC. The dental staff shall be under PC's full control. All Dentists shall be independent contractors and/or employees of PC and not RHA. The Care Coordinators, who contact the potential patients' parents or guardians or the patients themselves, for enrollment and arranging dental care, shall be either full or part time employees of the PC and the PC shall exercise control over the standards relating to the hiring, training and possible termination and work activities of the Care Coordinators. The Program Developers, who contact the potential Schools to arrange for the Schools to participate in this program, shall be either full or part time employees of the PC and the PC shall exercise control over the standards relating to the hiring, training and possible termination and work activities of the Program Developers. RHA shall provide managerial and administrative support pursuant to applicable laws and regulations.

1.03 Administrative and Accounting Functions: RHA shall provide personnel for administrative and accounting duties of PC.

1.04 Relations with Schools: RHA shall arrange for scheduling of the dentist and dental staff with the Schools pursuant to PC standards.

1.05 Purchasing, Accounts Payable and Inventory Control: RHA shall order on behalf of the PC all general business inventory and supplies required by PC to provide dental services to the PC's patients and handle all accounts payable and inventory control of all dental equipment and supplies.

1.06 Billing of Dental Services, Posting, Refunds and PC's Duties: PC shall be responsible for the administrative functions of processing PC's patient billing, posting payments and sending back any necessary refunds. PC shall be solely responsible for all

billing of the PC's patients and the recordation of said payments and submitting any refunds for payments erroneously sent to the PC, and RHA shall have no rights or obligations in this regard.

1.07 Information Systems and Accounting: RHA shall establish, maintain and train its staff in the use of computer systems in the production of financial, marketing and operational information concerning PC's business operations other than for billing on behalf of dental patients. RHA shall analyze such information on an ongoing basis and make the same available to the PC as set forth in Exhibit A.

1.08 Accounting and Bookkeeping: RHA shall provide or arrange for all accounting and bookkeeping services related to PC's operations.

1.09 Financial Services pertaining to dental fees, payroll function, financial reports and PC expenses: RHA shall be responsible for: (i) receiving payments on behalf of the PC from patients, governmental agencies such as Medicaid, insurance companies, and all other third-party payers; (ii) taking possession of and endorsing the name of PC on any notes, checks, money orders, Medicaid payments, insurance payments and other instruments received in payment for professional services rendered; (iii) performance of all payroll functions and accounts payable functions; (iv) preparing and submitting to PC operating and financial reports with respect to the operations, including bank reconciliation; and (v) paying all PC expenses as set forth in Section 3.1.

1.10 Disbursement of Funds: All monies collected for services provided by PC pursuant to Section 1.06 and 1.09 above shall be deposited into a financial institution's account (the "PC Account"). The PC Account shall contain the name of the PC. In connection with the billing, collection and disbursement services to be provided by RHA under this Agreement, PC appoints RHA as PC's exclusive attorney-in-fact with the irrevocable right to endorse over payments and to disburse them pursuant to this Agreement and during the time after the end of this Agreement needed for any reason to satisfy the respective duties and rights of the parties to this Agreement. Upon the reasonable request of RHA, PC shall execute any additional documents or instruments as may be necessary to evidence or implement the special power of attorney granted to RHA by PC.

1.11 RHA shall account for all monies so collected and/or disbursed as follows from the PC Account: From the funds collected and deposited by RHA in the PC Account, RHA shall make the following disbursements in the following order of priority: First, payment, when due, of the normal salaries and/or fees of the dentists and dental staff and the salaries of the employees of the PC who are the Care Coordinators, and Program Developers and for all dental supplies, dental equipment and other standard costs incurred in providing dental services by the PC under this Agreement. Second, payment on a monthly basis of the Service Fee and monthly reimbursement of expenses and charges as set forth in Exhibit A. Third, all remaining funds shall be distributed in the PC's discretion at the end of each calendar year of this Agreement once there has been a full accounting for the entire year of all income and expenses of the PC and all obligations of the PC to RHA. If RHA provides funds to PC to cover shortfalls, such advances shall be deemed to be loans to PC and the deficiency shall accrue interest at a rate equal to one percentage point per annum higher than the "prime rate" of interest as announced by [redacted] Bank (or its successor), which indebtedness and interest thereon shall be deemed an operating expense of PC.

II. TERRITORY

2.01 Territory of this Agreement: RHA and PC agree that this Agreement shall cover Arizona during the term of this Agreement, excluding any military dental activities. The Agreement is non-exclusive to RHA and RHA is entitled at any time to work with any third party in the same or different manner as with the PC anywhere in Arizona after this 60 day period of notice established hereinafter

III. FINANCIAL ARRANGEMENTS

3.01 Consideration to RHA: As consideration for the services and duties performed by RHA as described in this Agreement and under Exhibit A, PC shall pay RHA as described in Exhibit A. RHA is responsible to pay any of its sub-contractors and the PC has no obligations in this regard.

3.02 Non-Dependence on Fees Generated: It is understood by the parties hereto that these fees and reimbursements to RHA, as set forth in Exhibit A, are not dependent in any way upon the amount of fees generated or not generated by the PC.

3.03 No Personal Liability for the Principal Shareholder and others involved with the PC: RHA agrees that [redacted] DDS (Principal Shareholder) and any present or future shareholders, directors or officers of the PC are not personally liable or responsible for any of the PC's fees, obligations, debts or expenses of whatsoever nature owed hereunder by PC to RHA or any other subcontractor. All financial obligations are the sole and exclusive obligation of the PC and RHA's only recourse is against the PC and funds collected and/or owed to the PC and/or to be billed by the PC. RHA is hereby granted a continuing, irrevocable recordable lien on any funds paid or payable to the PC for the dental services rendered by the PC under this Agreement to satisfy obligations owed to RHA under this Agreement and Exhibit A.

IV. INSURANCE AND INDEMNITY

4.01 Insurance to be maintained by the Dentists: Each Dentist providing services for the PC shall maintain, at his or her expense, comprehensive professional liability insurance with limits of not less than $1,000,000 per claim and with aggregate policy limits of not less than $2,000,000. RHA will be provided with a copy of the policy and coverage declaration sheet annually.

4.02 Additional Insured: The PC and RHA agree to use their reasonable efforts to have each other named as an additional insured on the other's respective liability insurance policies.

4.03 Indemnification:

The PC shall indemnify, hold harmless and defend RHA, its officers, directors, shareholders and employees from and against any and all liability, loss, damage, claim, and causes of action, whether or not covered by insurance, caused or asserted to have been caused, directly or indirectly, by or as a result of any intentional acts, negligent acts or omissions by the PC and/or its affiliates, its shareholders, agents, employees, subcontractors and/or Dentists during the term of this Agreement or extensions thereof without regard to when the claim is actually presented.

V. TERM AND TERMINATION

5.01 Term of Agreement: This Agreement shall be for an initial three (3) year term commencing on the effective date of this Agreement. This Agreement shall, after the initial three (3) year term, be automatically renewed for consecutive three (3) year periods unless RHA or PC gives written notice at least one hundred and twenty (120) days before the end of the term of its desire to terminate this Agreement. Notwithstanding the foregoing, PC or RHA shall have the right to terminate this Agreement by providing written notice at least sixty day days prior to the party's decision to terminate. PC and RHA may terminate this Agreement with or without cause.

5.02 Limitation of Liability: In no event shall RHA or its sub-contractors be liable to PC for any indirect, special or consequential damages or lost profits arising out of or related to this Agreement or the performance thereof, even if RHA, or its sub-contractors, have been advised of the possibility thereof. In no event shall PC or the Principal Shareholder be liable to RHA, or its sub-contractors, for any indirect, special or consequential damages or lost profits arising out of or related to this Agreement or the performance thereof, even if PC and/or the Principal Shareholder has been advised of the possibility thereof, unless such damages or lost profits are due to the PC or the Principal Shareholder breaching the Solicitation or Confidentiality Provisions of this Agreement.

5.03 Patient and Business Records: During this Agreement and upon termination of this Agreement, the PC shall continue to own and retain all patient dental records. During the term of this Agreement and for five years thereafter RHA, its sub-contractors or their designees, shall have reasonable access during normal business hours to the patient dental records including records of collections, expenses and disbursements in order to bill and/or examine and/or copy said records for audit purposes, billing or collection or any other reason. PC shall act in a cooperative fashion in regard to making said patient records available without charge so that any successor PC or Dentist contracted with by RHA can continue to provide dental care for that patient without interruption, delay or interference.

VI. PC DENTAL CONTROL OF DENTAL MATTERS

6.01 Dental Decisions: Despite the above listing of activities and areas of duties of RHA and its sub-contractors, all dental decisions, charting, billing and related dental decisions shall be made exclusively by the PC and any Dentists retained by PC.

VII. INDEPENDENT CONTRACTOR AND OTHER PROFESSIONAL RELATIONSHIPS

7.01 Independent Relationship: RHA, PC and the Principal Shareholder intend to act, perform and are independent contractors, and the provisions hereof are not intended to create any partnership, joint venture, agency or employment relationship between the parties.

7.02 Other Professionals Relationships: No provision of this Agreement is intended to limit RHA's right, authority, or ability to contract with other Dentists, any professional corporations, partnerships, joint ventures or any other relationships of any kind in any state.

7.03 RHA's rights after termination: Under all circumstances, without any exception, upon termination or the expiration of this Agreement for any reason RHA and its sub-

contractors (individually or jointly) are entitled to enter into the same or similar Agreement with any other PC or licensed Arizona dentists anywhere in Arizona without the PC or the Principal Shareholder's approval or participation

RIGHTS OF RHA AND ITS SUB-CONTRACTORS POST AGREEMENT AND CONFIDENTIALITY

8.01 RHA's right to have administrative agreements with dentists formerly associated with the PC: During this contract, and after termination of it for any reason, RHA is entitled to encourage any dentist or dental staff previously working with the PC to affiliate with a new dental professional corporation that selects RHA to work with in a School program in Arizona or anywhere else and the PC and Principal Shareholder will not prohibit by contract or otherwise or interfere with any such dentist or dental staff from working with such a new dental professional corporation associated with RHA.

8.02 Confident information: Both parties shall hold in confidence the confidential information of the other during this agreement and for 12 months thereafter. Patient information that is confidential shall remain confidential. The foregoing shall not apply to information which is required to be disclosed by law including securities laws or pursuant to court order.

8.03 Remedies for breach: PC and Principal Shareholder acknowledge that great loss and irreparable damage would be suffered by RHA if PC and/or Principal Shareholder should breach or violate the terms of this agreement because of the competitive nature of the industry and the special knowledge of the affairs and operations PC and Principal Shareholder will gain through its/his contractual relationship with RHA. If PC and/or Principal Shareholder breaches or violates any of the provision of this agreement, the parties agree that RHA would not have an adequate remedy at law and that, therefore, RHA will be entitled to a temporary restraining order and a permanent injunction to prevent a breach of any of the terms or provisions contained in this agreement.

PC and/or Principal Shareholder agree that its/his liability in any proceeding accruing from the breach of this agreement shall include not only the monetary proceeding commenced in breach of this agreement, but also all other damages, costs, and expenses sustained by the RHA on account of such action, including, without limitation, attorney fees and all other costs and expenses. PC and/or Principal Shareholder further agree that RHA shall be entitled to immediate (i.e., without prior notice) preliminary and final injunctive relief to enjoin and restrain PC and/or Principal Shareholder from performing any or all of the prohibitive actions described in Paragraphs 8.01 and 8.02, in addition to any other remedy provided by law or this agreement.

IX. GENERAL PROVISIONS

9.01 Whole Agreement; Modification: There are no other agreements or understandings, written or oral, between the parties other than as set forth herein. The Agreement shall not be modified or amended except by a written document executed by both parties to this Agreement and acknowledged as an amendment.

Notices: All notices, including the copy, required or permitted by this Agreement shall be in writing and shall be addressed as follows:

To: ReachOut Healthcare America LTD
Attention: [redacted]
1904 W Parkside Lane, Suite 201
Phoenix, Arizona 85027

To the PC: [redacted] DSS PC

To the Principal Shareholder [redacted]
[redacted]
Phoenix, Arizona 85027

or to such other address as either party shall notify the other.

9.02 Waiver of Provisions: Any waiver of any terms and conditions hereof must be in writing and signed by the parties hereto. A failure to enforce, on one or more occasions, a term or condition does not constitute a permanent waiver of the right to enforce that term or condition but rather same is to be considered in full force. 39.04 Compliance with Applicable Laws: Both parties shall comply with all applicable federal, state and local laws, regulations and restrictions in the conduct of their obligations under this Agreement.

9.04 Severability: The Provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the parties. To the maximum extent possible, any such severance shall be undertaken in a manner to preserve the underlying economic, non-competition, confidentiality and financial arrangements between the PC and RHA and its sub-contractors.

9.05 Attorneys' Fees: If legal action is commenced by either party to enforce or defend its rights under this Agreement neither party shall be entitled to recover its attorneys' fees, but each party shall be responsible for their own attorney fees, except as set forth in the attorney fee provisions of Section VIII of this Agreement is retained.

9.06 Contract Modifications for Legal Events: In the event any state or federal laws or regulations, now existing or enacted or promulgated after the effective date of this Agreement, are interpreted by judicial decision, a regulatory agency or legal counsel for both parties in such a manner as to indicate that the structure of this Agreement may be in violation of such laws, or regulations, the PC and RHA shall amend this Agreement as necessary to comply with the same. To the maximum extent possible, any such amendment shall preserve the underlying business activities, duties and financial arrangements between the PC and RHA.

9.07 Language Construction: The rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in this interpretation of this Agreement and no party is deemed to have drafted this agreement.

9.08 No Obligation to Third Parties Except as Provided Herein: None of the obligations and duties of RHA or PC under this Agreement shall in any way or in any manner be

deemed to create any obligation of RHA or of PC to, or any rights in, any person or entity not a party to this Agreement

9.09 Counterparts: This Agreement may be executed in two or more counterparts, each of which shall be deemed an original and all of which together shall be considered one and the same Agreement

9.10 Arbitration: All parties agree that any and all disputes shall be submitted to binding arbitration and the arbitrator shall be one individual. All arbitration hearings shall be held in Phoenix, Arizona at RHA's office (or at the location of the then current primary office). Any decision of the arbitrator shall be capable of being reduced to judgment in the court of appropriate jurisdiction including but not limited to Arizona. The arbitrator shall be entitled to issue decisions involving injunctive and other equitable relief. Both parties shall split the cost of the arbitrator's fee and each party shall pay its reasonable attorney's fees and costs subject to the Solicitation clause of this Agreement. The arbitrator upon the showing of reasonable necessity shall grant discovery. RHA shall submit three names of attorneys licensed in the State of Arizona in good standing as possible arbitrators to the PC and the PC shall select one of those three as an Arbitrator. None of the arbitrators submitted by RHA shall be past or present business associates, attorneys for RHA or its principals or personal friends. Although there shall not be arbitration within the American Arbitration Association itself and this shall be a private arbitration proceeding, the general rules of the America Arbitration Association shall be followed to the extent they are not in conflict with this Arbitration Clause. In the event there is conflict or ambiguity between the terms of this Arbitration clause and the American Arbitration Association rules then this instant Agreement and its Arbitration clause shall control.

9.11 Headings: Article and Section headings used in this Agreement are for convenience of reference only and shall not constitute a part of this Agreement for any other purpose or affect construction of this Agreement.

9.12 Assignment Rights: RHA, PC and Principal Shareholder hereby agree that RHA is entitled to assign this Administrative Agreement and any and all of RHA rights and obligations under this Administrative Agreement to any third party RHA selects in its sole and absolute discretion. This assignment can be in any fashion, form or substance that RHA deems proper in its sole and absolute discretion. PC and Principal Shareholder agree to execute any and all documents to accomplish this Assignment in a prompt fashion upon being requested and to act in a fully cooperative fashion to accomplish any such assignment without delay or requesting any compensation for allowing this Assignment to take place.

9.13 Exemptions: This instant Agreement does not extend to any dental related agreement that RHA undertakes with any branch of the military whether in the Territory covered by this agreement or not. This agreement only relates to School dental activities in the Territory covered by this Agreement and no other dental or business activity of RHA in this Arizona or elsewhere.

9.14 Law Applicable: This Contract shall be governed by and construed pursuant to the laws of the State of Arizona without regard to its conflict of law provisions.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first set forth above.

[redacted] DDS, PC
An Arizona Professional Corporation
[redacted]
It's President, [redacted] DDS

ReachOut Healthcare America LTD
a Corporation
By [redacted]
It's President, [redacted]

[redacted]
Principal Shareholder of PC

EXHIBIT A

Below are the duties to be undertaken by RHA for the benefit of the PC And the charges of RHA to the PC

The obligations set forth in this Exhibit A commence with the effective date of this Agreement by all parties being July 2, 2006 and continue during the original term and any renewal(s). During this Agreement, any renewal(s), after termination or after the end of the Agreement for any reason, RHA shall still be entitled to bill and receive any funds for dental services performed by PC during the term of this Agreement or any renewal thereof and to pay RHA for any sums still owed for its services and/or its sub-contractors. The compensation and/or reimbursement for the duties and expenses are divided into two categories as follows:

A. **Direct Expenses ("DE").** All Direct Expenses are the actual costs and expenses incurred by RHA (or its subcontractors) plus fifteen (15) % of all of the PC employee salaries and expenses paid from the PC's accounts.
B. **Administrative Services ("AS").** All Administrative Services charges are at a fee of five hundred dollars ($500) per Dental Visit.

Employees of PC and management relationship:

All individuals who are called Program Developers, having contact with Schools to encourage them to participate with the PC, shall be direct employees of the PC, whether full time or part time, depending upon the employment contract between the PC and the Program Developer as established by the PC's subject to the PC's control and direction. Under the direction of the PC, RHA shall provide the management supervision of the Program Developers. PC shall establish the standards of conduct through her PC Employee Handbook and by approving their activities.

All individuals, who are called Care Coordinators, having contact with the parents or guardians of patients or patients directly to educate them of the advantages to participate with the PC or to arrange the visit with the PC, shall be direct employees of the PC, whether full time or part time, depending upon the employment contract between the PC and the Care Coordinators subject to the PC's control and direction. Under the direction of the PC, RHA shall provide the management supervision of the Care Coordinators.

All individual dental staff members such as dental assistants and x-ray techs, shall be direct employees of the PC, whether full time or part time, depending upon the employment contract between the PC and the dental staff as established by the PC's subject to the PC's control and direction.

All dentists shall be independent contractors with the PC and be subject to the PC's control and direction.

MARKETING

- Design and produce all marketing materials including but not limited to; enrollment forms, parents' reports, posters and various handout materials subject to the PC's control and direction.

(All items set forth above in this Marketing paragraph are included in the AS fee.)

(All actual expenses to third parties and direct costs incurred by RHA in regard to the above activities in this paragraph. DE)

- Postage charges and delivery charges in regard to the above activities in this paragraph and in the fulfillment of all duties in this Agreement. DE

SCHOOL PROCUREMENT

- Compensate all managers of Program Developer who are employees of the PC. DE
- Provide all support materials including computers, telephones, etc. DE
- Pay direct telephone costs per line usage, individual call charges and monthly or annual maintenance and service contracts. DE
- The activities of the Program Developers shall be subject to the PC's control and direction.

CARE COORDINATION ACTIVITIES

- Compensate all managers of Care Coordinators who are employees of the PC. DE
- Compensate all employees of the PC DE
- Develop and/or update performance-tracking system for the EFs and track it. Charges are in AS fee.
- Maintain a 24-hour Hot Line for all incoming calls from patients' responsible parties for dental issues or questions. Charges are included in the AS fee.
- Provide all support equipment including computers, telephone, etc. DE
- Obtain Medifax or other information providing Denti-Cal or other payers' eligibility information per request. DE
- The activities of the Care Coordinators shall be subject to the PC's control and direction.

FINANCIAL

- Assist in maintaining all books of original entry. DE
- Assist in preparing financial statements. DE
- Assist in preparing and maintaining all payment documentation. DE
- Assist in the preparation of state and federal tax returns. DE
- Pay for all third-party professional accounting services and payroll company activities to accomplish the above. DE
- Deposit all payments received in the appropriate account. DE
- Pay all bills when due. DE
- Pay all salaries or PC employees when due from the PC's accounts
- Maintain standard accounting recording for all disbursements. DE

TECHNOLOGY

- Purchase phone support system technologies. DE
- Maintenance of phone support system is included in the AS fee plus DE for use of outside third parties.
- Purchase all computer hardware including but not limited to desktops, laptops, network server, printers, etc. (DE)
- Maintain all such computer hardware. Charges included in AS fee plus DE for use of outside third parties.
- Purchase or developed as needed all requisite computer software including but not limited to: Direct Vision dental software database, database management, accounting, scheduling, billing, Microsoft Office, payables, accounts receivable, patient tracking system, Call Center Software, etc. and maintain such software. DE
- Contact and pay for IT management consulting services. DE
- Provide and maintain a telephone recording system for all calls. Charges are included in AS fee plus DE for use of outside third parties and maintenance and service contracts.
- Provide all business support technology and equipment. (DE)
- Maintain RHA technology and equipment. Charges are included in the AS fee plus DE for use of outside third parties.
- Provide Network Services (DE) and maintain Network Services. Charges included in AS fee plus DE for use of outside third parties.

EXECUTIVE SUPPORT SERVICES

- Provide and pay for all executive business services. DE
- Provide and pay for all office supervisory services not previously covered. DE
- Provide and pay for all financial services. DE

SCHEDULING BY PARTNER RELATIONSHIP COORDINATORS

- According to PC's standards set by the PC, organize the Dentists' schedules as to when and where they will work. DE (Despite the above assistance the individual Dentists and PC shall arrange for those patients to be seen as needed as required by proper dental practices.)

DENTAL EQUIPMENT AND SUPPLIES

- Acquire and utilize appropriate software in order to evaluate the cost of any equipment and supplies and any potential for receiving volume discounts. DE
- Purchase and/or rent all equipment and supplies as directed by the PC DE (It is irrelevant for the purpose of earning the 15% on the DE whether the PC purchases same directly or through the RHA and or its sub-contractors.)

DENTAL STAFF

- Recruit the dental staff such as dental assistants, x-ray technicians who will work for the PC according to PC standards.
- Pay for all recruitment ads. DE
- Pay the dental staff, including the Dentists that are contracted with the PC from PC's accounts. DE
- Pay for all equipment repair and or maintenance. DE.
- Verify that any necessary licensing for any dental assistant or x-ray tech is current. DE
- Manage the schedules of dental staff as directed by the PC. DE

INSURANCE

- In RHA's discretion, evaluate and price any and all insurance that might be needed by the PC, including workmen's compensation, general liability, property insurance and the like subject to the PC's direction. Submit said premiums when due subject to RHA being reimbursed by PC. Provide documentation of the insurance as requested by Schools. AS
- Pay for all such insurance. DE

TRANSPORTATION

- Facilitate the process of providing transportation for client patients as needed to clinical sites through the Care Coordinators. DE

IN-HOUSE LEGAL SERVICES

- Provide legal advice through in-house corporate counsel on an as needed basis so long as there is not a conflict between the PC and RHA (and its subcontractors) and does not involve litigation of any type. Charges included in AS fee
- Pay all legal fees and costs for third-party attorneys and experts if approved by RHA. DE
- To travel to all locations where necessary to promote and/or implement the administrative activities provided for under this Agreement and to have all reasonable travel expenses reimbursed. DE

RENT, UTILITIES, PROPERTY TAXES, GOVERNMENT TAXES

- To pay all office rent, utilities, property taxes and business operation taxes of whatsoever nature such as single business taxes, personal property taxes, sales taxes and the like, for any space, equipment, supplies or business activities in Arizona, and all telephone charges (all of the above is referred to as "Rent,

etc ") without regard to where they originate, that are for the benefit of the Arizona activities. As there are multiple state activities from the main office in Arizona the "Rent, etc ", as described above, will be prorated based upon the "Formula" as described in the Definitions of this Agreement. DE

DUTIES COVERING MULTIPLE STATES:

- For any person working for RHA or any sub-contractor that has Arizona and non-Arizona duties covered as a DE expense, then RHA shall allocate the charges based upon the "Formula" as described in the Definitions of this Agreement.

INCREASED DUTIES AND COMPENSATION

- The AS fee of $500 per Dental Visit is based upon each Dental Visit per day in the PC's territory. For each additional Dental Visit in the PC's territory, RHA shall receive an additional AS fee of $500 per Dental Visit. For example, if there was one Dental Visit in any day then RHA would receive an AS fee of $500 plus all DE expenses. If there were two Dental Visits in one day then RHA would receive $1000 plus all DE expenses.

MISCELLEANOUS

- Any and all expenses incurred that have not been specified previously that are reasonably necessary to provide the administrative services required by RHA. DE

[redacted] DDS, PC

By [redacted]

It's President, [redacted] DDS

Principal Shareholder

[redacted]

[redacted] DDS, MBA

ReachOut Healthcare America LTD
a corporation

By [redacted]

It's President, [redacted]

EXHIBIT B

ACTIVITIES TO BE UNDERTAKEN BY PC UNDER THIS AGREEMENT

All reference to RHA includes its sub-contractors It is the obligation of the PC to undertake the following activities:

1. Dr. [redacted] shall maintain an office full time in the same office as RHA and work closely on a day to day basis on all aspects of the Agreement including the PC's employee's duties and performance and these other items as set forth in the remainder of this Exhibit B.
2. PC has reviewed and approved the Employee Policy and Procedure Manual (Employee Handbook) which shall cover the duties of all its employees
3. PC has establish standards for the hiring of dentists, which are that any dentist that is an independent contractor or employee of the PC, shall have a criminal background check by a third party agency because they are going into Schools, verify that the dentist has a valid dental license and be in good standing with the dental board, current malpractice insurance and there are no citations with the dental board of a serious nature. RHA agrees to supply PC, upon its request, this information on the person.
4. PC has established standards for the hiring of dental staff that are employees of the PC including a criminal background check by a third party agency because they are going into the Schools and receive the training set forth in the Operations Manual approved by the PC. RHA agrees to supply the PC, upon its request, this information on this person.
5. PC has established standards for the hiring of Care Coordinators and have received the training set forth in the Operations Manual which is approved by the PC. RHA agrees to supply PC, upon its request, this information. PC has reviewed and approved the words to be spoken to the family members when contacting them by phone on behalf of the PC
6. PC has approved the flyers being brought to the parents from the school by the children about enrollment in the school dental program and the take home sheet that child brings to the parent or guardian after the visit
7. PC has established standards for the hiring of Program Developers and have received the training set forth in the Operations Manual approved by the PC. RHA agrees to supply the PC, upon its request, this information on this person.
8. PC has approved the form of contracts for all employees and Independent Contractors and RHA will have made available to its copies of all contracts relating to any and all employees and independent contractors of its PC upon her request.
9. PC has and will continue to review the various reports pertaining to dentists' activities and financial activities and to respond in the manner it deems appropriate.
10. PC will speak or communicate with the Director of Operations of RHA, regularly in regard to all activities of Care Coordinators, Program Developers, and dental staff and other relevant matters.
11. PC will receive all income tax or corporate tax documents for review and signature before submission.
12. PC has established that it wishes the Schools covered by this program to be in the state of Arizona and is to be supplied regularly with reports of the Schools participating in the program.

13 PC has and will have made available to it any copies of any charts of any patient seen by its dentists upon its request
14 PC will undertake any duties set forth in this Administrative Agreement.

Approved by:

[redacted] DDS, PC

By [redacted]

It's President, [redacted] DDS

Principal Shareholder

[redacted]

[redacted] DDS

ReachOut Healthcare America LTD

By [redacted]

It's President, [redacted]

EXHIBIT 33

Execution Copy

SOPUTHERN CALIFORNIA ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") is effective April 23, 2009 ("Effective Date") by and between ReachOut Healthcare America, LTD., a Delaware corporation (the "Administrator") and [redacted] DDS, Professional Corporation, a California corporation (the "Provider).

BACKGROUND

A. Provider is a professional corporation which operates a mobile dental practice in the State of California (the "Practice") and is duly organized under the laws of the State of California and this agreement is limited to the area in California which is from the northern edge of Los Angeles County and to the southern most point in California.

B. [redacted] DDS [redacted] is a dentist duly licensed in good standing under the laws of the State of California and is the sole shareholder of Provider.

C. Administrator has special expertise and experience in the operation and administrative aspects of such mobile dental practices of the type operated or intended to be operated by Provider. Administrator provides business services to other dental providers in many States and as such is uniquely qualified to provide business services to Provider. Administrator has made a significant investment in the development of computer software and system of policies and procedures addressing certain operations and administrative functions which are desirable to Provider.

D. Provider and other employees and/or contractors of Provider, desire to devote the necessary time to providing quality mobile dental services to patients, and in connection therewith desire to obtain the expert assistance of Administrator in administrating certain business aspects of the Practice.

E. Provider has three dental offices that it owns and this agreement does not apply to these three dental offices in any manner.

DEFINITIONS

A. Practice Providers: The term "Practice Providers" shall mean the Dentists who are employees of the Provider or otherwise under contract with the Provider to provide dental services to patients of Provider.
B. Professional Services Revenues: The term "Professional Services Revenues" shall mean the gross sum of all professional fees actually recorded each month on an accrual basis under GAAP (net of Adjustments) as a result of dental services rendered by Practice Providers of the Provider.
C. Adjusted Gross Revenue: The term "Adjusted Gross Revenue" shall mean the sum of all Professional Services Revenue billed at Practice's "usual and customary fees".
D. Adjustments: The term "Adjustments" shall mean any adjustments on an accrual basis for uncollectible accounts, third-party payor contractual adjustments, discounts,

professional courtesies, and other reductions in gross Professional Service Revenue that result from activities that do not result in collectible charges.

E. The term "Administrative Fee" shall mean the amount hereinafter described and which amount is payable to the Administrator.

F. Office Expense: The term "Office Expense" shall mean all non-professional operating and non-operating expenses incurred by the Administrator or Provider on behalf of the Provider. Office Expense shall not include any expense that is exclusively a Provider Expense. Office Expense shall include, but not limited to, those non-professional expenses incurred for the benefit of the Provider as follows:

1. The direct salaries and benefits of all employees and independent contractors of the Administrator working solely for the Provider or whose cost can be directly allocated to the Provider, but not the salaries, benefits, or other direct costs of the Practice Providers and the other employees or independent contractors of the Provider.
2. The direct cost of any employee or consultant that provides services such as administrative services, billing and collections, business office consultation, business development and accounting and legal services.
3. Recruitment costs and out-of-pocket expenses of Administrator for the Provider directly related to the recruitment of additional Practice Providers of the Provider and other individuals.
4. Professional liability insurance expenses for Practice Providers and the Provider and comprehensive, general liability and workers' compensation insurance for employees of Provider and Administrator (but only to the extent Administrator's employees/contractors are solely assigned to Provider or whose cost can be directly allocated to Provider) and the Provider and Administrator.
5. The expense of leasing, purchasing or otherwise procuring of equipment and related depreciation directly for Provider's benefit.
6. The reasonable out-of-pocket travel expenses associated with visiting any dental practice activities, conferences, recruitment trips, supervisory activities or conventions to directly benefit Provider.
7. The reasonable costs and expenses associated with marketing, advertising, printing enrollment flyers and delivery and pick up expenses to retrieve the filled out enrollment flyers and promotional activities to directly benefit the Provider.
8. The cost of Provider's dental supplies office supplies and inventory items.
9. Telephone, utilities, shipping and postage charges of Provider.
10. The cost of Medifax or other information costs to determine the Provider's patient's eligibility information.

G. "Provider Expense": The term Provider Expense shall mean an expense incurred by the Provider and for which Provider and not the Administrator, is financially liable. Practice Provider's salaries and benefits, payments, benefits, and other direct costs and those expenses associated with the Provider's other employees, cost of equipment and the like.

H. "Biller": Biller may be a sub-contractor to the Administrator for billing and collection purposes as set forth in the Administrative Agreement.

I. "Any dental practice activities": This is defined as any school or school district, out of children's home facility or children's agency or nursing home or any other dental practice activity in the state of California
J. "School Relations": This is defined as the working with and coordination of the Provider's dental activities with the school.

NOW THEREFORE, in consideration of the mutual covenants and conditions hereinafter set forth and in exchange for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

AGREEMENT

1. Incorporation. The above Background recitals and Definitions are hereby incorporated into this agreement as if fully set forth herein.

2. Engagement of Administrator and Restrictions on Parties. Provider hereby engages Administrator on an exclusive basis to provide administrative services for the Provider, as described in this Agreement, on the terms and conditions described herein, in California for any dental practice activities and Administrator accepts such engagement during the term of this Agreement, the Provider agrees to use the business services of Administrator when providing mobile dental services for any dental practice activities in California.

3. Agency. Subject to Section 5.16 and 5.17 hereof, Administrator shall have access to Provider's bank account(s) solely for the benefit of Provider and the purposes stated herein and shall use all funds on deposit therein in accordance with the terms of this Agreement. Provider hereby appoints Administrator as Provider's true and lawful agent for the sole purpose of providing the services set forth in this Agreement throughout the term, and Administrator hereby accepts such appointment, to make withdrawals from such account(s) for payments specified in this Agreement.

4. Term. This Agreement shall have an initial term commencing as of the Effective Date and continuing in full force and effect through May 31, 2019 ("Initial Term"), and shall renew automatically for additional ten (10) year terms thereafter, unless terminated earlier as provided herein.

5. Duties and Responsibilities of Administrator. As set forth below, during the Term of this Agreement, subject to the provisions of Section 6.1 herein, at the Provider's request the Administrator shall arrange for the provision of comprehensive business practice management, financial and marketing services, and such facilities, equipment and support personnel as are reasonably required by the Provider to operate its Practice in the State of California, as properly determined by the Administrator in consultation with the Provider. Notwithstanding anything herein to the contrary, the Administrator shall perform only those service listed herein that are specifically requested by the Provider. In exchange for the Administrative Fee herein and payment of its Office Expense, Administrator shall provide all such business services as are

necessary and appropriate for the day-to-day administrative support of Provider's Practice in a manner consistent with good business practices and in conformance with applicable dental standards in the community, including without limitation those services set forth in this Section 5.

5.1 Licenses. License to the Provider, for the purposes of this Agreement only, the following as requested by Provider:

- The use of all Administrator's computer hardware and servers needed to provide administrative support to the Provider
- The use of the Administrator's network software system needed to provide administrative support to the Provider.
- The use of the Administrator's proprietary Case Manager Software System whereby new patient registration information can be recorded in a patient registration form on the proprietary software program such as the health history and the treatment authorization. This information can be entered into the patient registration form on the software of the computer in a "fail safe" manner with warning if information is missing.
- The use of a proprietary software program where every Provider patient's complete records are retrievable promptly by entering the name and certain other information and thereby avoiding searching paper records.
- If a directory Alpha list for each student is provided by the schools then the use of the Administrator's proprietary Patient Tracking Software System whereby a student who is originally registered as a patient attending a school with a certain telephone number and address moves to a new school or gets a new address or a new telephone number then these changes can be tracked by having the outdated information on the child changed automatically to the correct information.
- The use of the Administrator's proprietary "paperless model" software system so that all dental records, x-rays and patient information on every patient can be transmitted electronically to the dental team wherever they are located and upon completion of the visit "up loaded" electronically to the server system.
- The use of the Administrator's commercial phone support system technologies needed to provide administrative support to the Provider.
- The use of the Administrator's two completely separate telephone recording systems so that all calls to and from patients of the Provider are automatically recorded twice.
- Provide all business support technology software needed to provide administrative support to the Provider.

5.2 Services Relating to schools. Administrator shall provide the following business services to Provider in relation to the schools Provider services or may service:

- Contact schools in this State for purposes of introducing them to the Provider's School program.
- Work with the supervisory personnel of the schools in regard to the manner in which the school dental program will be implemented.
- Meet with the school nurses to further the implementation of the school dental program.

- Arrange for each school to have a person assigned as a support person for the individual dental visits at their school and provide training to that support person relating to pre-visit, day of visit and post-visit protocols to be followed by the support personnel.
- Coordinate with the appropriate school the potential schedule dates of the dental visits and the starting and finishing times and locations for the dental services to be rendered.
- Arrange for the delivery of the Provider consent forms to the proper school employee in each school for each student to take home.
- Coordinate that each school obtains completed consent forms by the students and that they are provided to the Administrator.
- Arrange to schedule the minimum number of dental visits at each school that are required, based upon the Provider's direction, for the efficient use of Provider's time and assets.
- Assist each school on the day of the visits to efficiently coordinate the attendance of the student for his/her appointment and return to class to effectively manage the Provider's time at the particular school.
- Obtain patient satisfaction reports.

5.3 Supplies. Administrator shall arrange for the purchase of dental and office supplies necessary for the operation of the Practice as directed by the Provider.

5.4 Licensing. Administrator shall coordinate all reasonable and necessary actions to maintain all licenses, permits and certificates required for the operation of the Practice by Provider. Administrator shall prepare and file all reports, forms and returns required by law in connection with workers' compensation, unemployment insurance, social security and other similar laws with respect to the operation of the Practice.

5.5 Policies, Procedures and Protocols. Administrator has expended substantial time and resources to develop standard dental practice models, policies, procedures, government compliance documents and programs and practice protocols (the "Policies, Procedures and Protocols"). Provider recognizes and acknowledges that the name "ReachOut Healthcare America" belongs to and at all times shall remain the property of Administrator and that the Practice is being permitted to utilize the name and other intellectual property of Administrators, as well as Policies, Procedures and Protocols only pursuant to this Agreement. Nothing in this Section 5.5 shall be construed to interfere with the provisions set forth below in Section 6.1 or impose an obligation on the Provider to utilize the Policies, Procedures and Protocols.

5.6 Personnel. Provider shall establish and implement guidelines for the recruitment, selection, hiring, firing, compensation, terms, conditions, obligations and privileges of employment or engagement of Practice Provider dentists and non-dentist personnel, and all other persons working for Provider. Administrator will assist Provider in recruiting new Practice Provider dentists and non-dentist personnel and will carry out such administrative functions as may be appropriate for such recruitment, including advertising for and identifying potential candidates, assisting Provider in examining and investigating the credentials of such potential candidates, criminal background checks and arranging interviews with such potential candidates;

provided, however, Provider shall make the ultimate decision as to whether to employ or retain a specific candidate and all terms and conditions of said relationship. All non-dentist personnel recruited with the assistance of Administrator to support the providing of professional services on behalf of Provider by Practice Provider's dentists shall be the employees or contractors of the Provider.

5.7 Training. Administrator shall train Provider's personnel with respect to certain aspects of Provider's business operations (not professional services), including, but not limited to, administrative, financial and equipment maintenance matters.

5.8 Insurance. In consultation with Provider, Administrator shall arrange for the purchase by Provider of necessary insurance coverage for Provider including evaluation of Provider's insurance needs and pricing of such insurance. All premiums for Provider's insurance shall be either Office Expenses or Provider Expenses depending upon the insurer and nature of the coverage. Administrator shall also provide documentation of Provider's insurance coverage for any dental practice activities as requested.

5.9 Accounting. Administrator shall establish and administer accounting procedures and controls and systems for the development, preparation, and keeping of records and books of accounting related to the business and financial affairs of Provider. The Administrator shall provide or arrange to provide: (i) an operating budget setting forth an estimate of revenues and expenses for the next fiscal year, together with an explanation of anticipated changes or modifications, if any, in the Provider's utilization, rates, charges to patients or third party payers, salaries, costs of Practice Providers, non-wage cost increases, and similar factors expected to differ significantly from those prevailing during the current fiscal year; (ii) other expenses of operation; (iii) the amount of reasonable reserves to satisfy possible shortfalls from operations; and (iv) the estimated Administrative Fees, as prescribed in paragraph 8.6, hereof, for the next fiscal year. Additionally, the Administrator shall provide or arrange to provide the Provider with an un-audited internal quarterly statement within thirty (30) days after the end of each quarter. At the end of each fiscal year of the Provider, the Administrator shall arrange for a financial statement with respect to the Provider to be prepared by the Administrator's accountant. At the Provider's request, the Administrator shall prepare reports indicating the gross revenues, number of patients, type of patients, and the activity and the productivity of the Provider

5.10 Tax Matters. Administrator shall oversee the preparation of the annual report and tax information returns required to be filed by Provider.

5.11 Reports and Information. Administrator shall furnish Provider in a timely fashion annual or more frequent operating reports and other reports as requested by Provider, including without limitation (i) copies of bank statements and checks relating to Provider's bank accounts, (ii) financial statements, (iii) the reports prescribed in paragraph 5.9, above.

5.12 Planning and Budgeting. The Administrator shall advise the Provider of short and long range planning, including the projection of personnel needs, evaluation of compensation of Provider's employees and contractors, fees for services provided, analyses of future markets, and other necessary planning services. The Administrator shall prepare annual capital and operating

budgets for the Provider ("Annual Budget"), in an orderly fashion containing the information prescribed in paragraph 5.9, above. Administrator shall provide Provider copies of the annual profit and loss statement.

5.13 Maintenance of Equipment. Administrator shall arrange for the provision of maintenance of Provider's equipment, subject to Provider maintaining care, custody and control of any dental and other equipment used in the provision of dental services.

5.14 Expenditures. Administrator shall manage all cash receipts and disbursements of Provider, including the payment on behalf of Provider of all taxes, assessments, licensing fees and other fees of any nature whatsoever in connection with the operation of the Practice as the same become due and payable, unless payment thereof is being contested in good faith by Provider.

5.15 Contract Negotiations. Administrator shall advise Provider with respect to and negotiate, either directly or on Provider's behalf, as appropriate and permitted by applicable law such contractual arrangements with third parties as are reasonably necessary and appropriate for Provider's provision of healthcare services, including without limitation negotiated price agreements with third party payers. Provided, however, that no contract or arrangement regarding the provision of dental care shall be entered into without Provider's consent.

5.16 Billing and Collection. Subject to paragraph 5.17 below, on behalf of and for the account of Provider and with Provider's direction, Administrator may subcontract to a "Biller" any and all billing and collection duties. Provider shall establish and maintain credit and billing and collection policies and procedures, and Biller shall exercise reasonable efforts to bill and collect in a timely manner all professional and other fees for all billable services provided by Provider. In connection with the billing and collection services to be provided hereunder, Provider hereby appoints Administrator as Provider's exclusive true and lawful agent, and Administrator hereby accepts such appointment, for the following purposes:

(a) To bill, in Provider's name and on Provider's behalf, all claims for reimbursement or indemnification from patients, insurance companies and plans, all state or federally funded benefit plans, and all other third party payers or fiscal intermediaries for all covered billable dental care provided by or on behalf of Provider to patients.

(b) To collect and receive, in Provider's name and on Provider's behalf, all accounts receivable generated by such billings and claims for reimbursement, to take possession of, endorse in the name of Provider, and deposit solely into Provider's master collection account all notes, checks, money orders, cash or cash equivalents, insurance payments, and any other instruments received in payment of services rendered. At all times the Provider shall own its accounts receivable and no lien is granted to Administrator for accounts receivable. As directed by Provider Administrator may administer such accounts including, but not limited to, extending the time or payment of any such accounts for cash, credit or otherwise; discharging or releasing the obligors of any such accounts; suing, assigning or selling at a discount such accounts to collection agencies; or taking other measures to require the payment of any such accounts; provided, however, that extraordinary collection measures, such as filing lawsuits, or assigning

or selling accounts at a discount to collection agencies shall not be undertaken without Provider's written consent.

(c) To sign checks, drafts, bank notes or other instruments on behalf of Provider, and to make withdrawals only from Provider's specified account for payments specified in this Agreement and as requested from time to time by Provider.

(d) Upon request of Administrator, Provider shall execute and deliver to the financial institution at which Provider's account is maintained such additional documents or instruments as Administrator may reasonably request to demonstrate its authority. The agency granted herein is coupled with an interest and shall be irrevocable during the Term of this Agreement except with Administrator's written consent.

5.17 Deposit of Governmental Payor Funds. Provider and/or Administrator shall deposit in Provider's account (i.e., a bank account over which Provider shall have exclusive dominion and control that is opened by Provider at a bank mutually agreed upon by the parties, whose deposits are FDIC insured) all governmental payor (i.e., Medicare, TRICARE, etc.) collections collected by Provider or by Administrator on Provider's behalf pursuant to Section 5.16 above (or any other payments required by law to be received under the sole control of Provider). To the extent that Provider or any of its employees or agents receives funds for services paid for or reimbursed by governmental payers, such funds shall be deposited in Provider's account. Administrator shall be entitled to receive copies of the monthly bank statements for Provider's account in order to properly render the accountings and provide the services required under this Agreement.

5.18 Litigation. As directed by the Provider, Administrator shall (a) direct the defense of all claims, actions, proceedings or investigations against Provider or any of its officers, directors, employees or agents in their capacity as such, and (b) direct the initiation and prosecution of all claims, actions, proceedings or investigations brought by Provider against any person other than Administrator.

5.19 Marketing, Advertising and School Relations Programs. Administrator has developed marketing and advertising programs to be implemented by Provider to effectively notify the School District schools, parents and guardian and students and nursing home and nursing home residents and other dental practices of the services offered by Provider. Administrator shall advise and assist Provider in implementing such marketing and advertising programs, including, but not limited to, analyzing the effectiveness of such programs, preparing marketing materials, negotiating marketing contracts on Provider's behalf, and obtaining services necessary to produce and present such marketing programs. Administrator shall provide the School Relations services as set forth in Paragraph 5.2 above. The parties expressly acknowledge and agree that Provider shall exercise complete control over all policies and decisions relating to every element of such marketing; provided, however, that Provider shall have no right whatsoever to use Administrator's name, trademark, copyrighted materials, or any of Administrator's other intellectual property except as expressly permitted in this Agreement. Administrator and Provider agree that all marketing programs shall be conducted in compliance with all applicable standards of dental ethics, laws and regulations.

5.20 Answering Service. Maintain a twenty four (24) hour per day answering service for all incoming calls from patients' responsible parties for dental issues or other questions. All requests involving dental issues shall be forwarded by such answering service to the Provider.

5.21 Dental Practice Laws. Notwithstanding any provision in this Agreement, the Administrator shall not take any action in connection with the services to be rendered hereunder that violates any Law, including, without limitation, the performance of any task or the taking of any action which violates the Dental Practice Act or equivalent law as it relates to professional dental practices.

6. Relationship of the Parties.

6.1 Sole Authority to Practice. Notwithstanding any other provision of this Agreement, Provider shall have exclusive authority and control over the healthcare aspects of Provider and its practice to the extent they constitute the practice of a licensed profession, including all diagnosis, treatment and ethical determinations with respect to patients which are required by law to be decided by a licensed professional. Any delegation of authority by Provider to Administrator that would require or permit Administrator to engage in the practice of a profession or subject to licensure under State or local law or ordinance with the exception of state business registration and local business permits shall be prohibited and deemed ineffective, and Provider shall have the sole authority with respect to such matters. Administrator shall not be required or permitted to engage in, and Provider shall not request Administrator to engage in, activities that constitute the practice of dentistry or another similar profession in the State. Administrator shall not direct, control, attempt to control, influence, restrict or interfere with Practice Provider's Dentists or non-dentist personnel's exercise of independent clinical or professional judgment in providing healthcare or dentistry related services. To the extent that any provision hereof is found to violate any State law, rule or dental board regulation such provision shall be void and unenforceable.

6.2 Relationship Between The Parties. Provider agrees that the purpose and intent of this Agreement is to relieve Provider, its shareholders and Provider's employees and contractors of the administrative, accounting and business aspects of their practice at the Practice to the maximum extent possible, and the Administrator is hereby expressly authorized to perform services hereunder in whatever manner it deems reasonably appropriate to meet the day-to-day non-medical requirements of Provider's dental practice. Provider shall be responsible for the hiring, supervision, compensation and termination of its Dentists, and all issues related to the professional and ethical aspects of its dental practice. The Administrator shall neither exercise control over nor interfere with the dentist-patient relationship, which shall be maintained strictly between the Dentists employed by or contracted with Provider and their patients.

6.3 No Patient Referrals. Administrator shall neither have nor exercise any control or direction over the number, type, or recipient of patient referrals and nothing in this Agreement shall be construed as directing or influencing such referrals. Nothing in this Agreement is to be construed to restrict the professional judgment of Provider, any dentist or any non-dentist personnel to use any dental practice, facility or pharmacy where necessary or desirable in order

to provide proper and appropriate treatment or care to a patient or to comply with the wishes of the patient. No part of this Agreement shall be construed to induce, encourage, solicit or reimburse for the referral of any patients or business, including any patient or business funded in whole or in part by federal or state government programs (i.e., Medicare, TRICARE, etc.). The parties acknowledge that there is no requirement under this Agreement or any other agreement between the parties that either refer patients to the other or any of their respective affiliates.

6.4 Compliance with Corporate Practice of Medicine. The parties hereto have made all reasonable efforts to ensure that this Agreement complies with the corporate practice of medicine prohibitions in the State. The parties hereto understand and acknowledge that such laws may change, be amended, have guidance or have a different interpretation and the parties intend to comply with such laws in the event of such occurrences. Under this Agreement, Provider and its dentists and non-dentist personnel shall have the exclusive authority and control over the professional aspects of Provider's dental practice to the extent they constitute the practice of dentistry as defined under state laws and regulations, while Administrator shall have the authority to provide the administrative services to the Provider as provided in this Section 6.. The parties agree to cooperate with one another in the fulfillment of their respective obligations under this Agreement, and to comply with the requirements of law and with all ordinances, statutes, regulations, directives, orders, or other lawful enactments or pronouncements of any federal, state, municipal, local or other lawful authority applicable to the parties and the Practice.

7. Responsibilities of Provider. Provider shall operate its practice and the dental program for any dental practice activities covered by this Administrative Agreement during the term of this Agreement, in conformance with all applicable laws, rules and regulations. In furtherance of the foregoing, Provider shall provide and perform the following during the Term of this Agreement:

7.1 Dentists and Non-Dentist Personnel. Provider shall establish guidelines and these guidelines shall be implemented by the Administrator for the recruiting, compensation, terms, conditions, obligations and privileges of employment or engagement of Dentists. Provider shall have the sole authority to engage (whether as employees or as independent contractors), promote, direct, discipline, suspend and terminate the services of all licensed Dentists and non-dentist personnel. Provider shall employ or contract with all Dentists who provide professional services on behalf of Provider. Provider shall control all aspects of the practice of dentistry, including clinical training and clinical supervision of the Dentists and non-dentist personnel. Provider shall, in consultation with Administrator, establish work schedules for all Dentists and non-dentist personnel necessary to ensure adequate coverage of Provider's Practice dental locations; Provider shall ensure that all non-dentist personnel are appropriately supervised with respect to the provision of services to patients in accordance with all applicable laws. Specifically, Provider and its Dentists shall have full responsibility for and shall supervise and control all non-dentist personnel in their provision of health-related services as required by applicable law. Provider shall have the authority to engage and terminate the services of all licensed professional employees and independent contractors. Provider shall consult with Administrator from time to time regarding the number, work schedules and evaluation of the Dentists and non-dentist personnel. Provider shall staff its practice as required for the efficient operation of Provider, and as otherwise necessary to meet the requirements of payor contracts

and applicable law. Provider shall provide full and prompt dental coverage to its patients consistent with comparable practice standards in the community. In addition, Provider shall cause each Dentist employed or engaged by Provider to:

7.1.1 Maintain an unrestricted license to practice in the State, maintain all narcotics and controlled substances numbers and licenses, including without limitation a DEA registration or permit if required, and maintain good standing with the applicable professional boards;

7.1.2 Perform services and otherwise operate in accordance with all laws and with prevailing and applicable standards of care;

7.1.3 Maintain his or her skills through continuing education and training;

7.1.4 Maintain eligibility for professional liability insurance for his or her specialty;

7.1.5 Satisfy such other requirements as are reasonably requested by Provider;

7.1.6 In the case of non-dentist personnel, practice under a properly licensed dentist's supervision, control and responsibility as required by applicable law;

7.1.7 Avoid all personal acts, habits and usages which might injure in any way, directly or indirectly, his or her professional judgment or professional reputation;

7.1.8 Not be (and shall avoid being) suspended or excluded from any federal or state healthcare program (e.g., Medicare, or TRICARE); and

7.1.9 Subject to Section 6.1 hereof, adhere to the Policies, Procedures and Protocols, except to the extent that verbal authority to deviate is given by Provider or other appropriately licensed supervising dentist or other dentist employee of Provider.

7.2 Reserved

7.3 Reports; Practice Guidelines. Subject to Section 6.1 above, Provider shall provide such reasonable reports about the Practice as Administrator may request from time to time. Neither this clause nor any other provision of this Agreement, nor any aspect of the actual operation of the Practice, shall be construed as limiting the right, authority and duty of a dentist or non-dentist personnel to exercise professional independent judgment in any particular instance for or on behalf of a patient of the Practice.

7.4 Billing Information. Provider shall be responsible for ensuring that it and its Dentists and, as applicable, all non-dentist personnel timely submit accurate, true, complete, legible and correct information necessary for billing purposes to Administrator. Such information shall be submitted in a format in accordance with normal dental standards.

7.5 Reserved.

7.6 Dental/Patient Records. Provider shall control and shall be responsible for the confidentiality, privacy, maintenance, storage, retention and custody of all dental/patient records of Provider. Provider agrees to comply with all state and federal patient confidentiality and privacy laws regarding dental/patient records. Upon termination of this Agreement for any reason, the Provider shall agree with the Administrator's support to act as custodian of all the records and billing of the Provider's patient's as provided in paragraph 12.4 of this Agreement. Additionally, Administrator shall be allowed to retain and maintain the records as provided in paragraph 12.1 below

8. Administrative Fee; Application of Payments. As consideration for the performance of all of its duties and obligations as provided in this Agreement, including but not limited to, the costs and expenses associated with furnishing the services, facilities, leasehold improvements, fixtures, furniture, furnishings and equipment provided for herein, the Administrator shall receive compensation in the form of Administrative Fees, as defined and determined in accordance with the provisions set forth in paragraph 8.6 herein. It is acknowledged by and between the parties that the Administrator and/or its affiliates has (have) incurred substantial expenses and future obligations in acquiring the capital stock of the Administrator, acquiring or otherwise establishing a portable dental network, establishing its systems, including but not limited to fees for consultants and other professionals, interest expenses, lease obligations, costs of providing the portable dental units where the services will be rendered and the establishing and maintaining its computerized, proprietary paperless dental charting system. The Administrator has also incurred substantial obligations associated with the continuing operation of the dental network, including but not limited to those of obligor and guarantor on loans to establish and operate the portable dental units. The parties, therefore, having considered various compensation formulae, acknowledge and agree that in order for the Administrator to receive a fair and reasonable return for its expenses and obligations, and a fair return for the lease of such premises and equipment required by this Agreement and for providing the services contemplated hereunder, that the agreed Administrative Fee is not excessive. Provider has executed a Dentist's Affidavit attached hereto as Exhibit 8, attesting to the reasonableness of the fees. The Administrator acknowledges that the compensation arrangement is reasonable under the circumstances. In consideration of the foregoing, the parties agree that the Administrative Fees payable to the Administrator by the Provider for services rendered pursuant to this Agreement shall be reviewed and subject to adjustment at the close of each year of the Term of this Agreement based upon industry standards of practice and the Administrator's costs in performing the required services. If the parties cannot agree within thirty (30) days prior to the close of any such year on the terms of any adjustment to the Administrative Fees for the following year, then the then existing Administrative Fees shall remain in effect. The Provider specifically agrees that the Administrator may defer actual receipt of its Administrative Fees and/or advance monies to the Provider for purposes of managing the Provider's cash flow, and that the Administrator shall be paid said deferred Administrative Fees or be reimbursed said advances, including interest thereon, when the Administrator deems reasonably appropriate. In consideration of all of the foregoing the parties agree that the obligations of the Practice will be paid in the order set forth below:

8.1 Provider Expenses. Provider shall pay all the "Provider Expenses" as defined in paragraph (G) under Definitions herein

8.2 Provider's Office Expense. Revenues shall next be applied to pay all the "Office Expenses" of the Provider as may be incurred by the Administrator on behalf of the Provider as defined in paragraph (F) of Definitions, above for carrying out its duties hereunder on behalf of Provider. Provider shall reimburse Administrator for such expenses within five (5) days after the end of the month in which such expenses were incurred.

8.3 Administrative Fee. Administrator shall be paid an Administrative Fee in the amount of set forth under paragraph 8.6 herein (the "Administrative Fee"). Provider shall pay Administrator the Administrative Fee with respect to a given month within 5 days after the end of such month. Per paragraph 8 above, the parties have deemed the Administrative Fee paid to the Administrator to be fair and equitable and reflects the parties good faith attempt to pay fair market value for the services rendered by Administrator for Provider.

8.3.1 To secure its payment obligations under these Sections 8.2, 8.3 and 8.6 (the "Obligations") of this Agreement, the Provider hereby grants, conveys and assigns to the Administrator a first priority lien and security interest in all present and future bank accounts (except those relating to government payors), and accounts of the Practice and the proceeds thereof resulting from services rendered by the Provider, and all additions and substitutions thereto, whether presently owned or hereafter acquired, which shall secure payment of all amounts owed by the Provider to the Administrator under this Agreement and any other obligations or liabilities of the Provider to the Administrator arising, from time to time, pursuant to this Agreement "Accounts" and "proceeds" shall have the meaning ascribed to such terms in Article 9 of the state's Uniform Commercial Code. Accordingly, Provider has executed a Security agreement in favor of Administrator which is attached hereto as Exhibit 8.3.1 and incorporated herein by this reference.

8.3.2 The Provider shall execute, upon request of the Administrator, financing statements, security agreements and any other documents reasonably deemed necessary or desirable by the Administrator to perfect the aforesaid security interest. A financing statement may be filed without the Provider's signature on the basis of this security agreement where allowed by laws. The security interest granted herein, and any other of the Administrator's rights or remedies set forth herein, are not intended to alter, modify, substitute or otherwise restrict any other rights or remedies which the Administrator may have or which may be available to the Administrator by operation of law or otherwise.

8.4 No Personal Liability for [redacted] and others involved with the Provider. Notwithstanding any provision to the contrary in this Agreement, Administrator agrees [redacted] and any present or future shareholders, directors or officers of the Provider are not personally liable or responsible for any of the Provider's fees, obligations, debts or expenses of whatsoever nature owed hereunder by Provider to Administrator and/or any subcontractors nor for any Office Expenses, Administrative Fees, debts, obligations or other liabilities owed by Provider or Administrator to any third parties or other claimants.

8.5 Obligation of Provider. The Provider's obligation to pay Administrator in any tax period shall not be greater than the Provider's "ability to pay". "Ability to pay" is defined as the Provider's net earnings, plus depreciation and amortization expense in such period. If the Provider is determined not to have the ability to pay in any period, the Administrator may seek recovery of the deficiency from other professional entities which are under common ownership with the Provider at that time and are also parties to administrative service agreements with the Administrator, but only to the extent of such entities' ability to pay. Further, Provider consents to the recovery of amounts from it by Administrator under provisions in such other administrative service agreements corresponding to the preceding sentence, to cover deficiencies of professional entities under common ownership with the Provider at that time, to the extent Provider has the ability to pay such recoveries.

8.6 Business Expenses and Administrative Fee payment schedule and amount:

8.6.1 Each month the Provider pays the "Provider Expenses" and the "Office Expenses" as required under paragraphs 8.1 and 8.2 above from the Adjusted Gross Revenue

8.6.2 After the payments required under 8.6.1 are made the "Administrative Fee" shall be paid on a monthly basis equal to thirty percent (30%) of the Adjusted Gross Revenue attributable to the applicable month.

8.6.3 All remaining funds belong to the Provider. The Provider may instruct the Administrator to maintain or distribute said funds as Provider in its sole discretion decides.

9. Peer Review. Provider and Administrator shall cooperate to develop, from time to time, peer review procedures for the Dentists and non-dentist personnel providing services to patients of Provider. Provider shall provide Administrator with prompt notice of any material quality of care concerns relating to any Dentists or any non-dentist personnel providing services on behalf of Provider and shall also provide a corrective action plan for issues. Provider shall implement, and Administrator will support such corrective actions that Provider determines are necessary or appropriate to comply with the then current peer review procedures, community standards and laws. Provider will also comply with, and participate in, all peer review programs of any entity with whom Administrator and Provider contracts, including, but not limited to, payers.

10. Reserved.

11. Termination.

11.1 Termination by Administrator or Provider without Cause. Administrator or Provider may terminate this Agreement at any time without cause upon three hundred sixty (360) days advance written notice to the other party.

11.2 Immediate Termination by Administrator. Administrator shall have the right, but not the obligation, to terminate this Agreement immediately upon notice to Provider of any of the following events:

11.2.1 The revocation, suspension, cancellation or restriction, in any manner, of the license to practice dentistry in this State and/or the DEA registration of any shareholder of Provider.

11.2.2 The conviction of Provider or any shareholder of Provider of any crime punishable as a felony under federal or state law or of any material health care crime.

11.2.3 The cancellation or non-renewal of the professional or malpractice insurance of Provider or any shareholder of Provider.

11.2.4 The dissolution of Provider.

11.2.5 The suspension or exclusion of Provider or any shareholder of Provider from any state or federal healthcare program (e.g., Medicare, or TRICARE).

11.2.6 The date of death or permanent disability of any shareholder of Provider.

11.2.7 The date any shareholder of Provider becomes disqualified under applicable law to be a shareholder of the Provider.

11.2.8 Failure of the Provider to pay amounts owed under Section 8, provided that, Administrator shall first provide Provider with written notice of Provider's failure to timely reimburse Administrator for expenses or pay the Administrative Fee, and Provider shall have 5 days to cure such failure to pay.

11.3 Termination by Either Party. This Agreement may be terminated as follows:

11.3.1 by mutual written agreement of the parties.

11.3.2 By either party upon a material breach of a material provision hereof by the other party, provided that the non-breaching party provides the breaching party with sixty (60) days' written notice of any such breach, during which period of time the breaching party shall have the opportunity to cure any such breach (or in the event of a non-monetary breach which is not curable within such sixty (60) day period the breaching party shall have the opportunity to commence cure of any such breach). If any such breach is cured by the breaching party during such period of time (or in the event of a non-monetary breach which is not curable within such sixty (60) day period but the breaching party has commenced to cure such breach and does continue to cure such breach with the exercise of due diligence), it shall be as if such breach never occurred and this Agreement shall continue in full force and effect, unaffected by the non-breaching party's notice.

11.3.3 By either party pursuant to Section 15.17 ("Limited Renegotiation") hereof.

11.4 Termination Obligations. In the event of termination for any reason, Provider (and not Provider's shareholders personally) shall pay all "Office Expenses" and Administrative fees owing to Administrator pursuant to Section 8 hereof through and including the date of termination.

11.5 Effect of Termination. Except as otherwise provided herein or in any amendment hereto, following the effective date of termination of this Agreement:

11.5.1 The Agreement between the Provider and Administrator relating to the maintenance and storage of patient records shall become effective immediately.

11.5.2 For a period of six (6) months following termination of this Agreement, Administrator shall continue to permit the Provider or its authorized representatives to conduct financial audits relating only to Administrator's provision of services under this Agreement; provided that, Provider first provides Administrator with reasonable notice and performs any audit at a mutually agreed upon time and place and upon such other terms and conditions as Provider may reasonably request;

11.5.3 Reserved

11.5.4 Administrator and Provider shall cooperate in connection with the termination or assignment of other contractual arrangements, if applicable;

11.5.5 Administrator and Provider shall cooperate in the preparation of final financial statements and the final reconciliation to fees paid hereunder, which shall be calculated by Administrator within six (6) months after termination of this Agreement;

11.5.6 Upon termination or expiration of this Agreement, the Provider shall return to Administrator any and all property of Administrator which may be in their possession or under their control.

11.5.7 After termination of this Agreement for any reason, in the event that any tax audits arise which cover only tax years of the Provider prior to the termination date but while this Agreement was in effect, Administrator shall be responsible for the reasonable costs and expenses of all professional fees in connection with such audits. After the termination date, in the event any tax audits arise which cover only tax years of the Provider after the termination date, Administrator shall have no responsibility for the costs and expenses of professional fees in connection with such audit. After the termination date, in the event any tax audits arise for tax years of the Provider both prior to and following the termination date, Administrator shall be responsible for a portion of the reasonable costs and expenses of all professional fees in connection with such audits. Such portion will be based upon a fraction, the numerator of which is the additional taxes payable pursuant to such audits for years of the Provider prior to the termination date and the denominator of which is the additional taxes payable pursuant to such

audits for all years covered by such audits. Administrator shall not, however, be responsible for the taxes and penalties owed by the Provider.

11.5.8 Administrator shall prepare and file, or cause to be prepared and filed, all tax returns for the Provider for the periods covering the Effective Date of this Agreement through the termination date. All Tax Returns shall first be submitted to Provider, for its consent and approval, prior to filing within thirty (30) days prior to filing. Administrator shall agree to indemnify, defend and hold Provider harmless from any claim arising with respect to any tax return which Administrator prepared except to the extent that a claim is based upon false or fraudulent information provided to Administrator by Provider or its agents or shareholders.

11.5.9 Administrator and Provider shall (i) each provide the other with such assistance as may reasonably be requested by any of them in connection with the preparation of any return, audit, or other examination by any taxing authority or judicial or administrative proceedings relating to liability for taxes, (ii) each retain and provide the other with any records or other information that may be relevant to such return, audit or examination, proceeding or determination, and (iii) each provide the other with any final determination of any such audit or examination, proceeding, or determination that affects any amount required to be shown on any tax return of the other for any period.

12. Records and Recordkeeping.

12.1 Access to Information. Provider hereby authorizes and grants to Administrator full and complete access to all information, instruments and documents relating to Provider which may be reasonably requested by Administrator to perform its obligations hereunder, and shall disclose and make available to representatives of Administrator for review and photocopying all relevant books, agreements, papers and records of Provider, except as otherwise limited by law or regulation.

12.2 Patient Records.

12.2.1 In addition to the obligations under paragraph 7.6 above, Administrator shall be allowed to retain and maintain patient dental records on behalf of Provider as custodian. Provider shall be afforded unfettered access to such records by computer in this state, in full compliance with applicable laws and regulations. To the extent permitted by applicable law, Administrator shall be permitted to retain true and complete copies of such records, at its expense.

12.2.2 At all times during and after the term of this Agreement, all business records and information, including, but not limited to, all books of account and general administrative records and all information generated under or contained in the information system pertaining to Provider, relating to the business and activities of Administrator, shall be and remain the sole property of Administrator.

12.2.3 Provider acknowledges that Administrator is the sole owner of Administrator's software systems set forth in Paragraph 5.1 and the Provider's limited license to

use the software systems is shared with other users including the Administrator's other clients. Provider shall have no license or other right to copy, use, or transfer any rights to such systems, except for the right of access to the medical/dental information of patients as set forth herein and as required by law.

12.2.4 Provider shall at all times during the Term, and at all times thereafter, make available to Administrator for inspection by its authorized representatives, during regular business hours, at the principal place of business of Provider, any Provider records determined by Administrator to be necessary to perform its services and carry out its responsibilities hereunder or necessary for the defense of any legal or administrative action or claim relating to said records. Provided such right shall be in compliance with applicable laws and regulations.

12.3 Confidentiality of Records. Administrator and Provider will adopt procedures to assure the confidentiality of the records relating to the operations of Administrator and Provider, including, but not limited to, all statistical, financial and personnel data related to the operations of Administrator and Provider, which information is not otherwise available to third parties publicly or by law.

12.4 Maintenance, Retention and Storage of Records. In addition to the requirements of paragraphs 7.6 and 12.2 hereof, Administrator agrees to maintain, retain and store on behalf of Provider all records in its possession, including, but not limited to, patient medical records, at its sole cost and expense, for the longer of (i) five (5) years, (ii) in cases of patients under minority, their complete records shall be retained for the period of not less than one (1) year after the minor reaches the age of majority, or five (5) years from the date of Provider's last professional contact with the patient, whichever is longer, (iii) in the case of mentally incompetent patients, their dental records shall be maintained indefinitely or (iv) the period required by applicable law. Patient dental records shall be retained by Administrator in such form and manner as required by applicable law. Thereafter, Administrator shall be entitled to dispose of such records as it deems necessary or appropriate; provided, however, Administrator shall provide prior written notice to Provider of its intent to dispose of such records and shall provide Provider with a sixty (60) calendar day period, from the date that such notice is given by Administrator, for Provider to take control of or copy any or all of the records to be disposed of by Provider, at the sole cost and expense of Provider, to the extent permitted by applicable law.

12.5 HIPAA. Administrator has entered into a Business Associate Addendum with Provider and as such agrees to comply with all applicable federal, state and local laws, including without limitation the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all implementing regulations issued pursuant thereto, as may be amended from time to time.. Administrator shall protect the confidentiality, privacy and security of all medical records or other health-related information that Administrator or any employee or agent of Administrator creates or receives for or from Provider pursuant to this Agreement. Administrator agrees to comply with the HIPAA Business Associate Addendum attached hereto as Exhibit 12.5 and incorporated herein by this reference.

13. Intellectual Property and Other Proprietary Information.

13.1 Limited License of "ReachOut Healthcare America" Name and Logo. Pursuant to Section 5.1, Administrator grants to Provider the nonexclusive right and license to use the name "ReachOut Healthcare America" and any related trademarks and logos based on the mark "ReachOut Healthcare America" (collectively, the "Marks") during the term of this Agreement and subject to the prior written approval of Administrator.

13.2 Provider Outcomes and Other Data. Provider agrees to provide Administrator with access, without charge, to the outcomes and other data developed by Provider for Administrator's use in the operations of Provider.

13.3 Use of Information System (IS). The Provider shall use all software and hardware provided by Administrator as described in Paragraph 5.1 pursuant to this Agreement only for the purpose of conducting the Practice and solely in accordance with and subject to all of the terms and conditions of any license or sublicense agreements, leases or any other agreements that such software and hardware are subject to, and shall not allow or permit any person to use the software or hardware or any portion thereof in violation of this Agreement or any such license, sublicense, agreements, lease or any other agreements.

13.4 Confidentiality. Provider acknowledges that during the course of its relationship with Administrator hereunder, Provider may be given access to or may become acquainted with Confidential Business Information (as defined below) of Administrator. In recognition of the foregoing and in addition to any other requirements of confidentiality under applicable law, Provider hereby agrees not to disclose or use any of the Confidential Business Information (except in connection with the services rendered to Provider hereunder) during the Term of this Agreement and an additional period of five (5) years thereafter. For purposes of this Agreement, "Confidential Business Information" shall mean any and all information, know-how and data, technical or non-technical, whether written, oral, electronic, graphic or otherwise of Administrator that is reasonably considered or treated as confidential and proprietary whether labeled as confidential or not, and shall include, but not be limited to:

(a) Business methods;
(b) Any dental practice activities and locations;
(c) Billing policies, procedures, processes and records;
(d) Tax returns and records;
(e) Any records, memoranda and correspondences dealing with the business of Administrator;
(f) Policies, including the Policies, Procedures and Protocols;
(g) Financial, pricing and operational information, including all insurance records;
(h) Internal memoranda, emails or correspondence;
(i) Form agreements, checklists or pleadings;
(j) Officer, director and shareholder information;
(k) Suppliers, marketing, and other information and know-how, all relating to or useful in Administrator's business and which have not been disclosed to the general public;
(l) Operational and business systems, policies and procedures;

(m) Software and processes, including those set forth in 5.1; systems design; and algorithms;
(n) Business strategies;
(o) Business opportunities;
(p) Customer lists and information but not patient records and information as this is the property of the Provider;
(q) Research and technical information;
(r) Outcomes and related data; and
(s) Intellectual property, know-how and trade secrets.

Provider agrees and acknowledges that the Confidential Business Information of Administrator as such may exist from time to time, constitutes valuable, confidential, special and unique assets of Administrator. The parties hereto agree that the documents relating to the business of Administrator, including all Confidential Business Information, are the exclusive property of Administrator. Provider understands and agrees that its obligations and duties under this Section do not cease upon termination of this Agreement and, further, Provider shall return all such documents (including any copies thereof) to Administrator immediately upon the termination of this Agreement.

14. Reserved.

15. Miscellaneous.

15.1 Indemnification.

15.1.1 Indemnification by Provider. Provider (and not its shareholders personally) hereby agrees to indemnify, defend and hold harmless Administrator, its officers, directors, owners, members, employees, agents, affiliates and subcontractors, from and against any and all claims, damages, demands, diminution in value, losses, liabilities, actions, lawsuits and other proceedings, judgments, fines, assessments, penalties, awards, costs and expenses (including reasonable attorneys' fees), whether or not covered by insurance, arising directly or indirectly, in whole or in part, out of (a) any breach of this Agreement by Provider or (b) any acts or omissions by Provider, its shareholders, employees, Dentists, non-dentist personnel, agents or subcontractors not directly supervised by Administrator. The provisions of this Section 15.1.1 shall survive termination or expiration of this Agreement. Provider shall immediately notify Administrator of any lawsuits or actions, or any threat thereof, that are known or become known to Provider that might adversely affect any interest of Provider or Administrator whatsoever.

15.1.2 Indemnification by Administrator. Administrator hereby agrees to indemnify, defend with attorney of Provider's selection(but subject to Administrator's reasonable approval) and hold harmless Provider, its officers, directors, shareholders, employees and agents, including its shareholders, from and against any and all claims, damages, demands, losses, liabilities, actions, lawsuits and other proceedings, judgments and awards, and costs and expenses (including reasonable attorneys' fees), arising, directly or indirectly, in whole or in part, out of (a) any material breach of this Agreement by Administrator, (b) any intentional acts, negligence or omissions by Administrator to the extent that such is not paid or covered by the

proceeds of insurance; provided, however, such indemnity agreement shall not apply to any portion of any such loss, claim, damage, obligation, penalty, judgment, award, liability, cost, expense or disbursement to the extent it is found in a final judgment by a court of competent jurisdiction (not subject to further appeal) or pursuant to binding arbitration pursuant to Section 15.2 hereof, to have resulted from the acts, omissions, negligence or willful misconduct of Provider, Provider dentists or staff or its shareholders (as the case may be). Notwithstanding anything else Administrator shall not reimburse or indemnify the Provider for any lost profits or diminution in value of Provider or the contractual relationship with the Administrator. The provisions of this Section 15.1.2 shall survive termination or expiration of this Agreement. Notwithstanding the foregoing, Administrator shall not indemnify Provider for the acts or omissions of Provider, its shareholder, the Dentists, the non-dentist personnel or others employed or engaged by Provider not directly supervised by Administrator. Administrator shall immediately notify Provider of any lawsuits or actions, or any threat thereof, that are known or become known to Administrator that might adversely affect any interest of Administrator or Provider whatsoever. In conformance with the provisions of this paragraph 15.1.2

15.2 Arbitration. All parties agree that any and all disputes shall be submitted to binding arbitration and the arbitrator shall be one individual. All arbitration hearings shall be held in Phoenix, Arizona at Administrator's office (or at the location of the then current primary office). Any decision of the arbitrator shall be binding, final and capable of being reduced to final judgment in any court of competent jurisdiction including but not limited to those of Arizona and this state. The arbitrator shall be entitled to issue decisions involving injunctive and other equitable relief. Each party shall pay one-half the cost of arbitration including the arbitrator's fee. Each party shall pay its reasonable attorney's fees and costs. The arbitrator upon the showing of reasonable necessity shall grant discovery. Each party shall submit a name of an attorney licensed in the State of Arizona in good standing as possible arbitrator to the other. None of the arbitrators submitted by either party shall be past or present business associates, attorneys of either party or its principals or personal friends. If one of the named attorneys is acceptable to both parties said person shall be selected arbitrator. If neither is mutually acceptable said nominated attorneys shall select a third qualified attorney to serve as arbitrator. The proceeding shall be a private arbitration, however, to the extent possible and not in conflict with this paragraph the general rules of the America Arbitration Association shall be followed. In the event there is conflict or ambiguity between the terms of this arbitration clause and the American Arbitration Association rules this arbitration clause shall control.

15.3 Headings Article and Section headings used in this Agreement are for convenience of reference only and shall not constitute a part of this Agreement for any other purpose or affect construction of this Agreement.

15.4 Entire Agreement; Amendment. This Agreement, along with any Agreement of Succession, constitutes the entire agreement between the parties related to the subject matter hereof and supersedes all prior agreements, understandings, and letters of intent relating to the subject matter hereof. This Agreement may be amended or supplemented only by a writing executed by both parties.

15.5 Relationship of the Parties. The relationship of the parties is and shall be that of independent contractors, and nothing in this Agreement is intended as, and nothing shall be construed to create, an employer/employee relationship, partnership, or joint venture relationship between the parties, or to allow either to exercise control or direction over the manner or method by which the other performs the services that are the subject matter of this Agreement; provided, however, that the services to be provided hereunder shall always be furnished in a manner consistent with the standards governing such services and the provisions of this Agreement.

15.6 Notices. Any notice or other communication required or desired to be given to either party shall be in writing and shall be deemed given when hand-delivered or deposited in the United States mail, first-class postage prepaid, addressed to the parties at the addresses indicated on the first page hereto. Any party may change the address to which notices and other communications are to be given by giving the other parties notice of such change.

15.7 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which, when taken together, will constitute one and the same instrument.

15.8 Governing Law. This Agreement shall be construed and governed in accordance with the laws of the State of California, without reference to conflict of law principles.

15.9 Assignment. This Agreement may only be assigned with the written consent of the non-assigning party, which consent my not be unreasonably withheld. There is no consent required from Provider for Administrator's assignment of this Administrative Agreement to a third party in the event of a sale or transfer to a third party which occurs as a part of a sale of a "significant portion" of the assets (or stock) in Administrator or its the holding company. A "significant portion" is defined as more than fifty percent (50%) of the stock or assets of Administrator or its holding company.

15.10 Waiver. Waiver of any agreement or obligation set forth in this Agreement by either party shall not prevent that party from later insisting upon full performance of such agreement or obligation and no course of dealing, partial exercise or any delay or failure on the part of any party hereto in exercising any right, power, privilege, or remedy under this Agreement or any related agreement or instrument shall impair or restrict any such right, power, privilege or remedy or be construed as a waiver therefore. No waiver shall be valid against any party unless made in writing and signed by the party against whom enforcement of such waiver is sought.

15.11 Binding Effect. Subject to the provisions set forth in this Agreement, this Agreement shall be binding upon and inure to the benefit of the parties hereto and upon their respective successors and assigns.

15.12 Attorneys. The Provider and the Administrator acknowledge that this Agreement has been negotiated and prepared by legal counsel for both the Provider and Administrator.

15.13 Severability. If any one or more of the provisions of this Agreement is adjudged to any extent invalid, unenforceable, or contrary to law by a court of competent jurisdiction, each and all of the remaining provisions of this Agreement will not be affected thereby and shall be valid and enforceable to the fullest extent permitted by law.

15.14 Force Majeure. Either party shall be excused for failures and delays in performance of its respective obligations under this Agreement due to any cause beyond the control and without the fault of such party, including without limitation, any act of God, war, terrorism, bio-terrorism, riot or insurrection, law or regulation, strike, flood, earthquake, water shortage, fire, explosion or inability due to any of the aforementioned causes to obtain necessary labor, materials or facilities. This provision shall not, however, release such party from using its best efforts to avoid or remove such cause and such party shall continue performance hereunder with the utmost dispatch whenever such causes are removed. Upon claiming any such excuse or delay for non-performance, such party shall give prompt written notice thereof to the other party, provided that failure to give such notice shall not in any way limit the operation of this provision.

15.15 Authorization for Agreement. The execution and performance of this Agreement by Provider and Administrator have been duly authorized by all necessary laws, resolutions, and corporate or partnership action, and this Agreement constitutes the valid and enforceable obligations of Provider and Administrator in accordance with its terms.

15.16 Duty to Cooperate. The parties acknowledge that the parties' mutual cooperation is critical to the ability of Administrator to perform successfully and efficiently its duties hereunder. Accordingly, each party agrees to cooperate fully with the other in formulating and implementing goals and objectives which are in Provider's best interest.

15.17 Limited Renegotiation. This Agreement shall be construed to comply with any and all federal and state laws, including laws relating to Medicare, Denti Cal and other third party payers and Dental Board Regulations. In the event there is a change in such laws, whether by statute, regulation, agency or judicial decision or guidance that has any material effect on any term of this Agreement, then the applicable term(s) of this Agreement shall be subject to renegotiation and either party may request renegotiation of the affected term or terms of this Agreement, upon written notice to the other party, to remedy such condition.

The parties expressly recognize that upon request for renegotiation, each party has a duty and obligation to the other only to renegotiate the affected term(s) in good faith and, further, each party expressly agrees that its consent to proposals submitted by the other party during renegotiation efforts shall not be unreasonably withheld.

Should the parties be unable to renegotiate the term or terms so affected so as to bring it/them into compliance with the statute, regulation or judicial opinion or guidance that rendered it/them unlawful or unenforceable within ninety (90) days of the date on which notice of a desired renegotiation is given, then either party shall be entitled, after the expiration of said ninety (90) day period, to terminate this Agreement upon ninety (90) additional days written notice to the other party.

IN WITNESS WHEREOF, the parties have executed this Administrative Services Agreement as of the day and year first above written.

[redacted] DDS, Professional Corporation

By its President [redacted]

[redacted]

By its President

EXHIBIT 12.5

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum ("Addendum") amends and is made part of that certain Administrative Services Agreement is effective April 23, 2009 by and between [redacted] DDS, Professional Corporation ("Provider") or its assignee) , and ReachOut Healthcare America, LTD., a Delaware corporation ("Administrator") or its assignee.

Provider and Administrator agree that the parties incorporate this Addendum into the Agreement in order to be in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations (45 C.F.R. Parts 160 and 164) (the "Privacy and Security Rules"). It is the understanding of the parties that Administrator is acting as a business associate (as defined under HIPAA and the Privacy and Security Rules) of Provider when performing its services under the Agreement.

1. Privacy of Protected Health Information.

1.1 *Prohibition on Unauthorized Use or Disclosure.* Administrator will neither use nor disclose Protected Health Information it creates or receives for or from Provider except as permitted or required by this Addendum or as permitted or Required By Law.

1.1.1 *In General.* Administrator is permitted to use and disclose Protected Health Information it creates or receives for or from Provider:

(a) to perform any and all obligations of Administrator as described in the Agreement, provided that such use or disclosure is consistent with the terms of Provider's notice of privacy practices and would not violate the Privacy and Security Rules if done by Provider directly; or

(b) As otherwise permitted by law, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Provider directly.

Administrator may disclose Protected Health Information to subcontractors and agents to the extent necessary to assist Administrator in using Protected Health Information for the purposes set forth in this Addendum Section 1.1.1, provided that Administrator complies with Addendum Section Article 1.4.

1.1.2 *Administrator's Operations.* Administrator may use Protected Health Information it creates or receives for or from Provider as necessary for Administrator's proper administration and to carry out Administrator's legal

responsibilities (collectively, "Administrator's Operations"). Administrator may disclose Protected Health Information as necessary for Administrator's Operations only if:

(a) The disclosure is required by law; or

(b) Administrator obtains reasonable assurance from any person or organization to which Administrator will disclose such Protected Health Information that the person or organization will: (1) hold such Protected Health Information in confidence and use or further disclose it only for the purpose for which Administrator disclosed it to the person or organization or as permitted or Required By Law; and (2) notify Administrator of any instance of which the person or organization becomes aware in which the confidentiality of such Protected Health Information was breached.

1.2 *De-Identification; Data Aggregation.* Administrator may De-identify any Protected Health Information that it receives or creates and may use or disclose such De-identified information in any manner permitted by applicable law. Administrator may use or disclose Protected Health Information to provide Data Aggregation Services.

1.3 *Information Safeguards.* Administrator will use appropriate administrative, technical and physical safeguards to prevent use or disclosure of Protected Health Information created or received for or from Provider (except for uses or disclosures provided for by this Addendum). Administrator agrees to implement administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that Administrator creates, receives, maintains or transmits on behalf of Provider.

1.4 *Subcontractors and Agents.* Administrator will require any of its subcontractors and agents, to which Administrator discloses any of the Protected Health Information that Administrator creates or receives for or from Provider, to agree by written contract to comply with the same privacy and security obligations as Administrator with respect to such Protected Health Information.

2. Protected Health Information Access, Amendment and Disclosure Accounting.

2.1 *Access.* To the extent required for Covered Entities by 45 C.F.R. § 164.524, Administrator will permit Provider or, at Provider's request, an individual (or the individual's personal representative) to inspect and obtain copies of any Protected Health Information about the individual that Administrator created or received for or from Provider and that is in Administrator's custody or control. Administrator will notify Provider of any request (including, but not limited to, subpoenas) that Administrator receives for access to Protected Health Information that is in Administrator's custody or control within three (3) business days of receipt of such request. Provider shall be responsible for making determinations about access.

2.2 *Amendment.* Administrator will, upon receipt of notice from Provider, promptly amend or permit Provider access to amend any portion of the Protected Health Information that Administrator created or received for or from Provider and that is in Administrator's custody or control so that Provider may meet its amendment obligations under 45 C.F.R. § 164.526.

2.3 *Disclosure Accounting.* To assist Provider in meeting its disclosure accounting obligations under 45 C.F.R. § 164.528:

2.3.1 *Disclosure Tracking.* Administrator will record for each disclosure, not excepted from disclosure accounting under Addendum Section 2.3.2 below, that Administrator makes to a third party of Protected Health Information that Administrator creates or receives for or from Provider, (i) the disclosure date, (ii) the name and (if known) address of the person or Provider to whom Administrator made the disclosure, (iii) a brief description of the Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure. Items (i)–(iv) are collectively referred to as the "Disclosure Information." Administrator will make this Disclosure Information available to Provider promptly upon Provider's request.

2.3.2 *Exceptions from Disclosure Tracking.* Administrator need not record disclosure information or otherwise account for disclosures of Protected Health Information to any recipient or for any purpose excluded from the accounting obligation by the Privacy and Security Rules.

2.3.3 *Disclosure Tracking Time Periods.* Administrator shall have available for Provider the Disclosure Information required by Addendum Section 2.3.1 for the six (6) years preceding Provider's request for the Disclosure Information (except Administrator need have no Disclosure Information for disclosures occurring before the Effective Date of this Agreement).

2.4 *Inspection of Books and Records.* Administrator will make its internal practices, books, and records, relating to its use and disclosure of the Protected Health Information it creates or receives for or from Provider, available upon request to Provider or the Secretary of U.S. Department of Health and Human Services to determine Provider's compliance with 45 C.F.R. Part 164, Subpart E.

3. Breach of Privacy Obligations.

3.1 *Reporting.* Administrator will promptly report to Provider any use or disclosure of Protected Health Information not permitted by this Addendum of which Administrator becomes aware. Administrator will also promptly report to Provider any Security Incident involving electronic Protected Health Information of which Administrator becomes aware.

3.2 *Mitigation.* Administrator shall mitigate, to the extent practicable, any harmful effect that is known to Administrator of a use or disclosure by Administrator or

by any subcontractor or agent of Administrator in violation of this Addendum or applicable law.

4. Term and Termination of Addendum.

4.1 *Term.* This Addendum shall be effective as of the Effective Date of the Agreement and shall remain in effect until termination of the Agreement.

4.2 *Obligations upon Termination.* Upon termination of the Agreement for any reason, Administrator will, if feasible, return to Provider or destroy all Protected Health

Information maintained by Administrator in any form or medium that Administrator created or received for or from Provider, including all copies of such Protected Health Information. Further, Administrator shall recover any Protected Health Information in the possession of its agents and subcontractors and return to Provider or destroy all such Protected Health Information. In the event that Administrator determines that returning or destroying any Protected Health Information is infeasible, Administrator shall promptly notify Provider of the conditions that make return or destruction infeasible. With regard to any Protected Health Information that cannot feasibly be returned to Provider or destroyed, Administrator may maintain such Protected Health Information but shall continue to abide by the terms and conditions of this Addendum with respect to such information and shall limit its further use or disclosure of such information to those purposes that make return or destruction of the information infeasible.

4.3 *Survival.* Upon termination of this Addendum for any reason, all of Administrator's obligations under this Addendum shall survive termination and remain in effect (a) until Administrator has completed the return or destruction of Protected Health Information as required by Addendum Section 4.2 and (b) to the extent Administrator retains any Protected Health Information created or received for or from Provider pursuant to Addendum Section 4.2.

5. General Provisions.

5.1 *Definitions.* Capitalized terms used in this Addendum and not otherwise defined shall have the meanings set forth in the Privacy and Security Rule. The term "De-identify" shall mean to create information that is de-identified in accordance with the requirements of 45 CFR 164.514(b).

5.2 *Amendment.* In the event that any final regulation or amendment to final regulations is promulgated by the U.S. Department of Health and Human Services or other government regulatory authority with respect to Protected Health Information, the parties will negotiate in good faith to amend this Addendum to remain in compliance with such regulations.

5.3 *Regulatory References.* A reference in this Addendum to a section in the Privacy and Security Rules means the section as in effect or as amended.

5.4 *Interpretation.* Any ambiguity in this Addendum shall be resolved to permit Provider to comply with the Privacy and Security Rules. References in this Addendum to Protected Health Information created or received for or from Provider shall be interpreted to include, but not be limited to, Protected Health Information received by Administrator from other business associates of Provider on behalf of Provider. Nothing in this Addendum shall be construed to create any rights or remedies in any third parties.

6. Conflicts. The terms and conditions of this Addendum override and control any conflicting term or condition of the Agreement. All non-conflicting terms and conditions of the Agreement remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this HIPAA Business Associate Addendum as of the day and year first above written

[redacted] DDS, Professional Corporation
By its President

ReachOut Healthcare America, LTD.,
A Delaware corporation

[redacted]
By its President

EXHIBIT 34

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") is dated as of July 1, 2009 by and between ReachOut Healthcare America, LTD., a Delaware corporation (the "Administrator"), and a professional corporation owned by a Colorado licensed dentist entitled Big Smiles Colorado PC ("Provider").

BACKGROUND

A. Provider's owner and President is a licensed dentist under the laws of the state of Colorado and in good standing with the Colorado dental board.

B. Administrator has special expertise and experience in the administrative aspects of portable dental practices for long term care facilities and assisted living facilities. Administrator has made a significant investment in the development of computer software and systems addressing certain non dental administrative functions which are desirable to Provider.

DEFINITIONS

A. "Administrative Fee" shall mean the amount hereinafter described under Section 9 and which amount is payable to the Administrator.

B. "Office Expense" shall mean the amount described under Section 9 and includes all operating and non-operating expenses incurred by the Administrator in support of the providing of dental services by Provider. Office Expense shall not include any expense that is strictly a Provider Expense. For any common Office Expense that is not specifically attributable exclusively to the instant Provider but are for the benefit of the instant Provider and other dentists or dental professional corporations in and out of Colorado then they shall be allocated in a fair and equitable manner with the other dentists an/or dental professional corporations based upon the number of Dental Visit Events per entity per month (long term care nursing facility or assisted living facility or school dental visit in other states).

C. "Provider Expense" shall mean a dentist, dental support staff expense and any other expenses required by Colorado laws and regulations to be a duty and corresponding expense of the Provider.

D. "Dental Visit Event" is where the Provider's dentist and support staff go to a school out of home facilities for children or a long term care nursing facility or assisted living facility for a day to provide dental care in the facility.

NOW THEREFORE, in consideration of the mutual covenants and conditions hereinafter set forth and in exchange for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

AGREEMENT

1. Incorporation. The above Background recitals and Definitions are hereby incorporated into this agreement as if fully set forth herein.

2. Engagement of Administrator during this agreement in the state of Colorado. Provider hereby engages Administrator and the Administrator accepts this engagement on an exclusive basis in the state of Colorado. The Administrator shall provide administrative services to the Provider in support of the Provider's efforts to provide dental services to patients in schools and children out of home placement facilities ("Schools") and/or those long term nursing care facilities and/or assisted living facilities ("Nursing Homes") patients as the parties mutually agree, subject to the terms and conditions of this Agreement. This engagement has nothing to do with the Provider's private dental practice but only for dental activities at in Schools and/or Nursing Homes in the state of Colorado.

3. Term. This Agreement shall have an initial term commencing as of the Effective Date and continuing in full force and effect through ten years ("Initial Term"), and shall renew automatically for additional one (1) year terms thereafter, unless terminated as provided herein.

4. Termination by Administrator or Provider without Cause. Administrator or Provider may terminate this Agreement at any time without cause upon ninety (90) days advance written notice to the other.
5. General Duties and Responsibilities of Administrator. During the Term of this Agreement, subject to the provisions of Section 7.1, 7.2 and 7.3 herein, Administrator shall provide, in exchange for the Administrative Fee herein and payment of its Office Expense, all such administrative services as are necessary and appropriate for the day-to-day administration and support of Provider's Schools and/or Nursing Homes dental activities in a manner consistent with good business practice and the laws of the state of Colorado:
6. Specific duties of Administrator

6.1 Licenses. License to the Provider, for the purposes of this Agreement only, the following. This is a non exclusive license for use of the Adminsitrator's propriatary software program by Provider including its "paperless model" during the term of this agreement and only in support of this administrative agreement. :

- The use of all Administrator's computer hardware and servers needed to provide administrative support to the Provider
- The use of the Administrator's network software system needed to provide administrative support to the Provider.
- The use of the Administrator's proprietary Case Manager Software System whereby new patient registration information can be recorded in a patient registration form on the proprietary software program such as the health history and the treatment authorization. This information can be entered into the patient registration form on the software of the computer in a "fail safe" manner with warning if information is missing.
- The use of a proprietary software program where every Provider patient's complete records are retrievable promptly by entering the name and certain other information and thereby avoiding searching paper records.
- The use of the Administrator's proprietary "paperless model" software system so that all dental records, x-rays and patient information on every patient can be transmitted electronically to the Provider's dental team(s) wherever they are located and upon completion of the visit "up loaded" electronically to the server system.
- The use of the Administrator's commercial phone support system technologies needed to provide administrative support to the Provider.
- The use of the Administrator's two completely separate telephone recording systems so that all calls to and from patients, guardians, next of kin and Nursing Home staff and parents or guardians of the children in Schools, of the Provider dental business activities are automatically recorded twice.
- Provide all business support technology software needed to provide administrative support to the Provider.

6.2 Services Relating to Nursing Homes and Schools. Administrator shall provide the following business services to Provider in relation to the Nursing Homes and Schools per the Provider's direction but the Administrator shall not exercise any control over the Provider's dentists, dental staff, its office personnel or the hours of the practice in any manner or context:

- Work with the supervisory personnel of the Nursing Homes and Schools in regard to the manner in which the dental program will be physically

implemented including obtaining for the Provider the medical histories of the residents at the Nursing Home or students.

- Meet with the Nursing Homes and School nurses to further the implementation of the dental program.
- Arrange for each Nursing Home or School to have a person assigned as a support person for the dental visits at their Nursing Home and School and provide training to that support person relating to pre-visit, day of visit and post-visit protocols to be followed by the support personnel.
- Coordinate with the appropriate Nursing Home or School the potential schedule dates of the dental visits and the starting and finishing times and locations for the dental services to be rendered subject to the direction of the Provider when patient's shall be scheduled and starting and finishing times for the dental services to be rendered.
- Arrange to schedule the minimum number of dental visits at each Nursing Home or Schools that are required for the efficient use of Provider's time and assets.
- Assist each Nursing Home or School on the day of the visits to efficiently coordinate the attendance of the patients in order to effectively manage the Provider's time at the particular Nursing Homes or Schools.
- Obtain patient, parent, guardian, Schools and/or Nursing Homes satisfaction reports.
- Obtain background information including status of licenses, criminal background checks, and former employer's references on all potential employees or independent contractors of the Provider.
- Assist the Provider in obtaining the necessary information for the credentialing of any employee or independent contractor and submitting same to a potential insurance or governmental payer.

6.3 *Supplies and Equipment*. Administrator shall arrange for the purchase of all dental equipment dental supplies necessary for the operation of the Nursing Home and Schools practice as directed by the Provider and Provider shall maintain custody and control over all dental supplies and dental equipment.

7.1 *Sole Authority to Practice*. Notwithstanding the other provisions of this Agreement, Provider shall have exclusive authority and control over all healthcare aspects of Provider's patients including all diagnosis, treatment and ethical determinations which are required by law to be decided by a licensed professional. The clinical judgment of the licensed dentist shall be exercised solely for the benefit of his/her patients, and shall be free from any compromising control, influences, obligations, or loyalties.

7.2 *No Patient Referrals*. Neither Provider nor Administrator shall exercise any control or direction over the number, type, or recipient of patient referrals and nothing in this Agreement shall be construed as directing or influencing such referrals. No payment made under this Agreement shall be in return for the referral of patients or business, including those paid in whole or in part by federal or state government programs from the Provider to the Administrator or the Administrator to the Provider.

7.3 *Compliance with Corporate Practice of Medicine*. The parties hereto have made all reasonable efforts to ensure that this Agreement complies with the corporate practice of medicine prohibitions in the State of Colorado. The parties do not intend that any portion of this

Administrative Agreement shall provide for the Provider, whether by contract or employment, with or without fee, to use any practice management service which attempts to govern in any way, whether directly or indirectly, the clinical sufficiency, suitability, reliability or efficacy of a particular product, service, process or activity as it relates to the delivery of dental care. This instant agreement shall not:

(a) Preclude or otherwise restrict, by penalty or operation, the dentist of record's ability to exercise independent professional judgment over all qualitative and quantitative aspects of the delivery of dental care;

(b) Allow anyone other than a dentist of record or the dentist of record's practice to supervise and control the selection, compensation, terms, conditions, obligations or privileges of employment or retention of clinical personnel of the practice;

(c) Limit or define the scope of services offered by the dentist of record or the dentist of record's practice;

(d) Limit the methods of payment accepted by the dentist of record or the dentist of record's practice;

(e) Directly or indirectly condition the payment or the amount of the management fee on the referral of patients, and in addition, the administrative fee is agreed by the parties to reasonably relate to the fair market value of the services provided;

(f) The parties hereto understand and acknowledge that such laws may change, be amended, have guidance or have a different interpretation and the parties intend to comply with such laws in the event of such occurrences.

8. Responsibilities of Provider. Provider shall solely own and operate its dental program at Schools and in Nursing Homes conformity with Colorado laws and regulations.

9. Financial Arrangements; Application of Payments. The parties agree that the obligations of the Practice will be paid in the order set out below:

9.1 *Payments*.

Each month, the Provider shall pay expenses and fees from the Account as follows:

1. Pay all "Provider Expenses" for the given month.
2. Pay to the Administrator the amount of all "Office Expenses" incurred for Provider by the Administrator for the given month.
3. Pay the Administrator the "Administrative fee" the fees as set forth in the attached Exhibit Section 9.1.3
4. All remaining profits shall belong to the Provider.

9.2 No shareholder personal liability: There is no personal liability for the individual dentist owner of the Provider pursuant to Colorado corporate law under this Administrative Agreement as any office expenses and administrative fees are to be paid exclusively from the fees generated by the dental activities of the Provider entity and not from the dentist owner's other income or assets.

9.3 *Termination Obligations*. In the event of termination for any reason, Provider shall pay all "Office Expenses and Administrative fee owing to Administrator pursuant to Section 9.1 (1-4) hereof up through and including the date of termination.

10.1 *Patient Records*. The services herein shall include Administrator's maintenance of patient dental records on behalf of Provider as custodian and with Providers access to them at all times by computer in Colorado, in full accordance with all applicable laws and regulations regarding confidentiality and maintenance. To the extent permitted by applicable law, Administrator shall be permitted to retain true and complete copies of such records, at its expense. The Provider shall at all times exclusively own and control its patient records and direct all aspects of the storage during this Administrative agreement and after termination.

10.2 *Confidentiality of Patient Records*. Administrator and Provider will adopt procedures to assure the confidentiality of the records relating to the operations of Administrator and Provider, including, but not limited to, all statistical, financial and personnel data related to the operations of Administrator and Provider, which information is not otherwise available to third parties publicly or by law and each agrees

to hold this information in a confidential manner during the term of this Agreement and for thirty six months after termination.

11. *HIPAA*. Administrator, as a business associate of Provider, agrees to comply to the extent applicable with all applicable federal, state and local laws, including without limitation the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all implementing regulations issued pursuant thereto, as may be amended from time to time. Administrator agrees to comply with the HIPAA Business Associate Addendum attached hereto as Exhibit Section 11 and incorporated by reference and the necessary provisions of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act").

12. *Arbitration*. All disputes relative to interpretation of the provisions of this Agreement or any other dispute arising among the parties shall be resolved by binding arbitration pursuant to the rules of the American Arbitration Association. Arbitration proceedings shall be held in Phoenix, Arizona where the American Arbitration Association has an office. There shall be a single arbitrator selected to resolve disputes which Arbitrator shall be appointed by the American Arbitration Association pursuant to its rules. Each party shall pay its own expenses of arbitration, attorney fees and one-half of the expenses of the Arbitrator without regard to the results of the Arbitration. The cost of the Arbitration filing fee shall be split equally by the parties without regard to the outcome. There shall not be punitive damages, loss wages, lost income, or incidental damages awarded to either party under any circumstances.

13. *Entire Agreement; Amendment*. This Agreement constitutes the entire agreement between the parties related to the subject matter hereof and supersedes all prior agreements or understandings, relating to the subject matter hereof. This Agreement may be amended or supplemented only by a writing executed by both parties.

14 *Relationships of the Parties*. The relationship of the parties is and shall be that of independent contractors, and nothing in this Agreement is intended as, and nothing shall be construed to create, an employer/employee relationship, partnership, or joint venture relationship between the parties, or to allow either to exercise control or direction over the manner or method by which the other performs the services that are the subject matter of this Agreement; provided, however, that the services to be provided hereunder shall always be furnished in a manner consistent with the legal standards governing such services and the provisions of this Agreement.

15. *Limited Renegotiation*. This Agreement shall be construed to be in accordance with any and all federal and state laws, including laws relating to Medicare, Medicaid and other third party payers and Colorado Dental Board Regulations. In the event there is a change in such laws, whether by statute, regulation, agency or judicial decision or guidance that has any material effect on any term of this Agreement, then the applicable term(s) of this Agreement shall be subject to renegotiation and either party may request renegotiation of the affected term or terms of this Agreement, upon written notice to the other party, to remedy such condition.

16. This is the full agreement of the parties.

IN WITNESS WHEREOF, the parties have executed this Administrative Services Agreement as of the day and year first above written.

ReachOut Healthcare America, LTD.,
A Delaware corporation

[redacted]

Name: [redacted]
It's President

Provider's Name
Big Smiles Colorado PC

[redacted]

By its President [redacted] DDS
a licensed Colorado dentist

Exhibit Section 9.1.3

This Exhibit Section 9.1.3 is incorporated by reference into the instant Administrative Service Agreement.

ReachOut Healthcare America's menu for services and charges for those services selected.

Preamble:

Who we are and what we have to offer:

a. ReachOut is one of the largest administrative services company for individual dentists and corporations devoted to dental care in the country. We have a perfect ethical record. Our mission is to provide non-professional support to dentists who serve the needy. ReachOut does not provide any services that have anything to do with dental decisions. All dental decisions pertaining to the dentist's practice and patient care are exclusively left to the decision of the licensed dentist in each state.

b. ReachOut has in excess of 100 employees in its offices. These individuals have a variety of unique skills and knowledge in the field of administrative support for portable dentistry and traditional dental offices based on years of training and experience. The areas of expertise include but are not limited to areas such as marketing, advertising support, financial planning, human resources, payroll, payables, credentialing, recruiting, criminal background checks, billing and posting, legal, tax planning, budgeting, equipment maintenance, purchasing of supplies and national wide health insurance for you and your staff through companies such as Blue Cross with favorable group rates. ReachOut has a contract with the largest dental supply company in the world, Henry Schein, for their best price nationwide for supplies which will result in substantial savings to you. In addition, ReachOut has over $1,000,000 worth of computers and programs in what we call the "Virtual Computer System". Years of planning and execution have gone into the development of our computer system and it is a very unique and reliable system tailored to the needs of a dentist providing portable dental care and in traditional dental offices. The Virtual Computer System is a combination of software provided by various major corporations such as Microsoft and its Exchange system, its Client Relationship Manager and their financial software known as Great Plains: Schick's digital x-ray system, Dental Vision and their dental management software for billing and many other activities, Medifax, Digital Call Logger, Scan Document Manager and the powerful proprietary ReachOut Application System that we have developed over several years. These various software programs have been integrated into one system to perform multiple tasks with a maximum of performance, efficiency, reliability and reporting capacity. The use of any of the provided software program is restricted to the time when the instant Administrative Service Agreement is in force

and the license to use automatically terminates when the Administrative Service Agreement is terminated by either party.

c. All of the above has one purpose and that is to allow the dentist to practice dentistry while ReachOut performs the traditional front office activities with hi-tech systems. The dentist gives ReachOut detailed "marching orders" and we will perform according to the dentist's mandate. The dentist is the boss and we are the helpers. All our services are limited in scope to the extent mandated by the laws and dental board regulations in your state.

The following is what you have acquired with your Administrative Service Agreement and the cost of each service provided to you.

1. **Full time access to the Virtual Computer System**

Price: $700 per month for one dentist, $650 a month per dentist for from 2 to 5 dentists and $600 a month per dentist for 6 or more dentists with unlimited numbers of days of use each month.

You get a license and access to use the below parts of the Virtual Computer System for your practice:

- Exchange
- Microsoft office Suite
- Schick CDR – for storage of all digital x-rays
- Dental Vision
- Digital Call Logger
- Great Plains Accounting System
- Microsoft Client Relations Manager (CRM)
- Scan Doc Manager
- Medifax
- ReachOut Application software
- SAN storage – primary storage
- MD1000 – 2nd tier storage
- XR800 – Tape Drive for Offsite Backup
- T-1 bundler for transmission of visit data
- T-Tappers for call recording
- Buffalo storage for storage of recorded calls

2. **The ReachOut system for transmitting and receiving all dental records and instant retrieval storage system?**

Price: $700 a dentist per month, $650 a month for from 2 to 5 dentists and $600 a month per dentist for 6 or more dentists with unlimited number of days of use each month.

What you get:

- One computer tablet per dentist

- Application to bundle patent records, both current and historical including x-rays and prepare for transmission to field staff via secure website log to the computer tablet
- Application to receive electronic files of completed visits from the field which sent from the tablet and send a copy to storage and to billing
- Digitize and store Patient records in a secure location which are accessible at all times to you from the dentist's office or from wherever he or she is located with access to the internet.
- Catalog and stored Patient X-ray Files
- Maintain confidentiality, privacy and custody of all dental records for the dentist
- Maintain HIPAA standards for dental records for your practice

3. **Credentialing, criminal background check, billing, posting of payments and support system**

Price: $14 per patient billing and supportive services without regard to number of procedures or amount of billing for a patient. (All decisions as to credentialing standards, background checks, the billing amounts, selection of payers, arrangement for payments, discounts (if any), collection procedures and all other items relating to your relationship with the patient must be made by you in your professional judgment and we will only follow your orders)

What you get:

- Credential all dentists with all necessary payers,
- Obtain and insure that all dental licenses, malpractice insurance and DEA licenses are current
- Bill all patient charges to the appropriate payor
- Receive payments and post the payments
- Investigate discrepancies for non-payments
- Sending any chart errors of a non technical nature such as unsigned charts or not dated back to the doctor for review and correction
- Issue refunds or adjustments as directed by the dentist
- Send notification letters to patient's parent or guardian whenever the dentist has written on the chart that there is an outside referral required.
- Prepare report on patients name, school location and type of follow up work required so they are reappointed to the next visit

4. **Consent form program**

Price: Eighty (80) cents per consent form distributed with ReachOut being obligated for all out of pocket costs associated with the consent forms and their distribution.

What you get:

You will get a turn key program in that once you approve the content of the consent forms and where they are to be distributed, ReachOut will handle everything and pay all out of pocket costs.

- Maintaining updated demographic information on client's school sites
- Contacting school for distribution of flyers
- Subject to the direction of the dentist as to content and style, ReachOut shall have consent forms printed at ReachOut's cost per flyer
- Shipping consent forms to each school at ReachOut's bearing the shipment costs
  Getting the consent forms back from school

- Subject to the dentist's direction, determining the number of dental visits to conduct at the school based upon the number of flyers in an organized fashion
- Obtaining customer satisfaction reports from the schools and patients
- Sending reports to school nurses and principal itemizing the dental services provided for their students.

5. Contacting schools on your behalf to explain the logistical aspects of the program and record their decision to participate or not

Price: The actual labor cost of the employee plus their benefits at 150%.

What you get:

You will have a trained person under your direction calling and communicating with the schools that you select about your portable dental program and the logistics.

6. Scheduling dental visits at schools

Price: $75 per school day visit

What you get:

Pursuant to your metrics, determine which schools need a full day dental visit based upon the number of consent forms where the parent has said YES and are eligible with Medicaid and/ or are uninsured children that will be included in the full day visit and which patients need follow up treatment as established by your dental records or need to contacted for their recall
Contact those schools as which days they are available for the dentist and dental team to come to the school
Contact the dentist and dental team as to their availability to go to a specific school
Confirm in writing with the school and dental team the time, date and location in the school where the visit will take place.
Contact the school after the dental visit to determine their satisfaction or lack of satisfaction with the visit.
Communicate with the dentist about any issues of which we become aware that have occurred with the school day visit.

7. Data entry charge and reporting in regard to each patient on the school patient list for a dental visit

Price: $15 per patient

What you get:

Enter all the consent form information into the ReachOut application so the patient information and patient number is part of the permanent record.
Check on the payment eligibility of each patient or if they are uninsured and are being sponsored by a non profit organization

Verifying that the patient has not seen another dentist during the time period that Medicaid will provide this information so the patient can be advised to returned to their regular dentist
A report from the billing department as to the names of patients needs follow up work or a regular recall
Create an electronic list of the patients
Create an electronic file for each patient and include all historic charting, x-rays, and historic and current consent forms.
Send a list of proposed patients to the school nurse to verify each patient still attend and any students in pain that she/he wishes to add to the list.
Contact any parent wishing to be at the school during a dental visit for their child so he or she can attend.

8. Supplies selection and distribution per dentist's direction.

All supplies are selected and owned by the dentist and financing is available at commercial rates from ReachOut
(You pay for all supplies)

Price $200 a month dentist

What you get:

- Process and send supply orders from each dentist on demand and on a monthly schedule
- Maintain supply formulary
- Negotiate with suppliers for best pricing which includes getting for the dentist Henry Schein's best price for any dentist or institution in the country at great savings for the dentist.

9. Equipment

All equipment is selected and owned by the dentist and financing is available at commercial rates from ReachOut
(You pay for all equipment)

Price: $150 a month per dentist

What you get:

- Process and send equipment orders
- To the extent we can perform the routine repairs in our office we will perform that task (If we cannot do the repair in our office then all third party repair charges are borne by you at the actual costs by the third party as well as shipping charges. We will coordinate the shipping of any equipment needed to be repaired by a third party without charge by us)
- Routine maintenance equipment to help keep the equipment in proper working order
- Trouble shoot with staff on equipment issues as needed
- Maintain docimeter records (You must pay the lab fees for this verification of proper functioning of the x-ray head)
- Maintain lab sterilization records (You must pay the outside lab fees for this verification of proper functioning of the sterilizer)

10. **Complete Human Resources services:**

Price: $200 a month per employee or independent contractor

What you get.

- Help you have access to and maintain a proper work force of dentists and dental staff of your selection and with work schedules and pay schedules as you direct
- Place help wanted ads as necessary
- Field calls from help wanted ads
- Initial interviews of prospective employees, both staff and dentists
- Background check of all prospective staff
- Issuance of the dentist's employee handbook to all employed staff in compliance with state and federal laws
- Maintenance of weekly hours report for staff
- Preparation of payroll for staff
- Management of benefits for staff
- Management of vacation and personal time for staff
- Maintaining and updating your dentist's training manual as directed by you
- Maintaining all licensing for both equipment and staff current

11. **Monthly Dentist Activity Reports involving statistical analysis and comparisons of dental services provided among your dentists.**

Verifying that the patient has not seen another dentist during the time period that Medicaid will provide this information so the patient can be advised to returned to their regular dentist
A report from the billing department as to the names of patients needs follow up work or a regular recall
Create an electronic list of the patients
Create an electronic file for each patient and include all historic charting, x-rays, and historic and current consent forms.
Send a list of proposed patients to the school nurse to verify each patient still attend and any students in pain that she/he wishes to add to the list.
Contact any parent wishing to be at the school during a dental visit for their child so he or she can attend.

8. Supplies selection and distribution per dentist's direction.

All supplies are selected and owned by the dentist and financing is available at commercial rates from ReachOut
(You pay for all supplies)

Price $200 a month dentist

What you get:

- Process and send supply orders from each dentist on demand and on a monthly schedule
- Maintain supply formulary
- Negotiate with suppliers for best pricing which includes getting for the dentist Henry Schein's best price for any dentist or institution in the country at great savings for the dentist.

9. Equipment

All equipment is selected and owned by the dentist and financing is available at commercial rates from ReachOut
(You pay for all equipment)

Price: $150 a month per dentist

What you get:

- Process and send equipment orders
- To the extent we can perform the routine repairs in our office we will perform that task (If we cannot do the repair in our office then all third party repair charges are borne by you at the actual costs by the third party as well as shipping charges. We will coordinate the shipping of any equipment needed to be repaired by a third party without charge by us)
- Routine maintenance equipment to help keep the equipment in proper working order
- Trouble shoot with staff on equipment issues as needed
- Maintain docimeter records (You must pay the lab fees for this verification of proper functioning of the x-ray head)
- Maintain lab sterilization records (You must pay the outside lab fees for this verification of proper functioning of the sterilizer)

10. **Complete Human Resources services:**

Price: $200 a month per employee or independent contractor

What you get.

- Help you have access to and maintain a proper work force of dentists and dental staff of your selection and with work schedules and pay schedules as you direct
- Place help wanted ads as necessary
- Field calls from help wanted ads
- Initial interviews of prospective employees, both staff and dentists
- Background check of all prospective staff
- Issuance of the dentist's employee handbook to all employed staff in compliance with state and federal laws
- Maintenance of weekly hours report for staff
- Preparation of payroll for staff
- Management of benefits for staff
- Management of vacation and personal time for staff
- Maintaining and updating your dentist's training manual as directed by you
- Maintaining all licensing for both equipment and staff current

11. **Monthly Dentist Activity Reports involving statistical analysis and comparisons of dental services provided among your dentists.**

Price: $100 a month per dentist

What you get:

You get monthly reports setting forth for each dentist's statistical information such as number of patients seen each day, the number and type of procedures performed, the number of follow-up patients left at the end of a day's work and the number of outside referrals where the dentist did not feel the work should be done at the school. These reports will compare the performance of each of your dentist with other dentist that you employ

- Provide utilization reporting per overall and per dentists
- Provide follow-up statistical reporting
- Provide financial analysis

12. **Comprehensive Financial services:**

Price: $3,000 a month for up to 4 dentists and then $300 a month extra for each dentist over 4

What you get:

You will get an experience group of 5 experience people to handle all your practice's financial matters including all of the below items.

- Financial services for the entire practice such as accounting and bookkeeping, monitoring and payment of accounts receivable, payment of leases and subleases, payroll or benefits administration, payment with dentist's funds of federal or state income tax, personal

property or intangible taxes, administration of interest expense or indebtedness incurred to finance the operation of the dental practice, or malpractice insurance expenses. There will be created annual budgets based upon your factual impute.

Exhibit Section 11

HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement (HIPAA Agreement), effective as of July 1, 2009, is made by and between Covered Entity and ReachOut Healthcare America (ReachOut) for the purpose of compliance with the Health Insurance Portability and Accountability Act and its implementing administrative simplification regulations (45 CFR 160-164) (HIPAA) and Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH). This HIPAA Agreement hereby amends and is incorporated into any underlying agreement between Covered Entity and ReachOut; to the extent that the provisions of this HIPAA Agreement conflict with those of an underlying agreement, the provisions of this HIPAA Agreement shall control. Terms used but not otherwise defined herein shall have the same meaning as those terms defined in 45 CFR 160.103 and 164.501.

If, in the provision of services to Covered Entity, ReachOut representatives may receive or have access to Protected Health Information (PHI) that is created and/or maintained by Covered Entity, ReachOut shall be bound to the following terms:

1. Permitted Uses and Disclosures. ReachOut may use and disclose PHI, if in the course of performing services for or on behalf of Covered Entity or as required or permitted by law, regulation, regulatory agency or by any accrediting body to whom Covered Entity or ReachOut may be required to disclose such PHI; ReachOut may also use PHI for the proper management and administration, or to carry out the legal responsibilities of ReachOut.

2. ReachOut's Obligations. ReachOut shall:

    a. ensure that its agents and subcontractors to whom it may provide PHI agree to the same terms and conditions as are applicable to ReachOut as set forth herein;
    b. implement appropriate and reasonable safeguards to prevent use or disclosure of PHI other than as permitted herein and report to Covered Entity any use or disclosure of PHI not provided for by this Agreement;
    c. make available to the Secretary of Health and Human Services, ReachOut's practices, books and records relating to the use or disclosure of PHI for purposes of determining Covered Entity's compliance with HIPAA; subject to any attorney-client or other privileges;
    d. report to the Covered Entity, and mitigate to the extent practicable, any harmful effect that is known to ReachOut of uses or disclosures of PHI of which ReachOut becomes aware that do not comply with the terms herein;
    e. to the extent that Covered Entity and ReachOut agree in writing that ReachOut shall maintain PHI as part of a Designated Record Set, upon Covered Entity's request, provide access and make amendments to such PHI, in order to meet the requirements under HIPAA.
    f. document such uses and disclosures of PHI and, upon Covered Entity's request, provide such information as would be required for Covered Entity to account for disclosures of PHI as required under HIPAA;
    g. when ReachOut ceases to perform services for or on behalf of Covered Entity, ReachOut will destroy all PHI received or if such destruction of PHI is not feasible, continue to abide by the terms set forth herein with respect to such PHI; and
    h. following a discovery of a breach of Unsecured Protected Health Information, as defined in HITECH, notify Covered Entity of such breach within sixty (60) days of the discovery of the breach.

3. Term and Termination. The term of this HIPAA Agreement shall be effective as of the date set forth above and shall terminate when ReachOut ceases to perform services for Covered Entity, except as provided in 2(g) above. Covered Entity

may terminate this HIPAA Agreement if ReachOut fails to cure or take substantial steps to cure a material breach of this HIPAA Agreement within 30 days after receiving written notice of such material breach from Covered Entity.

4. Agreement. This Agreement constitutes the entire Agreement between the parties. This Agreement may be amended only in writing signed by Covered Entity and ReachOut. The parties agree to take such action to amend this Agreement as is necessary to comply with the requirements of HIPAA and HITECH. This Agreement and the rights and obligations of the parties hereunder shall in all respects be governed by, and construed in accordance with, the laws of the State of Colorado, including all matters of construction, validity and performance.

ReachOut Healthcare America Ltd. (Business Associate)	Big Smiles Colorado PC (COVERED ENTITY)
By: [redacted]	By: [redacted]
President	President

EXHIBIT 35

Execution Copy

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") is dated as of April 1, 2009 and is to be effective as of April 1, 2009 ("Effective Date") by and between ReachOut Healthcare America, LTD., a Delaware corporation (the "Administrator") and [redacted] D.D.S., Big Smiles Maryland PC, a Maryland professional corporation (the "Provider").

BACKGROUND

A. Provider is a professional corporation which operates a mobile dental practice in the State of Maryland (the "Practice") and is duly organized under the laws of the State of Maryland and this agreement is limited to this state.

B. [redacted], DDS ("[redacted]") is a dentist duly licensed in good standing under the laws of the State of Maryland and is the sole shareholder of Provider.

C. Administrator has special expertise and experience in the operation and administrative aspects of such mobile dental practices of the type operated or intended to be operated by Provider. Administrator provides business services to other dental providers in many States and as such is uniquely qualified to provide business services to Provider. Administrator has made a significant investment in the development of computer software and system of policies and procedures addressing certain operations and administrative functions which are desirable to Provider.

D. Provider and other employees and/or contractors of Provider, desire to devote the necessary time to providing quality mobile dental services to patients, and in connection therewith desire to obtain the expert assistance of Administrator in administrating certain business aspects of the Practice.

E. On or about the date hereof, Provider has merged with Smile Maryland, P.L.L.C. Administrator and Smile Maryland, P.L.L.C. are party to an existing Administrative Services Agreements (the "Old Agreement"). This Agreement is to be the basis of the business relationship between the parties as of the effective date of this Agreement and the Old Agreement shall not continue as the business relationship between the parties and shall have no further force or effect except that any and all financial obligations of the parties under the Old Agreement that have not yet been satisfied shall continue to be the obligations of the respective parties (including Provider as successor to Smile Maryland, P.L.L.C.).

DEFINITIONS

A. Practice Providers: The term "Practice Providers" shall mean the Dentists who are employees of the Provider or otherwise under contract with the Provider to provide dental services to patients of Provider.

B. Professional Services Revenues: The term "Professional Services Revenues" shall mean the gross sum of all professional fees actually recorded each month on an accrual basis under GAAP (net of Adjustments) as a result of dental services rendered by Practice Providers of the Provider.

C. Adjusted Gross Revenue: The term "Adjusted Gross Revenue" shall mean the sum of all Professional Services Revenue billed at Practice's "usual and customary fees".
D. Adjustments: The term "Adjustments" shall mean any adjustments on an accrual basis for uncollectible accounts, third-party payor contractual adjustments, discounts, professional courtesies, and other reductions in gross Professional Service Revenue that result from activities that do not result in collectible charges.
E. The term "Administrative Fee" shall mean the amount hereinafter described and which amount is payable to the Administrator.
F. Office Expense: The term "Office Expense" shall mean all non-professional operating and non-operating expenses incurred by the Administrator or Provider on behalf of the Provider. Office Expense shall not include any expense that is exclusively a Provider Expense. Office Expense shall include, but not limited to, those non-professional expenses incurred for the benefit of the Provider as follows:

    1. The direct salaries and benefits of all employees and independent contractors of the Administrator working solely for the Provider or whose cost can be directly allocated to the Provider, but not the salaries, benefits, or other direct costs of the Practice Providers and the other employees or independent contractors of the Provider.
    2. The direct cost of any employee or consultant that provides services such as administrative services, billing and collections, business office consultation, business development and accounting and legal services.
    3. Recruitment costs and out-of-pocket expenses of Administrator for the Provider directly related to the recruitment of additional Practice Providers of the Provider and other individuals.
    4. Professional liability insurance expenses for Practice Providers and the Provider and comprehensive, general liability and workers' compensation insurance for employees of Provider and Administrator (but only to the extent Administrator's employees/contractors are solely assigned to Provider or whose cost can be directly allocated to Provider) and the Provider and Administrator.
    5. The expense of leasing, purchasing or otherwise procuring of equipment and related depreciation directly for Provider's benefit.
    6. The reasonable out-of-pocket travel expenses associated with visiting any dental practice activities, conferences, recruitment trips, supervisory activities or conventions to directly benefit Provider.
    7. The reasonable costs and expenses associated with marketing, advertising, printing enrollment flyers and delivery and pick up expenses to retrieve the filled out enrollment flyers and promotional activities to directly benefit the Provider.
    8. The cost of Provider's dental supplies office supplies and inventory items.
    9. Telephone, utilities, shipping and postage charges of Provider.
    10. The cost of Medifax or other information costs to determine the Provider's patient's eligibility information.

G. "Provider Expense": The term Provider Expense shall mean an expense incurred by the Provider and for which Provider and not the Administrator, is financially liable. Practice Provider's salaries and benefits, payments, benefits, and other direct costs and those expenses associated with the Provider's other employees, cost of equipment and the like.

H. "Biller": Biller may be a sub-contractor to the Administrator for billing and collection purposes as set forth in the Administrative Agreement.
I. "Any dental practice activities": This is defined as any school or school district, out of children's home facility or children's agency or nursing home or any other dental practice activity in the state of Maryland
J. "School Relations": This is defined as the working with and coordination of the Provider's dental activities with the school.

NOW THEREFORE, in consideration of the mutual covenants and conditions hereinafter set forth and in exchange for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

AGREEMENT

1. Incorporation. The above Background recitals and Definitions are hereby incorporated into this agreement as if fully set forth herein.

2. Engagement of Administrator and Restrictions on Parties. Provider hereby engages Administrator on an exclusive basis to provide administrative services for the Provider, as described in this Agreement, on the terms and conditions described herein, in Maryland for any dental practice activities and Administrator accepts such engagement. the term of this Agreement, the Provider agrees to use the business services of Administrator when providing mobile dental services for any dental practice activities in Maryland.

3. Agency. Subject to Section 5.16 and 5.17 hereof, Administrator shall have access to Provider's bank account(s) solely for the benefit of Provider and the purposes stated herein and shall use all funds on deposit therein in accordance with the terms of this Agreement. Provider hereby appoints Administrator as Provider's true and lawful agent for the sole purpose of providing the services set forth in this Agreement throughout the term, and Administrator hereby accepts such appointment, to make withdrawals from such account(s) for payments specified in this Agreement.

4. Term. This Agreement shall have an initial term commencing as of the Effective Date and continuing in full force and effect through May 31, 2019 ("Initial Term"), and shall renew automatically for additional ten (10) year terms thereafter, unless terminated earlier as provided herein.

5. Duties and Responsibilities of Administrator. As set forth below, during the Term of this Agreement, subject to the provisions of Section 6.1 herein, at the Provider's request the Administrator shall arrange for the provision of comprehensive business practice management, financial and marketing services, and such facilities, equipment and support personnel as are reasonably required by the Provider to operate its Practice in the State of Maryland, as properly determined by the Administrator in consultation with the Provider. Notwithstanding anything herein to the contrary, the Administrator shall perform only those service listed herein that are

specifically requested by the Provider. In exchange for the Administrative Fee herein and payment of its Office Expense, Administrator shall provide all such business services as are necessary and appropriate for the day-to-day administrative support of Provider's Practice in a manner consistent with good business practices and in conformance with applicable dental standards in the community, including without limitation those services set forth in this Section 5.

5.1 Licenses. License to the Provider, for the purposes of this Agreement only, the following as requested by Provider:

- The use of all Administrator's computer hardware and servers needed to provide administrative support to the Provider
- The use of the Administrator's network software system needed to provide administrative support to the Provider.
- The use of the Administrator's proprietary Case Manager Software System whereby new patient registration information can be recorded in a patient registration form on the proprietary software program such as the health history and the treatment authorization. This information can be entered into the patient registration form on the software of the computer in a "fail safe" manner with warning if information is missing.
- The use of a proprietary software program where every Provider patient's complete records are retrievable promptly by entering the name and certain other information and thereby avoiding searching paper records.
- If a directory Alpha list for each student is provided by the schools then the use of the Administrator's proprietary Patient Tracking Software System whereby a student who is originally registered as a patient attending a school with a certain telephone number and address moves to a new school or gets a new address or a new telephone number then these changes can be tracked by having the outdated information on the child changed automatically to the correct information.
- The use of the Administrator's proprietary "paperless model" software system so that all dental records, x-rays and patient information on every patient can be transmitted electronically to the dental team wherever they are located and upon completion of the visit "up loaded" electronically to the server system.
- The use of the Administrator's commercial phone support system technologies needed to provide administrative support to the Provider.
- The use of the Administrator's two completely separate telephone recording systems so that all calls to and from patients of the Provider are automatically recorded twice.
- Provide all business support technology software needed to provide administrative support to the Provider.

5.2 Services Relating to schools. Administrator shall provide the following business services to Provider in relation to the schools Provider services or may service:

- Contact schools in this State for purposes of introducing them to the Provider's School program.
- Work with the supervisory personnel of the schools in regard to the manner in which the school dental program will be implemented.

- Meet with the school nurses to further the implementation of the school dental program.
- Arrange for each school to have a person assigned as a support person for the individual dental visits at their school and provide training to that support person relating to pre-visit, day of visit and post-visit protocols to be followed by the support personnel.
- Coordinate with the appropriate school the potential schedule dates of the dental visits and the starting and finishing times and locations for the dental services to be rendered.
- Arrange for the delivery of the Provider consent forms to the proper school employee in each school for each student to take home.
- Coordinate that each school obtains completed consent forms by the students and that they are provided to the Administrator.
- Arrange to schedule the minimum number of dental visits at each school that are required, based upon the Provider's direction, for the efficient use of Provider's time and assets.
- Assist each school on the day of the visits to efficiently coordinate the attendance of the student for his/her appointment and return to class to effectively manage the Provider's time at the particular school.
- Obtain patient satisfaction reports.

5.3 Supplies. Administrator shall arrange for the purchase of dental and office supplies necessary for the operation of the Practice as directed by the Provider.

5.4 Licensing. Administrator shall coordinate all reasonable and necessary actions to maintain all licenses, permits and certificates required for the operation of the Practice by Provider. Administrator shall prepare and file all reports, forms and returns required by law in connection with workers' compensation, unemployment insurance, social security and other similar laws with respect to the operation of the Practice.

5.5 Policies, Procedures and Protocols. Administrator has expended substantial time and resources to develop standard dental practice models, policies, procedures, government compliance documents and programs and practice protocols (the "Policies, Procedures and Protocols"). Provider recognizes and acknowledges that the name "ReachOut Healthcare America" belongs to and at all times shall remain the property of Administrator and that the Practice is being permitted to utilize the name and other intellectual property of Administrators, as well as Policies, Procedures and Protocols only pursuant to this Agreement. Nothing in this Section 5.5 shall be construed to interfere with the provisions set forth below in Section 6.1 or impose an obligation on the Provider to utilize the Policies, Procedures and Protocols.

5.6 Personnel. Provider shall establish and implement guidelines for the recruitment, selection, hiring, firing, compensation, terms, conditions, obligations and privileges of employment or engagement of Practice Provider dentists and non-dentist personnel, and all other persons working for Provider. Administrator will assist Provider in recruiting new Practice Provider dentists and non-dentist personnel and will carry out such administrative functions as may be appropriate for such recruitment, including advertising for and identifying potential

candidates, assisting Provider in examining and investigating the credentials of such potential candidates, criminal background checks and arranging interviews with such potential candidates; provided, however, Provider shall make the ultimate decision as to whether to employ or retain a specific candidate and all terms and conditions of said relationship. All non-dentist personnel recruited with the assistance of Administrator to support the providing of professional services on behalf of Provider by Practice Provider's dentists shall be the employees or contractors of the Provider.

5.7 Training. Administrator shall train Provider's personnel with respect to certain aspects of Provider's business operations (not professional services), including, but not limited to, administrative, financial and equipment maintenance matters.

5.8 Insurance. In consultation with Provider, Administrator shall arrange for the purchase by Provider of necessary insurance coverage for Provider including evaluation of Provider's insurance needs and pricing of such insurance. All premiums for Provider's insurance shall be either Office Expenses or Provider Expenses depending upon the insurer and nature of the coverage. Administrator shall also provide documentation of Provider's insurance coverage for any dental practice activities as requested.

5.9 Accounting. Administrator shall establish and administer accounting procedures and controls and systems for the development, preparation, and keeping of records and books of accounting related to the business and financial affairs of Provider. The Administrator shall provide or arrange to provide: (i) an operating budget setting forth an estimate of revenues and expenses for the next fiscal year, together with an explanation of anticipated changes or modifications, if any, in the Provider's utilization, rates, charges to patients or third party payers, salaries, costs of Practice Providers, non-wage cost increases, and similar factors expected to differ significantly from those prevailing during the current fiscal year; (ii) other expenses of operation; (iii) the amount of reasonable reserves to satisfy possible shortfalls from operations; and (iv) the estimated Administrative Fees, as prescribed in paragraph 8.6, hereof, for the next fiscal year. Additionally, the Administrator shall provide or arrange to provide the Provider with an un-audited internal quarterly statement within thirty (30) days after the end of each quarter. At the end of each fiscal year of the Provider, the Administrator shall arrange for a financial statement with respect to the Provider to be prepared by the Administrator's accountant. At the Provider's request, the Administrator shall prepare reports indicating the gross revenues, number of patients, type of patients, and the activity and the productivity of the Provider

5.10 Tax Matters. Administrator shall oversee the preparation of the annual report and tax information returns required to be filed by Provider.

5.11 Reports and Information. Administrator shall furnish Provider in a timely fashion annual or more frequent operating reports and other reports as requested by Provider, including without limitation (i) copies of bank statements and checks relating to Provider's bank accounts, (ii) financial statements, (iii) the reports prescribed in paragraph 5.9, above.

5.12 Planning and Budgeting. The Administrator shall advise the Provider of short and long range planning, including the projection of personnel needs, evaluation of compensation of

Provider's employees and contractors, fees for services provided, analyses of future markets, and other necessary planning services. The Administrator shall prepare annual capital and operating budgets for the Provider ("Annual Budget"), in an orderly fashion containing the information prescribed in paragraph 5.9, above. Administrator shall provide Provider copies of the annual profit and loss statement.

5.13 Maintenance of Equipment. Administrator shall arrange for the provision of maintenance of Provider's equipment, subject to Provider maintaining care, custody and control of any dental and other equipment used in the provision of dental services.

5.14 Expenditures. Administrator shall manage all cash receipts and disbursements of Provider, including the payment on behalf of Provider of all taxes, assessments, licensing fees and other fees of any nature whatsoever in connection with the operation of the Practice as the same become due and payable, unless payment thereof is being contested in good faith by Provider.

5.15 Contract Negotiations. Administrator shall advise Provider with respect to and negotiate, either directly or on Provider's behalf, as appropriate and permitted by applicable law such contractual arrangements with third parties as are reasonably necessary and appropriate for Provider's provision of healthcare services, including without limitation negotiated price agreements with third party payers. Provided, however, that no contract or arrangement regarding the provision of dental care shall be entered into without Provider's consent.

5.16 Billing and Collection. Subject to paragraph 5.17 below, on behalf of and for the account of Provider and with Provider's direction, Administrator may subcontract to a "Biller" any and all billing and collection duties. Provider shall establish and maintain credit and billing and collection policies and procedures, and Biller shall exercise reasonable efforts to bill and collect in a timely manner all professional and other fees for all billable services provided by Provider. In connection with the billing and collection services to be provided hereunder, Provider hereby appoints Administrator as Provider's exclusive true and lawful agent, and Administrator hereby accepts such appointment, for the following purposes:

(a) To bill, in Provider's name and on Provider's behalf, all claims for reimbursement or indemnification from patients, insurance companies and plans, all state or federally funded benefit plans, and all other third party payers or fiscal intermediaries for all covered billable dental care provided by or on behalf of Provider to patients.

(b) To collect and receive, in Provider's name and on Provider's behalf, all accounts receivable generated by such billings and claims for reimbursement, to take possession of, endorse in the name of Provider, and deposit solely into Provider's master collection account all notes, checks, money orders, cash or cash equivalents, insurance payments, and any other instruments received in payment of services rendered. At all times the Provider shall own its accounts receivable and no lien is granted to Administrator for accounts receivable. As directed by Provider Administrator may administer such accounts including, but not limited to, extending the time or payment of any such accounts for cash, credit or otherwise; discharging or releasing the obligors of any such accounts; suing, assigning or selling at a discount such accounts to

collection agencies; or taking other measures to require the payment of any such accounts; provided, however, that extraordinary collection measures, such as filing lawsuits, or assigning or selling accounts at a discount to collection agencies shall not be undertaken without Provider's written consent.

(c) To sign checks, drafts, bank notes or other instruments on behalf of Provider, and to make withdrawals only from Provider's specified account for payments specified in this Agreement and as requested from time to time by Provider.

(d) Upon request of Administrator, Provider shall execute and deliver to the financial institution at which Provider's account is maintained such additional documents or instruments as Administrator may reasonably request to demonstrate its authority. The agency granted herein is coupled with an interest and shall be irrevocable during the Term of this Agreement except with Administrator's written consent.

5.17 Deposit of Governmental Payor Funds. Provider and/or Administrator shall deposit in Provider's account (i.e., a bank account over which Provider shall have exclusive dominion and control that is opened by Provider at a bank mutually agreed upon by the parties, whose deposits are FDIC insured) all governmental payor (i.e., Medicare, TRICARE, etc.) collections collected by Provider or by Administrator on Provider's behalf pursuant to Section 5.16 above (or any other payments required by law to be received under the sole control of Provider). To the extent that Provider or any of its employees or agents receives funds for services paid for or reimbursed by governmental payers, such funds shall be deposited in Provider's account. Administrator shall be entitled to receive copies of the monthly bank statements for Provider's account in order to properly render the accountings and provide the services required under this Agreement.

5.18 Litigation. As directed by the Provider, Administrator shall (a) direct the defense of all claims, actions, proceedings or investigations against Provider or any of its officers, directors, employees or agents in their capacity as such, and (b) direct the initiation and prosecution of all claims, actions, proceedings or investigations brought by Provider against any person other than Administrator.

5.19 Marketing, Advertising and School Relations Programs. Administrator has developed marketing and advertising programs to be implemented by Provider to effectively notify the School District schools, parents and guardian and students and nursing home and nursing home residents and other dental practices of the services offered by Provider. Administrator shall advise and assist Provider in implementing such marketing and advertising programs, including, but not limited to, analyzing the effectiveness of such programs, preparing marketing materials, negotiating marketing contracts on Provider's behalf, and obtaining services necessary to produce and present such marketing programs. Administrator shall provide the School Relations services as set forth in Paragraph 5.2 above. The parties expressly acknowledge and agree that Provider shall exercise complete control over all policies and decisions relating to every element of such marketing; provided, however, that Provider shall have no right whatsoever to use Administrator's name, trademark, copyrighted materials, or any of Administrator's other intellectual property except as expressly permitted in this Agreement.

Administrator and Provider agree that all marketing programs shall be conducted in compliance with all applicable standards of dental ethics, laws and regulations.

5.20 Answering Service. Maintain a twenty four (24) hour per day answering service for all incoming calls from patients' responsible parties for dental issues or other questions. All requests involving dental issues shall be forwarded by such answering service to the Provider.

5.21 Dental Practice Laws. Notwithstanding any provision in this Agreement, the Administrator shall not take any action in connection with the services to be rendered hereunder that violates any Law, including, without limitation, the performance of any task or the taking of any action which violates the Dental Practice Act or equivalent law as it relates to professional dental practices.

6. Relationship of the Parties.

6.1 Sole Authority to Practice. Notwithstanding any other provision of this Agreement, Provider shall have exclusive authority and control over the healthcare aspects of Provider and its practice to the extent they constitute the practice of a licensed profession, including all diagnosis, treatment and ethical determinations with respect to patients which are required by law to be decided by a licensed professional. Any delegation of authority by Provider to Administrator that would require or permit Administrator to engage in the practice of a profession or subject to licensure under State or local law or ordinance with the exception of state business registration and local business permits shall be prohibited and deemed ineffective, and Provider shall have the sole authority with respect to such matters. Administrator shall not be required or permitted to engage in, and Provider shall not request Administrator to engage in, activities that constitute the practice of dentistry or another similar profession in the State. Administrator shall not direct, control, attempt to control, influence, restrict or interfere with Practice Provider's Dentists or non-dentist personnel's exercise of independent clinical or professional judgment in providing healthcare or dentistry related services. To the extent that any provision hereof is found to violate any State law, rule or dental board regulation such provision shall be void and unenforceable.

6.2 Relationship Between The Parties. Provider agrees that the purpose and intent of this Agreement is to relieve Provider, its shareholders and Provider's employees and contractors of the administrative, accounting and business aspects of their practice at the Practice to the maximum extent possible, and the Administrator is hereby expressly authorized to perform services hereunder in whatever manner it deems reasonably appropriate to meet the day-to-day non-medical requirements of Provider's dental practice. Provider shall be responsible for the hiring, supervision, compensation and termination of its Dentists, and all issues related to the professional and ethical aspects of its dental practice. The Administrator shall neither exercise control over nor interfere with the dentist-patient relationship, which shall be maintained strictly between the Dentists employed by or contracted with Provider and their patients.

6.3 No Patient Referrals. Administrator shall neither have nor exercise any control or direction over the number, type, or recipient of patient referrals and nothing in this Agreement shall be construed as directing or influencing such referrals. Nothing in this Agreement is to be

construed to restrict the professional judgment of Provider, any dentist or any non-dentist personnel to use any dental practice, facility or pharmacy where necessary or desirable in order to provide proper and appropriate treatment or care to a patient or to comply with the wishes of the patient. No part of this Agreement shall be construed to induce, encourage, solicit or reimburse for the referral of any patients or business, including any patient or business funded in whole or in part by federal or state government programs (i.e., Medicare, TRICARE, etc.). The parties acknowledge that there is no requirement under this Agreement or any other agreement between the parties that either refer patients to the other or any of their respective affiliates.

6.4 Compliance with Corporate Practice of Medicine. The parties hereto have made all reasonable efforts to ensure that this Agreement complies with the corporate practice of medicine prohibitions in the State. The parties hereto understand and acknowledge that such laws may change, be amended, have guidance or have a different interpretation and the parties intend to comply with such laws in the event of such occurrences. Under this Agreement, Provider and its dentists and non-dentist personnel shall have the exclusive authority and control over the professional aspects of Provider's dental practice to the extent they constitute the practice of dentistry as defined under state laws and regulations, while Administrator shall have the authority to provide the administrative services to the Provider as provided in this Section 6.. The parties agree to cooperate with one another in the fulfillment of their respective obligations under this Agreement, and to comply with the requirements of law and with all ordinances, statutes, regulations, directives, orders, or other lawful enactments or pronouncements of any federal, state, municipal, local or other lawful authority applicable to the parties and the Practice.

7. Responsibilities of Provider. Provider shall operate its practice and the dental program for any dental practice activities covered by this Administrative Agreement during the term of this Agreement, in conformance with all applicable laws, rules and regulations. In furtherance of the foregoing, Provider shall provide and perform the following during the Term of this Agreement:

7.1 Dentists and Non-Dentist Personnel. Provider shall establish guidelines and these guidelines shall be implemented by the Administrator for the recruiting, compensation, terms, conditions, obligations and privileges of employment or engagement of Dentists. Provider shall have the sole authority to engage (whether as employees or as independent contractors), promote, direct, discipline, suspend and terminate the services of all licensed Dentists and non-dentist personnel. Provider shall employ or contract with all Dentists who provide professional services on behalf of Provider. Provider shall control all aspects of the practice of dentistry, including clinical training and clinical supervision of the Dentists and non-dentist personnel. Provider shall, in consultation with Administrator, establish work schedules for all Dentists and non-dentist personnel necessary to ensure adequate coverage of Provider's Practice dental locations; Provider shall ensure that all non-dentist personnel are appropriately supervised with respect to the provision of services to patients in accordance with all applicable laws. Specifically, Provider and its Dentists shall have full responsibility for and shall supervise and control all non-dentist personnel in their provision of health-related services as required by applicable law. Provider shall have the authority to engage and terminate the services of all licensed professional employees and independent contractors. Provider shall consult with Administrator from time to time regarding the number, work schedules and evaluation of the

Dentists and non-dentist personnel. Provider shall staff its practice as required for the efficient operation of Provider, and as otherwise necessary to meet the requirements of payor contracts and applicable law. Provider shall provide full and prompt dental coverage to its patients consistent with comparable practice standards in the community. In addition, Provider shall cause each Dentist employed or engaged by Provider to:

7.1.1 Maintain an unrestricted license to practice in the State, maintain all narcotics and controlled substances numbers and licenses, including without limitation a DEA registration or permit if required, and maintain good standing with the applicable professional boards;

7.1.2 Perform services and otherwise operate in accordance with all laws and with prevailing and applicable standards of care;

7.1.3 Maintain his or her skills through continuing education and training;

7.1.4 Maintain eligibility for professional liability insurance for his or her specialty;

7.1.5 Satisfy such other requirements as are reasonably requested by Provider;

7.1.6 In the case of non-dentist personnel, practice under a properly licensed dentist's supervision, control and responsibility as required by applicable law;

7.1.7 Avoid all personal acts, habits and usages which might injure in any way, directly or indirectly, his or her professional judgment or professional reputation;

7.1.8 Not be (and shall avoid being) suspended or excluded from any federal or state healthcare program (e.g., Medicare, or TRICARE); and

7.1.9 Subject to Section 6.1 hereof, adhere to the Policies, Procedures and Protocols, except to the extent that verbal authority to deviate is given by Provider or other appropriately licensed supervising dentist or other dentist employee of Provider.

7.2 Reserved

7.3 Reports; Practice Guidelines. Subject to Section 6.1 above, Provider shall provide such reasonable reports about the Practice as Administrator may request from time to time. Neither this clause nor any other provision of this Agreement, nor any aspect of the actual operation of the Practice, shall be construed as limiting the right, authority and duty of a dentist or non-dentist personnel to exercise professional independent judgment in any particular instance for or on behalf of a patient of the Practice.

7.4 Billing Information. Provider shall be responsible for ensuring that it and its Dentists and, as applicable, all non-dentist personnel timely submit accurate, true, complete,

legible and correct information necessary for billing purposes to Administrator. Such information shall be submitted in a format in accordance with normal dental standards.

7.5 Reserved.

7.6 Dental/Patient Records. Provider shall control and shall be responsible for the confidentiality, privacy, maintenance, storage, retention and custody of all dental/patient records of Provider. Provider agrees to comply with all state and federal patient confidentiality and privacy laws regarding dental/patient records. Upon termination of this Agreement for any reason, the Provider shall agree with the Administrator's support to act as custodian of all the records and billing of the Provider's patient's as provided in paragraph 12.4 of this Agreement. Additionally, Administrator shall be allowed to retain and maintain the records as provided in paragraph 12.1 below

8. Administrative Fee; Application of Payments. As consideration for the performance of all of its duties and obligations as provided in this Agreement, including but not limited to, the costs and expenses associated with furnishing the services, facilities, leasehold improvements, fixtures, furniture, furnishings and equipment provided for herein, the Administrator shall receive compensation in the form of Administrative Fees, as defined and determined in accordance with the provisions set forth in paragraph 8.6 herein. It is acknowledged by and between the parties that the Administrator and/or its affiliates has (have) incurred substantial expenses and future obligations in acquiring the capital stock of the Administrator, acquiring or otherwise establishing a portable dental network, establishing its systems, including but not limited to fees for consultants and other professionals, interest expenses, lease obligations, costs of providing the portable dental units where the services will be rendered and the establishing and maintaining its computerized, proprietary paperless dental charting system. The Administrator has also incurred substantial obligations associated with the continuing operation of the dental network, including but not limited to those of obligor and guarantor on loans to establish and operate the portable dental units. The parties, therefore, having considered various compensation formulae, acknowledge and agree that in order for the Administrator to receive a fair and reasonable return for its expenses and obligations, and a fair return for the lease of such premises and equipment required by this Agreement and for providing the services contemplated hereunder, that the agreed Administrative Fee is not excessive. Provider has executed a Dentist's Affidavit attached hereto as Exhibit 8, attesting to the reasonableness of the fees. The Administrator acknowledges that the compensation arrangement is reasonable under the circumstances. In consideration of the foregoing, the parties agree that the Administrative Fees payable to the Administrator by the Provider for services rendered pursuant to this Agreement shall be reviewed and subject to adjustment at the close of each year of the Term of this Agreement based upon industry standards of practice and the Administrator's costs in performing the required services. If the parties cannot agree within thirty (30) days prior to the close of any such year on the terms of any adjustment to the Administrative Fees for the following year, then the then existing Administrative Fees shall remain in effect. The Provider specifically agrees that the Administrator may defer actual receipt of its Administrative Fees and/or advance monies to the Provider for purposes of managing the Provider's cash flow, and that the Administrator shall be paid said deferred Administrative Fees or be reimbursed said advances, including interest thereon, when the Administrator deems reasonably appropriate. In consideration of all of the

foregoing the parties agree that the obligations of the Practice will be paid in the order set forth below:

8.1 Provider Expenses. Provider shall pay all the "Provider Expenses" as defined in paragraph (G) under Definitions herein

8.2 Provider's Office Expense. Revenues shall next be applied to pay all the "Office Expenses" of the Provider as may be incurred by the Administrator on behalf of the Provider as defined in paragraph (F) of Definitions, above for carrying out its duties hereunder on behalf of Provider. Provider shall reimburse Administrator for such expenses within five (5) days after the end of the month in which such expenses were incurred.

8.3 Administrative Fee. Administrator shall be paid an Administrative Fee in the amount of set forth under paragraph 8.6 herein (the "Administrative Fee"). Provider shall pay Administrator the Administrative Fee with respect to a given month within 5 days after the end of such month. Per paragraph 8 above, the parties have deemed the Administrative Fee paid to the Administrator to be fair and equitable and reflects the parties good faith attempt to pay fair market value for the services rendered by Administrator for Provider.

8.3.1 To secure its payment obligations under these Sections 8.2, 8.3 and 8.6 (the "Obligations") of this Agreement, the Provider hereby grants, conveys and assigns to the Administrator a first priority lien and security interest in all present and future bank accounts (except those relating to government payors), and accounts of the Practice and the proceeds thereof resulting from services rendered by the Provider, and all additions and substitutions thereto, whether presently owned or hereafter acquired, which shall secure payment of all amounts owed by the Provider to the Administrator under this Agreement and any other obligations or liabilities of the Provider to the Administrator arising, from time to time, pursuant to this Agreement "Accounts" and "proceeds" shall have the meaning ascribed to such terms in Article 9 of the state's Uniform Commercial Code. Accordingly, Provider has executed a Security agreement in favor of Administrator which is attached hereto as Exhibit 8.3.1 and incorporated herein by this reference.

8.3.2 The Provider shall execute, upon request of the Administrator, financing statements, security agreements and any other documents reasonably deemed necessary or desirable by the Administrator to perfect the aforesaid security interest. A financing statement may be filed without the Provider's signature on the basis of this security agreement where allowed by laws. The security interest granted herein, and any other of the Administrator's rights or remedies set forth herein, are not intended to alter, modify, substitute or otherwise restrict any other rights or remedies which the Administrator may have or which may be available to the Administrator by operation of law or otherwise.

8.4 No Personal Liability for [redacted] and others involved with the Provider. Notwithstanding any provision to the contrary in this Agreement, Administrator agrees [redacted] and any present or future shareholders, directors or officers of the Provider are not personally liable or responsible for any of the Provider's fees, obligations, debts or expenses of whatsoever nature owed hereunder by Provider to Administrator and/or any subcontractors nor for any Office

Expenses, Administrative Fees, debts, obligations or other liabilities owed by Provider or Administrator to any third parties or other claimants.

8.5 Obligation of Provider. The Provider's obligation to pay Administrator in any tax period shall not be greater than the Provider's "ability to pay". "Ability to pay" is defined as the Provider's net earnings, plus depreciation and amortization expense in such period. If the Provider is determined not to have the ability to pay in any period, the Administrator may seek recovery of the deficiency from other professional entities which are under common ownership with the Provider at that time and are also parties to administrative service agreements with the Administrator, but only to the extent of such entities' ability to pay. Further, Provider consents to the recovery of amounts from it by Administrator under provisions in such other administrative service agreements corresponding to the preceding sentence, to cover deficiencies of professional entities under common ownership with the Provider at that time, to the extent Provider has the ability to pay such recoveries.

8.6 Business Expenses and Administrative Fee payment schedule and amount:

8.6.1 Each month the Provider pays the "Provider Expenses" and the "Office Expenses" as required under paragraphs 8.1 and 8.2 above from the Adjusted Gross Revenue

8.6.2 After the payments required under 8.6.1 are made the "Administrative Fee" shall be paid on a monthly basis equal to thirty percent (30%) of the Adjusted Gross Revenue attributable to the applicable month.

8.6.3 All remaining funds belong to the Provider. The Provider may instruct the Administrator to maintain or distribute said funds as Provider in its sole discretion decides.

9. Peer Review. Provider and Administrator shall cooperate to develop, from time to time, peer review procedures for the Dentists and non-dentist personnel providing services to patients of Provider. Provider shall provide Administrator with prompt notice of any material quality of care concerns relating to any Dentists or any non-dentist personnel providing services on behalf of Provider and shall also provide a corrective action plan for issues. Provider shall implement, and Administrator will support such corrective actions that Provider determines are necessary or appropriate to comply with the then current peer review procedures, community standards and laws. Provider will also comply with, and participate in, all peer review programs of any entity with whom Administrator and Provider contracts, including, but not limited to, payers.

10. Reserved.

11. Termination.

11.1 Termination by Administrator or Provider without Cause. Administrator or Provider may terminate this Agreement at any time without cause upon three hundred sixty (360) days advance written notice to the other party.

11.2 Immediate Termination by Administrator. Administrator shall have the right, but not the obligation, to terminate this Agreement immediately upon notice to Provider of any of the following events:

11.2.1 The revocation, suspension, cancellation or restriction, in any manner, of the license to practice dentistry in this State and/or the DEA registration of any shareholder of Provider.

11.2.2 The conviction of Provider or any shareholder of Provider of any crime punishable as a felony under federal or state law or of any material health care crime.

11.2.3 The cancellation or non-renewal of the professional or malpractice insurance of Provider or any shareholder of Provider.

11.2.4 The dissolution of Provider.

11.2.5 The suspension or exclusion of Provider or any shareholder of Provider from any state or federal healthcare program (e.g., Medicare, or TRICARE).

11.2.6 The date of death or permanent disability of any shareholder of Provider.

11.2.7 The date any shareholder of Provider becomes disqualified under applicable law to be a shareholder of the Provider.

11.2.8 Failure of the Provider to pay amounts owed under Section 8, provided that, Administrator shall first provide Provider with written notice of Provider's failure to timely reimburse Administrator for expenses or pay the Administrative Fee, and Provider shall have 5 days to cure such failure to pay.

11.3 Termination by Either Party. This Agreement may be terminated as follows:

11.3.1 by mutual written agreement of the parties.

11.3.2 By either party upon a material breach of a material provision hereof by the other party, provided that the non-breaching party provides the breaching party with sixty (60) days' written notice of any such breach, during which period of time the breaching party shall have the opportunity to cure any such breach (or in the event of a non-monetary breach which is not curable within such sixty (60) day period the breaching party shall have the opportunity to commence cure of any such breach). If any such breach is cured by the breaching party during such period of time (or in the event of a non-monetary breach which is not curable within such sixty (60) day period but the breaching party has commenced to cure such breach and does continue to cure such breach with the exercise of due diligence), it shall be as if such

breach never occurred and this Agreement shall continue in full force and effect, unaffected by the non-breaching party's notice.

11.3.3 By either party pursuant to Section 15.17 ("Limited Renegotiation") hereof.

11.4 Termination Obligations. In the event of termination for any reason, Provider (and not Provider's shareholders personally) shall pay all "Office Expenses" and Administrative fees owing to Administrator pursuant to Section 8 hereof through and including the date of termination.

11.5 Effect of Termination. Except as otherwise provided herein or in any amendment hereto, following the effective date of termination of this Agreement:

11.5.1 The Agreement between the Provider and Administrator relating to the maintenance and storage of patient records shall become effective immediately.

11.5.2 For a period of six (6) months following termination of this Agreement, Administrator shall continue to permit the Provider or its authorized representatives to conduct financial audits relating only to Administrator's provision of services under this Agreement; provided that, Provider first provides Administrator with reasonable notice and performs any audit at a mutually agreed upon time and place and upon such other terms and conditions as Provider may reasonably request;

11.5.3 Reserved

11.5.4 Administrator and Provider shall cooperate in connection with the termination or assignment of other contractual arrangements, if applicable;

11.5.5 Administrator and Provider shall cooperate in the preparation of final financial statements and the final reconciliation to fees paid hereunder, which shall be calculated by Administrator within six (6) months after termination of this Agreement;

11.5.6 Upon termination or expiration of this Agreement, the Provider shall return to Administrator any and all property of Administrator which may be in their possession or under their control.

11.5.7 After termination of this Agreement for any reason, in the event that any tax audits arise which cover only tax years of the Provider prior to the termination date but while this Agreement was in effect, Administrator shall be responsible for the reasonable costs and expenses of all professional fees in connection with such audits. After the termination date, in the event any tax audits arise which cover only tax years of the Provider after the termination date, Administrator shall have no responsibility for the costs and expenses of professional fees in connection with such audit. After the termination date, in the event any tax audits arise for tax years of the Provider both prior to and following the termination date, Administrator shall be responsible for a portion of the reasonable costs and expenses of all professional fees in

connection with such audits. Such portion will be based upon a fraction, the numerator of which is the additional taxes payable pursuant to such audits for years of the Provider prior to the termination date and the denominator of which is the additional taxes payable pursuant to such audits for all years covered by such audits. Administrator shall not, however, be responsible for the taxes and penalties owed by the Provider.

11.5.8 Administrator shall prepare and file, or cause to be prepared and filed, all tax returns for the Provider for the periods covering the Effective Date of this Agreement through the termination date. All Tax Returns shall first be submitted to Provider, for its consent and approval, prior to filing within thirty (30) days prior to filing. Administrator shall agree to indemnify, defend and hold Provider harmless from any claim arising with respect to any tax return which Administrator prepared except to the extent that a claim is based upon false or fraudulent information provided to Administrator by Provider or its agents or shareholders.

11.5.9 Administrator and Provider shall (i) each provide the other with such assistance as may reasonably be requested by any of them in connection with the preparation of any return, audit, or other examination by any taxing authority or judicial or administrative proceedings relating to liability for taxes, (ii) each retain and provide the other with any records or other information that may be relevant to such return, audit or examination, proceeding or determination, and (iii) each provide the other with any final determination of any such audit or examination, proceeding, or determination that affects any amount required to be shown on any tax return of the other for any period.

12. Records and Recordkeeping.

12.1 Access to Information. Provider hereby authorizes and grants to Administrator full and complete access to all information, instruments and documents relating to Provider which may be reasonably requested by Administrator to perform its obligations hereunder, and shall disclose and make available to representatives of Administrator for review and photocopying all relevant books, agreements, papers and records of Provider, except as otherwise limited by law or regulation.

12.2 Patient Records.

12.2.1 In addition to the obligations under paragraph 7.6 above, Administrator shall be allowed to retain and maintain patient dental records on behalf of Provider as custodian. Provider shall be afforded unfettered access to such records by computer in this state, in full compliance with applicable laws and regulations. To the extent permitted by applicable law, Administrator shall be permitted to retain true and complete copies of such records, at its expense.

12.2.2 At all times during and after the term of this Agreement, all business records and information, including, but not limited to, all books of account and general administrative records and all information generated under or contained in the information system pertaining to Provider, relating to the business and activities of Administrator, shall be and remain the sole property of Administrator.

12.2.3 Provider acknowledges that Administrator is the sole owner of Administrator's software systems set forth in Paragraph 5.1 and the Provider's limited license to use the software systems is shared with other users including the Administrator's other clients. Provider shall have no license or other right to copy, use, or transfer any rights to such systems, except for the right of access to the medical/dental information of patients as set forth herein and as required by law.

12.2.4 Provider shall at all times during the Term, and at all times thereafter, make available to Administrator for inspection by its authorized representatives, during regular business hours, at the principal place of business of Provider, any Provider records determined by Administrator to be necessary to perform its services and carry out its responsibilities hereunder or necessary for the defense of any legal or administrative action or claim relating to said records. Provided such right shall be in compliance with applicable laws and regulations.

12.3 Confidentiality of Records. Administrator and Provider will adopt procedures to assure the confidentiality of the records relating to the operations of Administrator and Provider, including, but not limited to, all statistical, financial and personnel data related to the operations of Administrator and Provider, which information is not otherwise available to third parties publicly or by law.

12.4 Maintenance, Retention and Storage of Records. In addition to the requirements of paragraphs 7.6 and 12.2 hereof, Administrator agrees to maintain, retain and store on behalf of Provider all records in its possession, including, but not limited to, patient medical records, at its sole cost and expense, for the longer of (i) five (5) years, (ii) in cases of patients under minority, their complete records shall be retained for the period of not less than one (1) year after the minor reaches the age of majority, or five (5) years from the date of Provider's last professional contact with the patient, whichever is longer, (iii) in the case of mentally incompetent patients, their dental records shall be maintained indefinitely or (iv) the period required by applicable law. Patient dental records shall be retained by Administrator in such form and manner as required by applicable law. Thereafter, Administrator shall be entitled to dispose of such records as it deems necessary or appropriate; provided, however, Administrator shall provide prior written notice to Provider of its intent to dispose of such records and shall provide Provider with a sixty (60) calendar day period, from the date that such notice is given by Administrator, for Provider to take control of or copy any or all of the records to be disposed of by Provider, at the sole cost and expense of Provider, to the extent permitted by applicable law.

12.5 HIPAA. Administrator has entered into a Business Associate Addendum with Provider and as such agrees to comply with all applicable federal, state and local laws, including without limitation the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all implementing regulations issued pursuant thereto, as may be amended from time to time.. Administrator shall protect the confidentiality, privacy and security of all medical records or other health-related information that Administrator or any employee or agent of Administrator creates or receives for or from Provider pursuant to this Agreement. Administrator agrees to comply with the HIPAA Business Associate Addendum attached hereto as Exhibit 12.5 and incorporated herein by this reference.

13. Intellectual Property and Other Proprietary Information.

13.1 Limited License of "ReachOut Healthcare America" Name and Logo. Pursuant to Section 5.1, Administrator grants to Provider the nonexclusive right and license to use the name "ReachOut Healthcare America" and any related trademarks and logos based on the mark "ReachOut Healthcare America" (collectively, the "Marks") during the term of this Agreement and subject to the prior written approval of Administrator.

13.2 Provider Outcomes and Other Data. Provider agrees to provide Administrator with access, without charge, to the outcomes and other data developed by Provider for Administrator's use in the operations of Provider.

13.3 Use of Information System (IS). The Provider shall use all software and hardware provided by Administrator as described in Paragraph 5.1 pursuant to this Agreement only for the purpose of conducting the Practice and solely in accordance with and subject to all of the terms and conditions of any license or sublicense agreements, leases or any other agreements that such software and hardware are subject to, and shall not allow or permit any person to use the software or hardware or any portion thereof in violation of this Agreement or any such license, sublicense, agreements, lease or any other agreements.

13.4 Confidentiality. Provider acknowledges that during the course of its relationship with Administrator hereunder, Provider may be given access to or may become acquainted with Confidential Business Information (as defined below) of Administrator. In recognition of the foregoing and in addition to any other requirements of confidentiality under applicable law, Provider hereby agrees not to disclose or use any of the Confidential Business Information (except in connection with the services rendered to Provider hereunder) during the Term of this Agreement and an additional period of five (5) years thereafter. For purposes of this Agreement, "Confidential Business Information" shall mean any and all information, know-how and data, technical or non-technical, whether written, oral, electronic, graphic or otherwise of Administrator that is reasonably considered or treated as confidential and proprietary whether labeled as confidential or not, and shall include, but not be limited to:

(a) Business methods;
(b) Any dental practice activities and locations;
(c) Billing policies, procedures, processes and records;
(d) Tax returns and records;
(e) Any records, memoranda and correspondences dealing with the business of Administrator;
(f) Policies, including the Policies, Procedures and Protocols;
(g) Financial, pricing and operational information, including all insurance records;
(h) Internal memoranda, emails or correspondence;
(i) Form agreements, checklists or pleadings;
(j) Officer, director and shareholder information;

(k) Suppliers, marketing, and other information and know-how, all relating to or useful in Administrator's business and which have not been disclosed to the general public;
(l) Operational and business systems, policies and procedures;
(m) Software and processes, including those set forth in 5.1; systems design; and algorithms;
(n) Business strategies;
(o) Business opportunities;
(p) Customer lists and information but not patient records and information as this is the property of the Provider;
(q) Research and technical information;
(r) Outcomes and related data; and
(s) Intellectual property, know-how and trade secrets.

Provider agrees and acknowledges that the Confidential Business Information of Administrator as such may exist from time to time, constitutes valuable, confidential, special and unique assets of Administrator. The parties hereto agree that the documents relating to the business of Administrator, including all Confidential Business Information, are the exclusive property of Administrator. Provider understands and agrees that its obligations and duties under this Section do not cease upon termination of this Agreement and, further, Provider shall return all such documents (including any copies thereof) to Administrator immediately upon the termination of this Agreement.

14. Reserved.

15. Miscellaneous.

15.1 Indemnification.

15.1.1 Indemnification by Provider. Provider (and not its shareholders personally) hereby agrees to indemnify, defend and hold harmless Administrator, its officers, directors, owners, members, employees, agents, affiliates and subcontractors, from and against any and all claims, damages, demands, diminution in value, losses, liabilities, actions, lawsuits and other proceedings, judgments, fines, assessments, penalties, awards, costs and expenses (including reasonable attorneys' fees), whether or not covered by insurance, arising directly or indirectly, in whole or in part, out of (a) any breach of this Agreement by Provider or (b) any acts or omissions by Provider, its shareholders, employees, Dentists, non-dentist personnel, agents or subcontractors not directly supervised by Administrator. The provisions of this Section 15.1.1 shall survive termination or expiration of this Agreement. Provider shall immediately notify Administrator of any lawsuits or actions, or any threat thereof, that are known or become known to Provider that might adversely affect any interest of Provider or Administrator whatsoever.

15.1.2 Indemnification by Administrator. Administrator hereby agrees to indemnify, defend with attorney of Provider's selection(but subject to Administrator's reasonable approval) and hold harmless Provider, its officers, directors, shareholders, employees and agents, including its shareholders, from and against any and all claims, damages, demands,

losses, liabilities, actions, lawsuits and other proceedings, judgments and awards, and costs and expenses (including reasonable attorneys' fees), arising, directly or indirectly, in whole or in part, out of (a) any material breach of this Agreement by Administrator, (b) any intentional acts, negligence or omissions by Administrator to the extent that such is not paid or covered by the proceeds of insurance; provided, however, such indemnity agreement shall not apply to any portion of any such loss, claim, damage, obligation, penalty, judgment, award, liability, cost, expense or disbursement to the extent it is found in a final judgment by a court of competent jurisdiction (not subject to further appeal) or pursuant to binding arbitration pursuant to Section 15.2 hereof, to have resulted from the acts, omissions, negligence or willful misconduct of Provider, Provider dentists or staff or its shareholders (as the case may be). Notwithstanding anything else Administrator shall not reimburse or indemnify the Provider for any lost profits or diminution in value of Provider or the contractual relationship with the Administrator. The provisions of this Section 15.1.2 shall survive termination or expiration of this Agreement. Notwithstanding the foregoing, Administrator shall not indemnify Provider for the acts or omissions of Provider, its shareholder, the Dentists, the non-dentist personnel or others employed or engaged by Provider not directly supervised by Administrator. Administrator shall immediately notify Provider of any lawsuits or actions, or any threat thereof, that are known or become known to Administrator that might adversely affect any interest of Administrator or Provider whatsoever. In conformance with the provisions of this paragraph 15.1.2

15.2 Arbitration. All parties agree that any and all disputes shall be submitted to binding arbitration and the arbitrator shall be one individual. All arbitration hearings shall be held in Phoenix, Arizona at Administrator's office (or at the location of the then current primary office). Any decision of the arbitrator shall be binding, final and capable of being reduced to final judgment in any court of competent jurisdiction including but not limited to those of Arizona and this state. The arbitrator shall be entitled to issue decisions involving injunctive and other equitable relief. Each party shall pay one-half the cost of arbitration including the arbitrator's fee. Each party shall pay its reasonable attorney's fees and costs. The arbitrator upon the showing of reasonable necessity shall grant discovery. Each party shall submit a name of an attorney licensed in the State of Arizona in good standing as possible arbitrator to the other. None of the arbitrators submitted by either party shall be past or present business associates, attorneys of either party or its principals or personal friends. If one of the named attorneys is acceptable to both parties said person shall be selected arbitrator. If neither is mutually acceptable said nominated attorneys shall select a third qualified attorney to serve as arbitrator. The proceeding shall be a private arbitration, however, to the extent possible and not in conflict with this paragraph the general rules of the America Arbitration Association shall be followed. In the event there is conflict or ambiguity between the terms of this arbitration clause and the American Arbitration Association rules this arbitration clause shall control.

15.3 Headings Article and Section headings used in this Agreement are for convenience of reference only and shall not constitute a part of this Agreement for any other purpose or affect construction of this Agreement.

15.4 Entire Agreement; Amendment. This Agreement, along with any Agreement of Succession, constitutes the entire agreement between the parties related to the subject matter hereof and supersedes all prior agreements, understandings, and letters of intent relating to the

subject matter hereof. This Agreement may be amended or supplemented only by a writing executed by both parties.

15.5 Relationship of the Parties. The relationship of the parties is and shall be that of independent contractors, and nothing in this Agreement is intended as, and nothing shall be construed to create, an employer/employee relationship, partnership, or joint venture relationship between the parties, or to allow either to exercise control or direction over the manner or method by which the other performs the services that are the subject matter of this Agreement; provided, however, that the services to be provided hereunder shall always be furnished in a manner consistent with the standards governing such services and the provisions of this Agreement.

15.6 Notices. Any notice or other communication required or desired to be given to either party shall be in writing and shall be deemed given when hand-delivered or deposited in the United States mail, first-class postage prepaid, addressed to the parties at the addresses indicated on the first page hereto. Any party may change the address to which notices and other communications are to be given by giving the other parties notice of such change.

15.7 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which, when taken together, will constitute one and the same instrument.

15.8 Governing Law. This Agreement shall be construed and governed in accordance with the laws of the State of Maryland, without reference to conflict of law principles.

15.9 Assignment. This Agreement may only be assigned with the written consent of the non-assigning party, which consent my not be unreasonably withheld. There is no consent required from Provider for Administrator's assignment of this Administrative Agreement to a third party in the event of a sale or transfer to a third party which occurs as a part of a sale of a "significant portion" of the assets (or stock) in Administrator or its the holding company. A "significant portion" is defined as more than fifty percent (50%) of the stock or assets of Administrator or its holding company.

15.10 Waiver. Waiver of any agreement or obligation set forth in this Agreement by either party shall not prevent that party from later insisting upon full performance of such agreement or obligation and no course of dealing, partial exercise or any delay or failure on the part of any party hereto in exercising any right, power, privilege, or remedy under this Agreement or any related agreement or instrument shall impair or restrict any such right, power, privilege or remedy or be construed as a waiver therefore. No waiver shall be valid against any party unless made in writing and signed by the party against whom enforcement of such waiver is sought.

15.11 Binding Effect. Subject to the provisions set forth in this Agreement, this Agreement shall be binding upon and inure to the benefit of the parties hereto and upon their respective successors and assigns.

15.12 Attorneys. The Provider and the Administrator acknowledge that this Agreement has been negotiated and prepared by legal counsel for both the Provider and Administrator.

15.13 Severability. If any one or more of the provisions of this Agreement is adjudged to any extent invalid, unenforceable, or contrary to law by a court of competent jurisdiction, each and all of the remaining provisions of this Agreement will not be affected thereby and shall be valid and enforceable to the fullest extent permitted by law.

15.14 Force Majeure. Either party shall be excused for failures and delays in performance of its respective obligations under this Agreement due to any cause beyond the control and without the fault of such party, including without limitation, any act of God, war, terrorism, bio-terrorism, riot or insurrection, law or regulation, strike, flood, earthquake, water shortage, fire, explosion or inability due to any of the aforementioned causes to obtain necessary labor, materials or facilities. This provision shall not, however, release such party from using its best efforts to avoid or remove such cause and such party shall continue performance hereunder with the utmost dispatch whenever such causes are removed. Upon claiming any such excuse or delay for non-performance, such party shall give prompt written notice thereof to the other party, provided that failure to give such notice shall not in any way limit the operation of this provision.

15.15 Authorization for Agreement. The execution and performance of this Agreement by Provider and Administrator have been duly authorized by all necessary laws, resolutions, and corporate or partnership action, and this Agreement constitutes the valid and enforceable obligations of Provider and Administrator in accordance with its terms.

15.16 Duty to Cooperate. The parties acknowledge that the parties' mutual cooperation is critical to the ability of Administrator to perform successfully and efficiently its duties hereunder. Accordingly, each party agrees to cooperate fully with the other in formulating and implementing goals and objectives which are in Provider's best interest.

15.17 Limited Renegotiation. This Agreement shall be construed to comply with any and all federal and state laws, including laws relating to Medicare, DentiCal and other third party payers and Dental Board Regulations. In the event there is a change in such laws, whether by statute, regulation, agency or judicial decision or guidance that has any material effect on any term of this Agreement, then the applicable term(s) of this Agreement shall be subject to renegotiation and either party may request renegotiation of the affected term or terms of this Agreement, upon written notice to the other party, to remedy such condition.

The parties expressly recognize that upon request for renegotiation, each party has a duty and obligation to the other only to renegotiate the affected term(s) in good faith and, further, each party expressly agrees that its consent to proposals submitted by the other party during renegotiation efforts shall not be unreasonably withheld.

Should the parties be unable to renegotiate the term or terms so affected so as to bring it/them into compliance with the statute, regulation or judicial opinion or guidance that rendered it/them unlawful or unenforceable within ninety (90) days of the date on which notice of a desired renegotiation is given, then either party shall be entitled, after the expiration of said

ninety (90) day period, to terminate this Agreement upon ninety (90) additional days written notice to the other party.

IN WITNESS WHEREOF, the parties have executed this Administrative Services Agreement as of the day and year first above written.

[redacted] D.D.S., Big Smiles Maryland PC, a Maryland professional corporation

[redacted]

By its President

ReachOut Healthcare America, LTD.,

[redacted]

By its President

EXHIBIT 12.5

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum ("Addendum") amends and is made part of that certain Administrative Services Agreement dated as of April 1, 2009 (the "Agreement"), but is effective as of August 1, 2008 by and between [redacted] D.D.S., Big Smiles Maryland PC, a Maryland professional corporation ("Provider") or its assignee) , and ReachOut Healthcare America, LTD., a Delaware corporation ("Administrator") or its assignee.

Provider and Administrator agree that the parties incorporate this Addendum into the Agreement in order to be in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations (45 C.F.R. Parts 160 and 164) (the "Privacy and Security Rules"). It is the understanding of the parties that Administrator is acting as a business associate (as defined under HIPAA and the Privacy and Security Rules) of Provider when performing its services under the Agreement.

1. Privacy of Protected Health Information.

1.1 *Prohibition on Unauthorized Use or Disclosure.* Administrator will neither use nor disclose Protected Health Information it creates or receives for or from Provider except as permitted or required by this Addendum or as permitted or Required By Law.

1.1.1 *In General.* Administrator is permitted to use and disclose Protected Health Information it creates or receives for or from Provider:

(a) to perform any and all obligations of Administrator as described in the Agreement, provided that such use or disclosure is consistent with the terms of Provider's notice of privacy practices and would not violate the Privacy and Security Rules if done by Provider directly; or

(b) As otherwise permitted by law, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Provider directly.

Administrator may disclose Protected Health Information to subcontractors and agents to the extent necessary to assist Administrator in using Protected Health Information for the purposes set forth in this Addendum Section 1.1.1, provided that Administrator complies with Addendum Section Article 1.4.

1.1.2 *Administrator's Operations.* Administrator may use Protected Health Information it creates or receives for or from Provider as necessary for

Administrator's proper administration and to carry out Administrator's legal responsibilities (collectively, "Administrator's Operations"). Administrator may disclose Protected Health Information as necessary for Administrator's Operations only if:

(a) The disclosure is required by law; or

(b) Administrator obtains reasonable assurance from any person or organization to which Administrator will disclose such Protected Health Information that the person or organization will: (1) hold such Protected Health Information in confidence and use or further disclose it only for the purpose for which Administrator disclosed it to the person or organization or as permitted or Required By Law; and (2) notify Administrator of any instance of which the person or organization becomes aware in which the confidentiality of such Protected Health Information was breached.

1.2 *De-Identification; Data Aggregation.* Administrator may De-identify any Protected Health Information that it receives or creates and may use or disclose such De-identified information in any manner permitted by applicable law. Administrator may use or disclose Protected Health Information to provide Data Aggregation Services.

1.3 *Information Safeguards.* Administrator will use appropriate administrative, technical and physical safeguards to prevent use or disclosure of Protected Health Information created or received for or from Provider (except for uses or disclosures provided for by this Addendum). Administrator agrees to implement administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that Administrator creates, receives, maintains or transmits on behalf of Provider.

1.4 *Subcontractors and Agents.* Administrator will require any of its subcontractors and agents, to which Administrator discloses any of the Protected Health Information that Administrator creates or receives for or from Provider, to agree by written contract to comply with the same privacy and security obligations as Administrator with respect to such Protected Health Information.

2. Protected Health Information Access, Amendment and Disclosure Accounting.

2.1 *Access.* To the extent required for Covered Entities by 45 C.F.R. § 164.524, Administrator will permit Provider or, at Provider's request, an individual (or the individual's personal representative) to inspect and obtain copies of any Protected Health Information about the individual that Administrator created or received for or from Provider and that is in Administrator's custody or control. Administrator will notify Provider of any request (including, but not limited to, subpoenas) that Administrator receives for access to Protected Health Information that is in Administrator's custody or control within three (3) business days of receipt of such request. Provider shall be responsible for making determinations about access.

2.2 *Amendment.* Administrator will, upon receipt of notice from Provider, promptly amend or permit Provider access to amend any portion of the Protected Health Information that Administrator created or received for or from Provider and that is in Administrator's custody or control so that Provider may meet its amendment obligations under 45 C.F.R. § 164.526.

2.3 *Disclosure Accounting.* To assist Provider in meeting its disclosure accounting obligations under 45 C.F.R. § 164.528:

2.3.1 *Disclosure Tracking.* Administrator will record for each disclosure, not excepted from disclosure accounting under Addendum Section 2.3.2 below, that Administrator makes to a third party of Protected Health Information that Administrator creates or receives for or from Provider, (i) the disclosure date, (ii) the name and (if known) address of the person or Provider to whom Administrator made the disclosure, (iii) a brief description of the Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure. Items (i)–(iv) are collectively referred to as the "Disclosure Information." Administrator will make this Disclosure Information available to Provider promptly upon Provider's request.

2.3.2 *Exceptions from Disclosure Tracking.* Administrator need not record disclosure information or otherwise account for disclosures of Protected Health Information to any recipient or for any purpose excluded from the accounting obligation by the Privacy and Security Rules.

2.3.3 *Disclosure Tracking Time Periods.* Administrator shall have available for Provider the Disclosure Information required by Addendum Section 2.3.1 for the six (6) years preceding Provider's request for the Disclosure Information (except Administrator need have no Disclosure Information for disclosures occurring before the Effective Date of this Agreement).

2.4 *Inspection of Books and Records.* Administrator will make its internal practices, books, and records, relating to its use and disclosure of the Protected Health Information it creates or receives for or from Provider, available upon request to Provider or the Secretary of U.S. Department of Health and Human Services to determine Provider's compliance with 45 C.F.R. Part 164, Subpart E.

3. Breach of Privacy Obligations.

3.1 *Reporting.* Administrator will promptly report to Provider any use or disclosure of Protected Health Information not permitted by this Addendum of which Administrator becomes aware. Administrator will also promptly report to Provider any Security Incident involving electronic Protected Health Information of which Administrator becomes aware.

3.2 *Mitigation.* Administrator shall mitigate, to the extent practicable, any harmful effect that is known to Administrator of a use or disclosure by Administrator or by any subcontractor or agent of Administrator in violation of this Addendum or applicable law.

4. Term and Termination of Addendum.

4.1 *Term.* This Addendum shall be effective as of the Effective Date of the Agreement and shall remain in effect until termination of the Agreement.

4.2 *Obligations upon Termination.* Upon termination of the Agreement for any reason, Administrator will, if feasible, return to Provider or destroy all Protected Health

Information maintained by Administrator in any form or medium that Administrator created or received for or from Provider, including all copies of such Protected Health Information. Further, Administrator shall recover any Protected Health Information in the possession of its agents and subcontractors and return to Provider or destroy all such Protected Health Information. In the event that Administrator determines that returning or destroying any Protected Health Information is infeasible, Administrator shall promptly notify Provider of the conditions that make return or destruction infeasible. With regard to any Protected Health Information that cannot feasibly be returned to Provider or destroyed, Administrator may maintain such Protected Health Information but shall continue to abide by the terms and conditions of this Addendum with respect to such information and shall limit its further use or disclosure of such information to those purposes that make return or destruction of the information infeasible.

4.3 *Survival.* Upon termination of this Addendum for any reason, all of Administrator's obligations under this Addendum shall survive termination and remain in effect (a) until Administrator has completed the return or destruction of Protected Health Information as required by Addendum Section 4.2 and (b) to the extent Administrator retains any Protected Health Information created or received for or from Provider pursuant to Addendum Section 4.2.

5. General Provisions.

5.1 *Definitions.* Capitalized terms used in this Addendum and not otherwise defined shall have the meanings set forth in the Privacy and Security Rule. The term "De-identify" shall mean to create information that is de-identified in accordance with the requirements of 45 CFR 164.514(b).

5.2 *Amendment.* In the event that any final regulation or amendment to final regulations is promulgated by the U.S. Department of Health and Human Services or other government regulatory authority with respect to Protected Health Information, the parties will negotiate in good faith to amend this Addendum to remain in compliance with such regulations.

5.3 *Regulatory References.* A reference in this Addendum to a section in the Privacy and Security Rules means the section as in effect or as amended.

5.4 *Interpretation.* Any ambiguity in this Addendum shall be resolved to permit Provider to comply with the Privacy and Security Rules. References in this Addendum to Protected Health Information created or received for or from Provider shall be interpreted to include, but not be limited to, Protected Health Information received by Administrator from other business associates of Provider on behalf of Provider. Nothing in this Addendum shall be construed to create any rights or remedies in any third parties.

6. Conflicts. The terms and conditions of this Addendum override and control any conflicting term or condition of the Agreement. All non-conflicting terms and conditions of the Agreement remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this HIPAA Business Associate Addendum as of the day and year first above written

[redacted] D.D.S., Big Smiles Maryland PC, a Maryland professional corporation

[redacted]

ReachOut Healthcare America, LTD.,
A Delaware corporation

[redacted]
By its President

EXHIBIT 36

JAMES R. MORIARTY
Licensed in Texas and Colorado
[redacted]
P. KEVIN LEYENDECKER
Licensed in Texas
[redacted]
HILARY S. GREENE
Licensed in Texas
[redacted]

M|L
MORIARTY LEYENDECKER
A Professional Corporation
Attorneys at Law
www.moriarty.com

Interview with Stacey Gagnon
[redacted]
Camp Verde, AZ 86322
[redacted]

By [redacted] on Friday, November 11, 2011

Background
Darren Gagnon, a high school biology teacher, and his wife Stacey, a former 3rd grade teacher, were brought uniquely close to the lives of children and young adults through teaching. Their relationships with students cultivated awareness for the need for good foster parents. Having experience with medical issues with their oldest daughter, born with a congenital heart defect, Darren and Stacey decided to specialize in becoming foster parents to children with medical needs. In 2009, Darren and Stacey were awarded the "Healer Award" in Arizona for opening their home to 10 children who needed special medical attention.

Isaac Gagnon was the first foster child that came into the Gagnon home with medical needs. Isaac was a traumatic brain injured baby as a result of being shaken by his mother. Diagnoses include five skull fractures in varying degrees of healing, bilateral retinal disorder (bleeding behind both eyeballs), subdural hematoma (bleeding on the brain), and a seizure disorder. Stacey met Isaac when she picked him up at the hospital to take him home. She describes that at this point, Isaac was basically nonfunctioning. He couldn't hold his head up, he had no facial expression, his mouth was open, and he wore a blank gaze on his face. It was as if "the lights were on, and no one was home."

Throughout this time, Isaac would wake up undergoing grand mal seizures and screaming for hours upon end. Through medical examinations, a discovery was made that migraines occurred when Isaac slept lying down. After a month of sleeping upright to relieve the pressure from his brain, Isaac "one day just woke up." He began responding to the things around him, and overall got stronger and stronger.

Finally, after rights were severed with Isaac's biological parents, Darren and Stacey adopted Isaac. Following the adoption, Isaac blossomed. He still had cognitive issues and was special needs but was overall progressing extremely well.

Isaac
Isaac is currently four years old and is described by Stacey as "all boy." He loves to play and can spend hours outside playing with metal trucks in the yard. He is very loving

and very compassionate. He is also very sensitive to other people's feelings and is always the first one that will ask, "Are you having a bad day?" But Isaac needs order and needs to understand the things around him, organizing everything in his brain. Stacey said, "If things aren't right in his world, everything is a mess."

Isaac is considered "medically fragile," a term that is not used lightly in the foster care system. To qualify under the description, extensive consensus and documentation must be gathered from numerous medical professionals. Medically fragile children are dependent on life sustaining medications, treatments, equipment, and has need for assistance with activities of daily living.

Darren and Stacey have adopted three children considered medically fragile and have two biological children of their own. Stacey describes that she and Darren are Christians and their whole life is believing in the Lord and teaching children about Him. She says that her children are the greatest blessing in their lives, and are amazing, wonderful kids.

Of the three adopted Gagnon children, Isaac is the least stable and is very psychologically scarred. Just six months ago, the night terrors that plagued Isaac in the night had lessened and Stacey and Darren believed that the "rough patch" was over. They believed that finally, Isaac would get to be the little boy that he deserved to be.

Before the Incident
Isaac was well familiar with doctors and did well at his first appointment at the dentist when he was 2.5 years old. His former dentist was Dr. [redacted], DDS, a pediatric dentist located in [redacted]. Isaac had no cavities and Darren and Stacey were told to "keep doing what they're doing."

In summer 2011, Stacey watched a rerun of 20/20's expose of a corporate owned dental chain abusing young children for profit. She watched in horror as she heard the story of children forcefully held down and/or restrained, receiving extensive and often unnecessary dental procedures while their parents waited unknowingly in the waiting room. She later spoke of the program with her best friend, and commented how "that could never happen to us" as she would never let her children receive any dental procedures without her presence.

Twice Stacey spoke with a representative from ReachOut Healthcare America, coordinator for a mobile dental unit that would be visiting Isaac's special needs preschool. She recalls stating that it was okay to go through the oral hygiene education and for Isaac to receive a cleaning. Stacey described how Isaac had intense medical issues and did not want any procedures performed. Stacey asked that if any decay was found to let her know so she could schedule a dental visit with Isaac's pediatric dentist.

Stacey had not heard again from ReachOut Healthcare America until she pulled their bill for dental procedures from Isaac's backpack.

Tuesday, October 4th
Darren and Stacey live just ¼ mile from the elementary and preschool. Stacey drives and drops her children off at school and they ride the bus home on the way back. Stacey

believed that Tuesday, October 4th was to be like any other school day—unaware that the mobile dental unit was visiting Isaac's preschool.

Statements from [redacted], [redacted] hearing aide, and from [redacted], an instructor at the preschool, document what happened that day.

Combined, their stories describe that Isaac and [redacted] were taken to the art room at the school, which was set up as a temporary dental room, shortly after preschool class began. Isaac was greeted first by "[redacted]," presumably a dental assistant, who began doing x-rays on Isaac's teeth. Despite seeming apprehensive and unsure of what [redacted] was doing, Isaac did his best to cooperate and do what he was told. After the x-rays were finished, Isaac was directed to the treatment area. [redacted] overheard the dentist say that he thought it was strange that Isaac could have crowns but not fillings.

[redacted]'s hearing aide, [redacted], arrived by then. [redacted] recalls the dentist speaking with his assistant about the paperwork, and the dentist had said, "It doesn't say anything about..." She did not hear the rest of what the dentist had said.

Soon, both [redacted] and [redacted] recognized the sounds of Isaac gagging, and [redacted] says she heard Isaac also screaming and kicking while on the table in the treatment area. [redacted] wrote that she shielded [redacted] so he couldn't see what was happening with Isaac, but Isaac was so loud that [redacted] would look to find where the sound was coming from. Both [redacted] and [redacted] recalled the dentist asking for [redacted] to come over to help him.

[redacted] remarked that three grown adults were holding down Isaac as he screamed, kicked and gagged. [redacted] estimates that the entire session took 40 minutes time, including the x-rays. After they were finished, Isaac was taken back to the preschool classroom. Though he walked calmly and quietly back it was obvious that he was upset.

Later, [redacted], a speech pathologist at the school, described how Isaac had hid in the little playhouse during playtime that day.

Stacey learned that the dentist who performed the treatment is Dr. [redacted], DDS. [redacted] is a general dentist with a clinic in [redacted].

Isaac returned from school by bus. Stacey was there to greet him and noticed immediately that something was wrong. She asked, "How was your day, bud?" Isaac's reply was hysterical sobs. Stacey assumed they must have hurt him while cleaning his teeth. Stacey asked Isaac to "show me where it hurts." Isaac opened his mouth and Stacey saw the two silver crowns.

From Isaac's backpack, Stacey pulled out a bill that showed Isaac had received two pulpotomies and two silver crowns. Stacey was livid. She is a stay-at-home mom, living a quarter mile from the school. She was doing laundry at the time. She asks, "Why was I not even called?"

Stacey called the school and spoke with the school nurse. It became clear that the school did not realize the mobile dental unit was performing procedures. The nurse spoke

with the company and said to Stacey, "They said you gave them permission [for the procedures], but you can call the company."

Stacey called the company and spoke with a man named [redacted]. He described that in the paperwork, it indeed said that they could not do fillings but that they could do root canals and teeth extractions. [redacted] described that the phone records would be consulted and a parent advocate would be in contact with her.

The next day, Darren spoke with the parent advocate who heard the phone records and admitted that Stacey explicitly told them not to perform any procedures.

Recourse
After speaking with the school superintendent and explaining what had happened to Isaac, the school board voted to break the contract with ReachOut Healthcare America and a cease and desist order was issued.

Stacey sought referrals from other parents and from her personal dentist to find a very good pediatric dentist. She was directed to Dr. [redacted], DDS.

Dr. [redacted] operates a clinic in [redacted]. It took a couple visits with "Dr. [redacted]" for Isaac to let the doctor near his mouth. The first visit, Isaac just received a prize for coming. The second visit, Dr. [redacted] counted Isaac's teeth. At this appointment, Dr. [redacted] told Stacey, "Honestly, just looking at the other teeth, he doesn't have any decay. If root canals were needed on one side, you would see decay on the other side." He hypothesized that the treatment was unnecessary.

Later, Dr. [redacted] office received the original x-rays from Isaac's dental visit with ReachOut Healthcare America. It was made clear by the radiographs that there was no decay on Isaac's teeth and that the procedures were unnecessary.

In addition, it was also found later that the "pulpotomies" performed on Isaac's teeth weren't even done correctly. Dr. [redacted] simply opened the pulp chamber and closed it again. Stacey was told that the work, previously unnecessary, now has to be done over.

Darren and Stacey filed with the Sheriff's department and the County Attorney is looking to press criminal charges, possibly aggravated assault, child abuse, fraud and kidnapping. As of now, the claim is still in the investigation phase.

The Vice President of ReachOut Healthcare America visited with them recently. The visit did not go very well. The Vice President said, "I have five kids, I know how you feel." Stacey said over the phone to me, "That's bull! This isn't a bad dental experience. Three grown-ups held him down for almost 40 minutes. He thought he was in a safe place. Isaac wasn't stable to begin with!"

Isaac Afterward
Stacey describes that Isaac is a "complete mess, emotionally." He simply cannot process what had happened to him. He has slept in Darren and Stacey's room every night. The "night terrors have come back 10-fold." Whereas the previous night terrors caused Isaac to scream out in his sleep, the current night terrors are much more severe. In addition to

the screaming, Isaac is now combative. When he is comforted, he responds by kicking and punching. Stacey says it has been "a month of hell."

Isaac does not want to go to bed at night and in the mornings he can't get out of bed. He can't dress himself. Overall, Stacey describes, he can't function during the day. Half of this morning (Friday, November, 11, 2011), Isaac spent on the floor crying. He says he "doesn't know why, I'm just so sad." The gains that Darren and Stacey had achieved have regressed completely.

Isaac has not returned back to school since the incident. He wets his pants again—something he hasn't done in 2.5 years. He is abnormally aggressive and acts out.

He has begun to role-play what happened to him. Stacey found Isaac with his three-year-old sister [redacted], saying "You better be brave" and then smashing her mouth with a toy.

Stacey has taken Isaac to an Eye Movement Desensitization and Reprocessing (EMDR) counselor to try to help his brain process the trauma. The counselor has diagnosed Isaac with acute stress disorder, but Stacey believes that since Isaac is not getting any better, he will end up with a post-traumatic stress disorder diagnosis.

Darren and Stacey have also visited a counselor themselves. They have been struggling to try to help Isaac and they don't know how to parent him right now. This situation is beyond anything Darren and Stacey have encountered—and they have dealt with a lot.

In regard to a potential lawsuit, Stacey says, "I don't care if we never see a dime. I want this to stop. This happened at a public school in America. I have the bill. My son was about making $750."

EXHIBIT 37

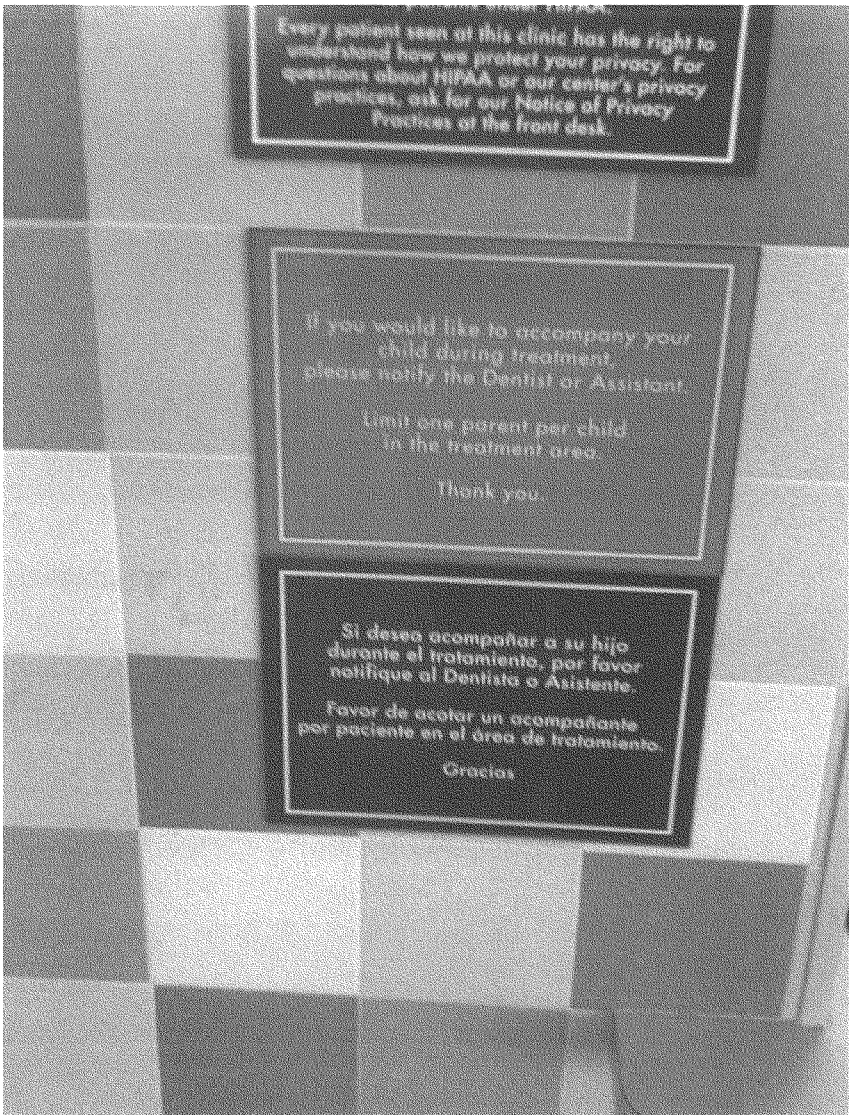

Every patient seen at this clinic has the right to understand how we protect your privacy. For questions about HIPAA or our center's privacy practices, ask for our Notice of Privacy Practices at the front desk.
If you would like to accompany your child during treatment, please notify the Dentist or Assistant.
Limit one parent per child in the treatment area.
Thank you.
Si desea acompañar a su hijo durante el tratamiento, por favor notifique al Dentista o Asistente.
Favor de acatar un acompañante por paciente en el área de tratamiento.
Gracias

EXHIBIT 38

[redacted] Small Smiles Dental Centers of Florence

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Chief Compliance Officer
CSHM LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor
CSHM LLC

Clinic Report
Florence, South Carolina

Deliverable #1-62

July 3, 2012

Executive Summary

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Florence, 943-A S. Irby, Florence, SC 29501 (Clinic).

Overall Clinic Impression

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were timely provided. Patient observations revealed good teamwork involving the dentists and staff, and patients were managed well during administration of appropriate local anesthesia.

Overall Summary of Critical Findings and Observations

The Monitor's critical findings and observations are summarized below:

The Monitor conducted a desk review of the Clinic in which a report was issued on January 24, 2012. Attachment A sets forth the verbatim CSHM responses to the Monitor's recommendations and reflects the Monitor's assessment of CSHM's implementation of the Monitor's recommendations.

Through interviews, documentation review, and treatment observations, the Monitor determined that CSHM had successfully met and implemented 8 of the 12 recommendations. The Monitor identified two recommendations that were partially met, one recommendation that will require additional evaluation, and one recommendation that remains unmet. With respect to the recommendation that requires additional evaluation, there was insufficient data to determine whether CSHM's measures were effective in the implementation of the recommendation related to the documentation of medical necessity. The remaining recommendation was determined as unmet because CSHM did not have documentation to show the Chief Dental Officer (CDO) performed a retrospective record review to evaluate quality of care or medical necessity in the three records specifically identified in the Monitor's recommendation. Although CSHM issued a refund for the Monitor's initial findings related to two of the three records, review of all services performed after the audited date of service was not performed as recommended. Upon re-review of these records, the Monitor found medically unnecessary pulpotomies were performed after the audited date of service in two of the three records. Further details of these findings are reported in the Review of Dental Record Documentation section below. Although substantial training measures were taken by CSHM in an effort to meet the Monitor's recommendations, lack of

communication of the Monitor's findings and need for retraining inhibited the Clinic in identifying the focused areas which required improvement.

Interviews with staff members and dentists revealed they were not aware of the Monitor's report, or of the findings or recommendations. Specifically, The Compliance Liaison reported she had been in communication with several members of CSHM's management team and determined from their questions there was a report. However, when she asked about it, she was told it had been divided and distributed by department. She reported she had not been given the report in spite of numerous requests.

The Health History form in six records did not provide adequate follow-up information to "yes" responses provided.

Four records did not document decay on the upper odontogram of the Tooth Chart. Six records did not document existing conditions on the upper odontogram of the Tooth Chart.

With respect to medical necessity, the Monitor found two records did not provide radiographic evidence to support the medical necessity for extractions performed; and eight records showed pulpotomies were performed on teeth where X-rays did not show decay was half way to the pulp. The findings related to three medically unnecessary pulpotomies performed in patients #052 and #053 are particularly significant in that the Monitor's retrospective review found these services were not reviewed by CSHM as recommended in the previous report.

In review of post-operative X-rays, the Monitor had the following quality of care critical findings: pulpotmoes were performed without complete removal of pulpal tissue in three records and oversized crowns were evident on the X-rays in two patient records. An additional patient's X-rays showed mesial decay on #T which went undiagnosed and a single surface occlusal amalgam filling was placed on tooth #T. Post-operative X-rays revealed the mesial decay had increased and the tooth then received a stainless steel crown (SSC).

The Monitor found four of five patient visits, reviewed for one associate dentist, documented the use of Septocaine for mandibular inferior alveolar block injections. During the retrospective review of treatment over time, the Monitor's pediatric dentist found three additional records where the same associate dentist used Septocaine for mandibular inferior alveolar block injections, and one record where the same provider administered Septocaine to a child younger than 4 years of age. The *CSHM Quality Assurance Protocols and Guidelines for Dental Centers* states "Septocaine is not recommended for block injection, however. In addition, the FDA has not approved the use of Septocaine in children younger than 4 years."

Eight patient visits were identified in which treatment times appeared to be of unusually short duration with respect to the amount of treatment performed.

Dentists administered appropriate local anesthetic for the procedures being performed with proper use of topical anesthetic.

The Monitor observed good teamwork between the dental assistants and dentists in managing patients and providing care.

The dentists demonstrated knowledge about techniques to ameliorate pain during injections, the proper techniques for different procedures and teeth, and the amount necessary to achieve pain control. Dentists also administered appropriate local anesthetic for the procedures being performed with proper use of topical anesthetic and demonstrated good techniques to mask the painful sensation associated with the injections. Patients appeared comfortable during the treatment.

Procedures were not apparent to ensure the final examination was performed on clean teeth, the maximum dose of local anesthetic had been calculated and modified for use in conjunction with IV sedation, and protection of the airway during extractions on a patient treated using IV sedations.

A gauze shield was not used to protect the airway during extractions and for fitting of an SSC.

Patients receiving nitrous oxide oxygen-oxygen analgesia were not titrated in 10% increments as directed in the *AAPD Guideline on Use of Nitrous Oxide for Pediatric Dental Patients.*

The dentists were generally knowledgeable about the indications for pulpotomies and the technique for performing them, with the exception of the length of time formocresol is to be left in contact with pulp tissue. They believed it to be 1-minute instead of the accepted 5-minute application time.

Overall Summary of Recommendations

The Monitor's recommendations are summarized below:

- Ensure the Monitor is provided with all requested documents with respect to chart audit appeals and all CAPs.
- Ensure the CAP for the September 2011 chart audit failure was completed.
- Ensure the Monitor's report findings and recommendations are clearly communicated with the Clinic staff.
- Ensure all recommendations made by the Monitor, especially those related to medically unnecessary treatment and quality of care, are promptly evaluated and implemented.
- Ensure CSHM documents findings and actions related to follow-up record reviews, site visits, or other measures of evaluation.
- Ensure staff members provide adequate follow-up information and explanations for "yes" responses on the Health History form.
- Ensure staff members document existing conditions, pathology, decay, and completed treatment in the designated areas on the Tooth Chart as described in the *Chart Documentation Guide*.

- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure dentists identify the radiographic and/or clinical criteria necessary to support the medical necessity for performing an extraction and pulpotomy.
- Ensure dentists recognize all radiographically demonstrable decay and pathology and address the patient's needs appropriately in the Treatment Plan.
- Ensure dentists employ proper techniques when performing pulpotomies and SSCs including adequate removal of all pulp tissue and proper crown sizes when placing SSCs.
- Ensure dentists comply with the recommendations regarding administration of Septocaine as set forth in the *CSHM Quality Assurance Protocols and Guidelines for Dental Centers.*
- Ensure staff members, who serve as a witness to consent for treatment, complete their signature immediately following a parent's or guardian's signature.
- Ensure the CDO reviews the records of patients #004, #005, #006, #007, #010, #011, #013, and #014 for accuracy and appropriateness of time recorded for treatment rendered.
- Ensure a root cause analysis is performed to determine if short treatment time has any correlation with quality of care.
- Ensure the Account History Report and the patient's record accurately reflects all procedures performed.
- Ensure only licenses of currently employed dentists and staff are displayed in the Clinic.
- Ensure sufficient protocols exist for patients receiving IV sedation that address cleaning the mouth prior to examining the teeth, documentation of the maximum dose of local anesthetic to include adjustments for combination with IV sedation, and methods used to protect the airway of patients during extractions and other procedures that could compromise the airway.
- Ensure techniques to protect the airway of patients during extractions and placement of SSCs are uniformly implemented.
- Ensure patients receiving nitrous oxide oxygen-oxygen analgesia are titrated in 10 percent increments as directed in the *AAPD Guideline on Use of Nitrous Oxide for Pediatric Dental Patients.*
- Ensure the maximum allowable dose of local anesthetic is calculated prior to administering the agent.

Clinic On-site Report

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management Systems, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Florence, 943-A S. Irby, Florence, SC 29501 (Clinic). This is a follow-up visit to a desk audit review issued January 24, 2012, evaluating CSHM's audit of Clinic records for the second quarter of 2011. The primary scope of this review is to determine whether the recommendations contained in the Monitor's report from the previous desk report have been implemented. It will also include, however, any additional findings discovered during this review. Specifically, adverse events, complaints, and chart audits were reviewed to identify any significant quality of care issues. There is no Lead Dentist in this Clinic. There were three dentists reviewed in the original desk audit; of these, two are still employed at the Clinic.

Implementation

The OIG approved an unannounced on-site visit to be conducted on June 13-15, 2012, at the Clinic. The Monitor notified Danette Manzi, Chief Compliance Officer on the morning of June 13, 2012, of the upcoming visit.

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were timely provided. Patient observations revealed good teamwork involving the dentists and staff, and patients were managed well during administration of appropriate local anesthesia.

Entrance Conference

An entrance conference was held on June 11, 2012. The Monitor Team of [redacted] CDA, RDH, [redacted], and [redacted], DDS, MSD attended. Clinic staff members [redacted] Practice Administrator and Compliance Liaison, and [redacted], Clinical Coordinator, also attended. Discussion included an overview of the process, point of contact information, intent to conduct treatment observations, and the need to interview individuals employed by the Clinic. The Monitor explained that this visit was a follow-up to the previous desk review conducted in January 2012 with the intent to conduct a more focused review related to findings and recommendations stemming from the desk review report.

General

Because the previous report was a desk review, there were no findings or recommendations in the previous report that required follow-up during this visit.

Review of Quality Control System

Policies and Procedures

Because the previous report was a desk review, there were no findings or recommendations in the previous report that required follow-up during this visit.

Training

Because the previous report was a desk review, there were no findings or recommendations in the previous report that required follow-up during this visit.

Internal Audits

The Monitor reviewed quarterly chart audits from August 2011 to present. The Clinic was audited in September, November, and December 2011, and March 2012. The Monitor received copies of the Attestation Letters for each audit. The Clinic and the dentists passed all chart audits with the exception of the September 2011 quarterly chart audit. The Monitor confirmed that all identified billing errors were corrected.

The Clinic and all two dentists failed the September 2011 audit. Billing errors were identified and a Corrective Action Plan (CAP) issued. An appeal was filed. The Monitor did not receive documentation of the appeal results or documentation of completion of the CAP. Due to the failed September 2011 audit, a re-audit was conducted in November 2011. The results e-mail indicated the Clinic and all dentists passed the audit.

Analysis of CSHM Corrective Action

The Monitor performed a desk review of the Clinic to evaluate CSHM's quarterly chart audit for the second quarter of 2011. The report was issued on January 24, 2012.

Attachment A sets forth the verbatim CSHM responses to the Monitor's recommendations and reflects the Monitor's assessment of CSHM's implementation of the Monitor's recommendations. Through interviews, documentation review, and treatment observations, the Monitor determined that CSHM had successfully met and implemented 8 of the 12 recommendations. The Monitor identified two recommendations that were partially met, one recommendation that will require additional evaluation, and one recommendation that remains unmet. With respect to the recommendation that requires additional evaluation, there was insufficient data to determine whether CSHM's measures were effective in the implementation of the recommendation related to the documentation of medical necessity. The remaining recommendation was determined as unmet because CSHM did not have documentation to show the Chief Dental Officer (CDO) performed a retrospective record review to evaluate quality of care or medical necessity in the three records specifically identified in the Monitor's recommendation. Although CSHM issued a refund for the

Monitor's initial findings related to the audited date of service, review of all services performed after the audited date of service was not performed as recommended. Upon re-review of these records, the Monitor found medically unnecessary pulpotomies were performed after the audited date of service in two of the three records. Further details of these findings are reported in the Review of Dental Record Documentation section below. Although substantial training measures were taken by CSHM in an effort to meet the Monitor's recommendations, lack of communication of the Monitor's findings and need for retraining inhibited the Clinic in identifying the focused areas which required improvement.

Interviews with staff members and dentists revealed they were not aware of the Monitor's report, or of the findings or recommendations. Specifically, The Compliance Liaison reported she had been in communication with several members of CSHM's management team and determined from their questions there was a report. However, when she asked about it, she was told it had been divided and distributed by department. She reported she had not been given the report in spite of numerous requests.

Staff members reported they were asked to review the Chart Documentation PowerPoint, but were not told why. The Clinical Coordinator reported there had been many training events, but she was unaware of any problems they were intended to target or focus. The Compliance Liaison reported she had been told to have everyone watch specified videos and administer quizzes but was unable to elicit a response from CSHM as to why they were retraining. The staff was able to articulate changes to policies and procedures but no other changes were identified. CSHM does not have documentation to show the CDO reviewed records for patients #005, #006, or #008, as recommended in the January 24, 2011, report; however documentation reflects refunds were made on patients #006 and #008.

Complaints

The Monitor reviewed the Adverse Event Log to identify quality of care issues. The Adverse Event Log was located in the Clinic. The signature sheet indicated no one asked to review the log. All adverse events within the past 18 months were reported on the Adverse Event Log.

According to the documentation provided to the Monitor, there have been eight confirmed adverse events since September 2010. The four adverse events in 2010 were a result of providing treatment without proper consent and involved a dentist who is no longer employed with CSHM. In 2011, there were three adverse events that included two cases where a cut to the mouth occurred during treatment and one case where the wrong tooth was treated. The two dentists involved in the 2011 adverse events are currently practicing in the Clinic. In 2012, there has only been one confirmed adverse event which involved treatment provided without consent. The treating dentist in this case was terminated on May 30, 2012. Another case appears to remain open and reportedly involved a dentist who was from Small Smiles Dental Centers of Columbia. Documentation related to this case indicates on January 3, 2012, the Office Manager reported to CSHM two examples of procedures that were billed by the treating

dentist but were identified during the patient's recall as not having been performed. This case (CD-935) was assigned to CSHM's Compliance Attorney and the Audit Manager, Compliance and appears to remain open with no documentation of a resolution provided to the Monitor.

It appears CAPs were issued for each confirmed adverse event; however, the Monitor did not receive complete documentation on all investigations, CAPS, or evidence to show completion of the CAPs.

Complaints

The Compliance Disclosure Log identified four complaints from parents/patients. There were two complaints of long wait times and two of rude staff. Four comment cards also expressed "great" and/or "wonderful" experiences at the Clinic. The Monitor received documentation of investigative reports, CAPs, and completion of CAPs associated with all parent/patient complaints.

Recommendations

- Ensure the Monitor is provided with all requested documents with respect to chart audit appeals and all CAPs.
- Ensure the CAP for the September 2011 chart audit failure was completed.
- Ensure the Monitor's report findings and recommendations are clearly communicated with the Clinic staff.
- Ensure all recommendations made by the Monitor, especially those related to medically unnecessary treatment and quality of care, are promptly evaluated and implemented.
- Ensure CSHM documents findings and actions related to follow-up record reviews, site visits, or other measures of evaluation.

Review of Communication System

Because the previous report was a desk review, there were no findings or recommendations in the previous report that required follow-up during this visit.

Review of Dental Record Documentation

The testing attributes related to the dental record documentation were designed to determine whether the documentation was complete and accurate, including HIPAA-related forms, medical necessity, and consent forms. A sample of 15 visits representing 15 separate patients and records was identified from the patient listing provided by CSHM, based on all Medicaid patients seen for operative visits from April 18, 2012, through June 12, 2012. The Monitor's pediatric dentist provided consultation on 14 of the 15 patient records reviewed.

This portion of the report also contains additional record review findings from the Monitor's pediatric dentist's observations of patient care and retrospective quality of care record review. Findings related to patients #031 to #034 are a result of the Monitor's pediatric dentist's treatment observations. Findings related to patients #036 to

#045 and patient #007 are a result of the Monitor's quality of care review. As a follow up to the Monitor's previous report, patients #050 through #053 were also included in the quality of care review group. In order to complete the retrospective quality of care record review, 10 additional records of patients who had received operative procedures and returned for post-operative X-rays were identified from a list provided by CSHM. The relevant findings from the review of the 15 visit records, 4 treatment observations, and the 15 quality of care review are as follows:

Health History

The Health History form in six records (patients #002, #004, #008, #013, #031, and #032) did not provide adequate follow-up information to "yes" responses provided.

The table below provides a summary of each finding.

Health History		
Patient	**Date**	**Finding**
#002	March 15, 2012	The Health History form did not document follow-up information to the "yes" response to "does the patient have any dental problems/concerns at this time."
#004	April 30, 2012	There was no follow-up information for the "yes" response for asthma/breathing problems.
#008	April 18, 2012	There was lack of follow-up information regarding the chief complaint which was documented in Spanish as "tooth no coming out good" and recorded on the Hygiene Procedures form as "crooked tooth."
#013	April 18, 2012	There was lack of follow-up information regarding "surgery for kidneys."
#031	February 13, 2012	There was lack of follow-up information regarding the "yes" response to "asthma/breathing problems."
#032	May 8, 2012	There was lack of follow-up information regarding the "yes" response to "asthma/breathing problems."

Tooth Chart

Four records (patients #001, #006, #010, and #041) did not document decay on the upper odontogram of the Tooth Chart.

Six records (patients #002, #007, #008, #011, #012, and #033) did not document existing conditions on the upper odontogram of the Tooth Chart.

Two records (patient #009 and #033) did not document the completed treatment on the lower odontogram of the Tooth Chart.

The tables below contain a summary of the findings related to the Tooth Chart.

Decay Not Documented on the Upper Odontogram		
Patient	**Date**	**Finding**
#001	April 23, 2012	Decay on tooth #Q
#006	May 15, 2012	Decay on tooth #T
#010	April 30, 2012	Decay on teeth #C and #H
#041	April 20, 2012	Decay on #L and #K

Existing Conditions Not Documented on the Tooth Chart		
Patient	**Date**	**Finding**
#002	April 17, 2012	Furcation radiolucency and distal root resorption on tooth #L
#007	May 15, 2012	Pulpotomies in teeth #B, #K, #L, or #S
#008	April 18, 2012	Pulpotomies in teeth #H, #I, #J, and #S
#011	May 17, 2012	Pulpotomies in teeth #A and #B and the occlusal filling in tooth # K
#012	May 17, 2012	Teeth #M and #N documented incorrectly as fused, when should have been teeth #Q and #R
#033	April 17, 2012	Pulpotomies and SSCs in teeth #L, #S, and #T

Completed Treatment Not Documented on the Lower Odontogram		
Patient	**Date**	**Finding**
#009	May 25, 2012	Sedative filling performed on tooth #T
#033	June 14, 2012	Extraction of teeth #I and #J

X-rays

X-rays contained within the records were generally of good diagnostic quality and labeled correctly. Some X-rays within the records were found in envelopes making them easy to find and others were found loose in the record making them more difficult to locate.

Medical Necessity

Within the records reviewed, the Monitor's pediatric dentist found two records (patients #004 and #005) did not provide radiographic evidence to support the medical necessity for extractions performed. Eight records (patients #007, #008, #036, #038, #042, #044, #052, and #053) showed pulpotomies were performed on teeth where X-rays did not show decay half way to the pulp. The findings related to three medically unnecessary pulpotomies performed in patients #052 and #053 are significant because these were treatments planned at the time of the CSHM desk audit and were the reason the Monitor recommended review of these records.

The following table provides details related to each finding:

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
#004	May 14, 2012	There was no medical necessity for the extraction of teeth #N and #Q because the X-rays dated April 30, 2012, revealed both teeth were fully rooted with no evidence of over-retention.
#005	April 25, 2012	There was no medical necessity for the extraction of tooth #K because the X-rays dated January 18, 2012, revealed no evidence of pathology, there was no documentation of symptoms such as pain, and the tooth appeared restorable.
#007	June 2, 2011	There was no medical necessity for the pulpotomy on tooth #K because decay was not half way to the pulp.
#008	June 4, 2012	There was no medical necessity for the pulpotomy performed on tooth #J because the X-rays dated April 18, 2012, did not show decay half way to the pulp.
#036	August 22, 2011	There was no medical necessity for the pulpotomy performed on tooth #S because the X-rays dated March 22, 2011, did not show decay half way to the pulp.
#038	August 5, 2011	There was no medical necessity for the pulpotomy performed on tooth #B because the X-rays dated January 6, 2011, did not show decay half way to the pulp.
#042	February 22, 2011	There was no medical necessity for the pulpotomy performed on tooth #T because the X-rays dated July 7, 2010, did not show decay half way to the pulp.
#044	November 18, 2011 and November 3, 2011, respectively	There was no medical necessity for the pulpotomies performed on teeth #K and #T because the X-rays dated November 3, 2011, did not show decay half way to the pulp.
#052 (#005 from desk review)	June 13, 2011	There was no medical necessity for the pulpotomy performed on tooth #S because the X-rays dated June 13, 2011, did not show decay half way to the pulp. CSHM did not provide documentation to show a review of these services had been performed as recommended in the Monitor's previous report.
#053 (#008 from	May 24, 2011	There was no medical necessity for the pulpotomies performed on teeth #A and #B because the X-rays dated March 25, 2011, did not show decay half way

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
desk review)		to the pulp. CSHM did not provide documentation to show a review of these services had been performed as recommended in the Monitor's previous report.

Treatment Plan

The Treatment Plan dated April 30, 2012, for patient #010 did not address the undiagnosed radiographic decay on teeth #C and #H.

Other Quality of Care Issues

In review of post-operative X-rays, the Monitor found three records (patients #008, #037, and #039) with incomplete removal of pulpal tissue in teeth that received pulpotomies. Two records (patients #008 and #038) revealed oversized crowns. Four records (#007, #036, #042, and #043) also showed pulpotomies that were well done.

In one record (patient #045), X-rays dated May 10, 2011, showed mesial decay on tooth #T that went undiagnosed and a single surface occlusal amalgam filling was placed on tooth #T on September 19, 2011. Post-operative X-rays dated April 10, 2012, revealed the mesial decay had increased and on May 3, 2012, tooth #T received an SSC.

The following table provides a summary related to these findings.

Incomplete Removal of Pulpal Tissue		
Patient	**Date**	**Finding**
#008	April 18, 2012	Teeth #H, #I, and #J were treated on December 29, 2011, with pulpotomy and SSCs. Post-operative bitewing X-rays revealed incomplete removal of pulpal tissue in tooth #H.
#037	May 31, 2012	Teeth #S and #T were treated with pulpotomy on October 19, 2011. Post-operative X-rays revealed incomplete removal of pulpal tissues, furcation radiolucency, distal root resorption, and internal resorption on the distal root in tooth #S, and beginning furcation radiolucency in tooth #T.
#039	April 24, 2012	Tooth #L received a pulpotomy on October 18, 2011. Post-operative X-rays revealed incomplete removal of pulpal tissue in tooth #L. (The Monitor also noted the Account History Report incorrectly documented tooth #K received the pulpotomy instead of tooth #L.)

Oversized Crowns		
Patient	**Date**	**Finding**
#008	April 18, 2012	Teeth #I and #J were treated on December 29, 2011, with pulpotomy and SSCs. Post-operative bitewing X-rays revealed large over-extended crowns on teeth

Oversized Crowns		
Patient	**Date**	**Finding**
		#I and #J.
#038	April 10, 2012	Tooth #B received SSC on August 5, 2011. Post-operative X-rays revealed oversized SSC on tooth #B.

Patient Management

Local Anesthesia

During the review of the 15 patient visits, the Monitor found four of five patient visits (patients #006, #007, #009, and #010), for one associate dentist, documented the use of Septocaine for mandibular inferior alveolar block injections. During the retrospective review of treatment over time, the Monitor's pediatric dentist found three additional records (patients #036, #037, and #040) where the same associate dentist used Septocaine for mandibular inferior alveolar block injections, and one record (patient #041) where the same provider administered Septocaine to a child younger than 4 years of age. The *CSHM Quality Assurance Protocols and Guidelines for Dental Centers* states "Septocaine is not recommended for block injection, however. In addition, the FDA has not approved the use of Septocaine in children younger than 4 years."

Nitrous Oxide Consent

During treatment observations, the Monitor noticed the Nitrous Oxide Consent form dated June 15, 2012, for patient #034 was signed only by the parent and did not have a witness signature.

Observation

Within the records reviewed, eight patient visits (patients #004, #005, #006, #007, #010, #011, #013, and #014) were identified in which treatment times appeared to be of unusually short duration with respect to the amount of treatment performed.

The following table provides a summary related to these findings.

Treatment Time of Short Duration		
Patient	**Date of Service**	**Finding**
#004	May 14, 2012	The treatment time was documented as two minutes for the extraction of teeth #N, #P, and #Q.
#005	April 25, 2012	The treatment time was documented as nine minutes for placement of SSCs on teeth #I and #J and the extraction of tooth #K.
#006	June 7, 2012	The treatment time was documented as nine minutes. Tooth #S was treated with an SSC. Decay was discovered on the mesial of tooth #T during treatment. Consent was then obtained for treatment

Treatment Time of Short Duration		
Patient	**Date of Service**	**Finding**
		of tooth #T and treatment resumed with tooth #T also receiving an SSC.
#007	June 5, 2012	The treatment time was documented as nine minutes for the pulpotomy and SSC performed on tooth #A and the filling on tooth #T.
#010	May 17, 2012	The treatment time was documented as 13 minutes for the pulpotomy and SSC performed on tooth #L, and SSC on tooth #S.
#011	June 8, 2012	Treatment time was documented as 12 minutes to perform an occlusal filling on tooth #19 and SSCs on teeth #K and #L.
#013	May 21, 2012	Treatment time was documented as one minute to extract teeth #O and #P.
#014	April 25, 2012	The treatment time was documented as 14 minutes for placement of pulpotomies and SSCs on teeth #S and #T.

Account History

The Account History Report and Hygiene Procedures form for patient #002 documented that a periapical X-ray was taken of tooth #L; however, the X-ray found in the record was a left bitewing X-ray.

Within the record for patient #006, a mandibular occlusal X-ray was found in the record dated May 15, 2012; however, the Hygiene Procedures form and Account History did not document the X-ray was taken or billed.

Recommendations

- Ensure staff members provide adequate follow-up information and explanations for "yes" responses on the Health History form.
- Ensure staff members document existing conditions, pathology, decay, and completed treatment in the designated areas on the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure dentists identify the radiographic and/or clinical criteria necessary to support the medical necessity for performing an extraction and pulpotomy.
- Ensure dentists recognize all radiographically demonstrable decay and pathology and address the patient's needs appropriately in the Treatment Plan.
- Ensure dentists employ proper techniques when performing pulpotomies and SSCs including adequate removal of all pulp tissue and proper crown sizes when placing SSCs.

- Ensure dentists comply with the recommendations regarding administration of Septocaine as set forth in the *CSHM Quality Assurance Protocols and Guidelines for Dental Centers*.
- Ensure staff members, who serve as a witness to consent for treatment, complete their signature immediately following a parent's or guardian's signature.
- Ensure the CDO reviews the records of patients #004, #005, #006, #007, #010, #011, #013, and #014 for accuracy and appropriateness of time recorded for treatment rendered.
- Ensure a root cause analysis is performed to determine if short treatment time has any correlation with quality of care.
- Ensure the Account History Report and the patient's record accurately reflects all procedures performed.

Treatment Observations, Findings, and Staff Interviews Related to Care

The treatment observation testing attributes were designed to determine if care is performed according to CSHM's policies and procedures, the *AAPD Guidelines*, and professionally recognized standards of care.

The on-site review included observations of treatments and interactions with patients, review of workspace, and review of dental records. Observation of treatment and patient interactions included observation of treatment on four patients who were receiving invasive dental treatment, three of whom also received nitrous oxide-oxygen analgesia and one patient who was receiving dental treatment with IV sedation. The review of workspace included observation of activities in the dental hygiene and sterilization areas. Five individuals were interviewed, including three Staff Dentists, the Compliance Liaison, and the Clinical Coordinator.

The CIA, Section III.A.2, specifies the CDO is "responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by CSHM and CSHM facilities meet the professionally recognized standards of health care." Such language directs that possessing knowledge of and following these policies are not at the discretion of the Clinic dentists and staff. The Monitor interviewed the dentists about their familiarity with the recent Best Practice e-mails and Internal Memoranda that modify, clarify, and add to *Clinical Policies and Guidelines for CSHM Associated Clinics*. The interviews targeted areas of concern identified in the Monitor's report from January 24, 2012. Queries focused on management of the patient's behavior during administration of local anesthesia and knowledge of indications for pulpotomies and the technique for performing them.

- The dentists were generally knowledgeable about the indications for pulpotomies and the technique for performing them, with the exception of the length of time formocresol was to be left in contact with pulp tissue. They believed it to be 1-minute instead of the accepted 5-minute application time.

- The dentists demonstrated knowledge about techniques to ameliorate pain during injections, the proper techniques for different procedures and teeth, and the amount necessary to achieve pain control.
- One dentist reported she had been taught in dental school to always perform a pulpotomy when placing an SSC on an anterior tooth.
- There was a new training tool, in the form of a flip calendar, which focused on clinical policies. It had been well accepted and was being used in morning huddles.

The Monitor also had the following relevant findings:

- The license of a dentist who was no longer employed by CSHM was displayed along with other current employee licenses.
- Patient #033 was treated using IV sedation.
  - The dentist performed an examination of the patient following adequate sedation. She did not brush or wipe the teeth clean before performing the examination. It is important to perform examinations on clean teeth to ensure all disease and pathology are identified. This is especially important in patients whose lack of cooperation requires sedation to perform treatment.
  - There was no Operative Procedures form (Op Sheet) observed in the treatment room and no observable documentation of the maximum dose of local anesthetic the patient could receive. In the records provided to the Monitor, there was a completed Op Sheet, and it did document the maximum dose of local anesthetic. The Monitor discussed with the Office Manager if she knew whether the nurse anesthetist requests a reduction in the total amount of local anesthesia for patients receiving IV sedation. The Office Manager evidenced sufficient knowledge of the process and reported there is a reduction in the total amount of local anesthesia. The Op Sheet recorded the patient received approximately one-half the maximum amount of the local anesthesia calculated. Without conducting an independent calculation however, anyone reviewing the calculation cannot determine whether the maximum dose calculated is the maximum dose for an individual with IV sedation, or the maximum dose for a patient who is not receiving such sedation.
  - Teeth #A, #B, #I, and #J were extracted without the use of a gauze shield. The Monitor asked the nurse anesthetist if she had protection for the airway, and she said "they are suctioning." The Monitor was unable to determine if a throat pack was in place. Protection of the airway is especially important in patients undergoing IV sedation because the patient's protective reflexes are obtunded.
- A gauze shield was not used to protect the airway during extractions on patients #031, #033, and #034, and for fitting of an SSC on Patient #032.
- Patients receiving nitrous oxide oxygen-oxygen analgesia were not titrated in 10 percent increments as directed in the *AAPD Guideline on Use of Nitrous Oxide for Pediatric Dental Patients*.

- The maximum dose of local anesthesia was not calculated before administering the agent for patients #031, #032, #033, and #034.
- Dentists administered appropriate local anesthetic for the procedures being performed with proper use of topical anesthetic.
- The Monitor observed good teamwork between the dental assistants and dentists in managing patients and providing care.

Recommendations

- Ensure only licenses of currently employed dentists and staff are displayed in the Clinic.
- Ensure sufficient protocols exist for patients receiving IV sedation that address cleaning the mouth prior to examining the teeth, documentation of the maximum dose of local anesthetic to include adjustments for combination with IV sedation, and methods used to protect the airway of patients during extractions and other procedures that could compromise the airway.
- Ensure techniques to protect the airway of patients during extractions and placement of SSCs are uniformly implemented.
- Ensure patients receiving nitrous oxide oxygen-oxygen analgesia are titrated in 10 percent increments as directed in the *AAPD Guideline on Use of Nitrous Oxide for Pediatric Dental Patients*.
- Ensure the maximum allowable dose of local anesthetic is calculated prior to administering the agent.

Exit Conference

The exit conference was held on June 15, 2012, at 11:30 a.m. Present at the conference were the Monitor Team of [redacted], CDA, RDH and [redacted] DDS, MSD. [redacted], Compliance Attorney, and [redacted] attended by phone. Clinic staff members, [redacted] Practice Administrator and Compliance Liaison, and [redacted] Clinic Coordinator, also attended. The preliminary findings discussed at the exit conference included the following:

- Staff members were welcoming and accommodating.
- Requested records and documents were received in a timely manner.
- Interviews revealed no staff members in the Clinic were aware of the Monitor's previous report or the findings contained within it.
- X-rays contained within the records were generally of good diagnostic quality and labeled correctly. Some X-rays within the records were found in envelopes making them easy to find while others were found loose in the record making them more difficult to locate.
- Generally, chart documentation has improved since the Monitor's January 2012 report as evidenced by:
  - Completed treatment was properly documented on the lower odontogram;
  - Documentation errors were properly corrected;

  - Medical necessity was appropriately documented on the Tooth Chart;
  - Consent forms were completed correctly; and
  - When using a protective stabilization device (PSD), the length of time was clearly documented.
- Some records did not document all existing conditions on the upper odontogram.
- The record review and treatment observations revealed a number of Health History forms without documentation of follow-up information for questions with "yes" responses.
- Four of the five records reviewed for one associate dentist revealed the use of Septocaine for inferior alveolar injections.
- Dentists administered appropriate local anesthetic for the procedures being performed with proper use of topical anesthetic.
- The Monitor observed good teamwork between the dental assistants and dentists in managing patients and providing care.
- Gauze shields were used inconsistently to protect the patient's airway during extractions.

[redacted] Small Smiles Dental Centers of Florence

Attachment A

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
1	Ensure staff members are reviewing Authorization forms to verify they have been completed correctly by the parent or guardian	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. At the time of this chart audit by CSHM, this training occurred informally. This recommendation will be addressed by the Regional Director during a future visit. She will remind staff members of the importance of ensuring accurate completion of the Authorization for Disclosure of Protected Health Information and the Authorization of Persons to Consent for Treatment forms.	Met
2	Ensure staff members are verifying all questions are answered on the Health History form and all "yes" responses have explanations.	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. At the time of this chart audit, this training occurred informally. The center will be required to view the VOPPs specific to the Health History by March 30, 2012. A quiz covering the presentation will also be administered to the staff to ensure understanding of the materials. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool was used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor each section of the Health History for proper completion and better assists the auditors with identifying trends. Finally, mandatory training for all staff members on the health history was conducted on November 22 and 23, 2011. This training included each of the health issue concerns along with a basic definition and the dental contraindications that should be considered, what questions to ask and why it is so important in regards to the overall well-being of the patient during dental treatment. This topic was also highlighted during the November 18, 2011 Compliance Liaison webinar.	Partially met

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
3	Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the Patient Care Manual.	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. At the time of this chart audit, this training occurred informally. The center will be required to view the VOPPs specific to the Health History by March 30, 2012. A quiz covering the presentation will also be administered to the staff to ensure understanding of the materials. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool was used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor each section of the Health History for proper completion and better assists the auditors with identifying trends. Finally, mandatory training for all staff members on the health history was conducted on November 22 and 23, 2011. This training included each of the health issue concerns along with a basic definition and the dental contraindications that should be considered, what questions to ask and why it is so important in regards to the overall well-being of the patient during dental treatment. This topic was also highlighted during the November 18, 2011 Compliance Liaison webinar.	Partially met

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
4	Ensure staff members are documenting the rationale for all X-rays taken outside of American Dental Association/Food and Drug Administration Guidelines.	In Process	CSHM implemented a new tooth chart on October 1, 2011 (after the date of this Desk Audit) that features an area dedicated solely to documentation related to radiographs. This area of the Tooth Chart includes prompts aimed at helping ensure that the type of radiograph, the rationale for taking the radiograph, and the interpretation of the radiographs are all documented. Additionally, the staff will be required to view the VOPPs specific to the Tooth Chart by March 30, 2012. A quiz covering the Tooth Chart will also be administered to the staff to ensure understanding of the materials. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool was used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor the documentation of interpretation of all exposed x-rays and ensuring that ADA/FDA Guide to Patient Selection is being followed. Dr. [redacted] also led a radiography webinar on November 15 and 16, 2011, which was mandatory for all dentists. The webinar stressed the importance of documenting why radiographs are taken outside *FDA/ADA guidelines for prescribing radiographs* and documenting that all x-rays have been read and interpreted. The webinar was attended by all dentists and hygienists in the Florence Center. Finally, this topic was addressed once more by Dr. [redacted] is his Best Practice Memorandum of November 22, 2011.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
5	Ensure all exposed X-rays are of diagnostic quality.	CSHM believes that it has adequately and appropriately addressed this.	The Chief Dental Officer specifically discussed the criteria required in order for X-rays to be considered diagnostic quality and the importance of diagnostic quality of radiographs as part of his Radiography in Pediatric Dentistry webinar on November 15 and 16, 2011. This webinar was mandatory for all dentists and was attended by all dentists and hygienists in the Florence Center. The Florence center received additional radiography training on November 2, 2011 (after the date of this chart audit). The diagnostic X-ray training covers topics including labeling of X-rays, mounting of X-rays, types of X-rays, proper angelation, proper placement, diagnostic quality, proper film size, bite tabs, processing, duplicating, and maintenance of the processors. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool was used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to ensure that radiographs are of diagnostic quality and identify trends in this area.	Met
6	Ensure staff members are correcting all documentation errors properly.	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. At the time of this chart audit, this training occurred informally. This recommendation will be addressed by the Regional Director during a future visit.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
7	Ensure staff members are recognizing, addressing, and treating all radiographically demonstrable decay appropriately.	In Process	Dr. [redacted] led a radiography webinar on November 15 and 16, 2011, which was mandatory for all dentists. The webinar provided examples and stressed recognition of decay from radiographs. This webinar was attended by all dentists and hygienists at the Florence Center. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool was used for November 2011 audits and thereafter. The revised audit tool has questions prompting the auditors to identify trends as it relates to proper recognition of, documentation of and planning for radiographically demonstrable decay. The new template also better assists auditors with identifying trends. CSHM's Chief Dental Officer will thoroughly review the Center's next quarterly chart audit to evaluate the effectiveness of training efforts to ensure staff members recognize, address and treat all radiographically demonstrable decay and evaluate further training needs.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
8	Ensure staff members are providing documentation to support the medical necessity for treatment when X-rays do not support the medical necessity.	In Process	Documenting medical necessity was a featured topic in the September 2011 Compliance Liaison webinar and a featured topic in the Compliance Liaison sub-region conference calls. The Compliance Liaisons were required to share the information in that webinar with all staff. Documentation of medical necessity was also the focus of the Q3 2011 Compliance Liaison Quarterly report. The importance of documenting medical necessity on the Tooth Chart was also heavily stressed during the training for the revised Chart Audit Process held on October 25 and 26, 2011 as a mandatory training for all staff. Because the Q3 2011 Compliance Liaison Quarterly reports as a whole did not show the level of knowledge desired regarding documenting medical necessity, CSHM introduced a creative, hands-on activity that was completed in December and intended to enhance awareness of and foster discussion about the Tooth Chart and medical necessity at each CSHM Associated Dental Center. During quarter 1 of 2012 CSHM will also be providing each center with posters of the Tooth Chart further reinforcing documentation of existing conditions, restorations, decay and medical necessity. CSHM continued the focus of documenting medical necessity in the Q4 2011 Compliance Liaison reports to measure the effectiveness of the recent hands on activity and training occurring during the fourth quarter. The Chief Dental Officer also discussed medical necessity and proper documentation during his Radiography in Pediatric Dentistry webinar on November 15 and 16, 2011. This webinar was mandatory for all dentists and was attended by all dentists and hygienists in the Florence Center. For additional training at the local level, the center will be required to view voice over Power Points (VOPPs) specific to the Tooth Chart by March 30, 2012. A quiz covering the Tooth Chart will be administered to the staff to ensure understanding of the materials.	Still Evaluating

[redacted]

#	Monitor's Site Visit Recommendations	CSHM's		
		Response	Action	Met/Unmet
9	Recommend the CDO assess the medical necessity and quality of pulp therapy in this Clinic; specifically, the charts for patients #005 and #008 should be reviewed to determine whether pulpotomies were performed on teeth, treated after the audited date of service, without radiographic evidence to support the medical necessity of such treatment. In addition, evaluate patient #006's chart to determine the justification of the extraction of an asymptomatic tooth with no successor.	In Process	These charts have been provided to the Chief Dental Officer for review. In the event Dr. [redacted] determines that medically unnecessary treatment was performed on patient #005 or #008 after the audited date of service, any amounts billed will be refunded. Additionally, the CDO will evaluate patient #006. After a review of each record, Dr. [redacted] will determine appropriate next steps, including a review of these charts with the treating dentist for clinical counseling.	Unmet

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
10	Ensure staff members are completing the Treatment Plan, Op Sheet, Consent for Nitrous Oxide, and Consent for Protective Stabilization forms correctly.	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. At the time of this chart audit, this training occurred informally. The center will be required to view the VOPPs specific to the Op Sheet, Consent Forms (including Nitrous Oxide form and Consent for Protective Stabilization form), and the Treatment Plan by March 30, 2012. A quiz covering each module will also be administered to the staff to ensure understanding of the materials. As you are aware, CSHM has revised the chart audit tool and guidelines. The revised audit tool was used for November 2011 audits and thereafter. The revised audit tool has questions prompting auditors to monitor each section of the Op Sheet, Nitrous Oxide form, Consent for Protective Stabilization form, and the Treatment Plan for proper completion and better assists the auditors with identifying trends. Additionally, during a future onsite visit the Regional Director will evaluate records to determine if the crown options box is completed correctly on the Treatment Plan, the Restorative Dentistry Checklist is completed correctly on the Op Sheet, the DCPW is recorded on the Op Sheet and HCR or CTS is included on the diagnosis line of the Op Sheet when SSC's are performed.	Met
11	Ensure the length of time associated with use of the PSD is clearly documented in the patient's record.	In Process	The center will be required to view the VOPPs specific to the Op Sheet and Consent Forms, including Protective Stabilization form, by March 30, 2012. A quiz covering these training modules will be administered to the staff to ensure understanding of the materials. Dr. [redacted] will review this recommendation with the Center and discuss its importance with the staff. The Regional Director will review records during a future visit to the Center to ensure the length of time associated with the use of a PSD is clearly documented in the patient's record and evaluate error rates.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	CSHM's Action	Met/Unmet
12	Ensure Chart Audit findings are clearly communicated to the Clinic and all billing errors are corrected.	In Process	CSHM believes that chart audit findings are clearly communicated to the Clinic through the revised chart audit tool. More specifically, the Clinic can now review findings and determine whether the finding was from a clinical auditor, the CDO or both. Additionally, the Center can now correlate the finding to the exact question and guideline within the chart audit template providing better guidance regarding chart documentation, medical necessity and quality of care requirements. The new chart audit template also includes a checklist for the auditor to complete to ensure that all questions answered with a "no" response also have a finding. In the 4th Quarter 2011 CSHM evaluated systems for ensuring that billing errors are corrected within 15 days and determined that the systems were ineffective. CSHM believes the root cause of the ineffectiveness was that communications were a generic statement instructing the Center to correct billing errors without specific details about the billing errors requiring correction. CSHM has begun communicating specific details about the billing issue, including: patient name, date of service, and procedure code via email from the CSHM Clinical Auditors to the Compliance Liaison. The CSHM Clinical Auditors then log the billing issue on CSHM's Overpayment Log. CSHM's Audit Manager obtains support from the Centers showing that the billing errors have been corrected.	Met

EXHIBIT 39

[redacted] Small Smiles Dental Centers of Lynn

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Chief Compliance Officer
CSHM LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor
CSHM LLC

Clinic Report
Lynn, Massachusetts

Deliverable #1-65

August 2, 2012

Executive Summary

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Lynn, 319 Lynnway, Lynn, MA 01901 (Clinic).

Overall Clinic Impression

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were promptly provided and well organized. Patient observations revealed good teamwork involving the dentists and staff, and children were managed well during administration of appropriate local anesthesia.

Overall Summary of Critical Findings and Observations

The Monitor's critical findings and observations are summarized below:

The Monitor assessed CSHM's implementation of the Monitor's recommendations from the previous on-site report. Through interviews, documentation review, and treatment observations, the Monitor determined that CSHM had successfully met and implemented 19 of the 29 recommendations. Six recommendations were partially met and four were unmet. Interviews with staff members and dentists who were employed at the time the Monitor issued its previous report revealed knowledge of its content.

The chart audit process has developed and is identifying more issues. There were multiple chart audit failures in this Clinic. The Monitor was unable to evaluate the Corrective Action Plans (CAPs) because it did not receive all documentation related to CAPs and their completion.

This Clinic does not have a nitrous oxide permit. In January 2011 it was represented to CSHM's Internal Audit Department (IAD) that the Clinic was actively pursuing the nitrous oxide permit. An IAD review in December found that it had still not obtained such a permit and recommended that all dentists should receive training and the application should then be submitted.

The Health History form in two records did not provide complete follow-up information to "yes" responses. With respect to the Tooth Chart, two records did not document decay and four records did not document existing conditions on the upper odontogram. Two records did not document completed treatment on the lower odontogram.

Four records contained non-diagnostic X-rays and two records showed diagnostic X-rays were not taken when indicated to determine the appropriate course of treatment and/or to support the medical necessity for treatment performed.

The Monitor found one record in which the Treatment Plan did not adequately address decay or pathology evident on diagnostic X-rays.

The Monitor found two records did not provide radiographic evidence to support the medical necessity for treatment provided.

Ten records did not document adequate justification for performing multiple surface fillings instead of stainless steel crowns (SSCs).

The Monitor found 11 records showed evidence of the same teeth treated multiple times.

Review of post-operative X-rays revealed that the quality of pulpotomies was inconsistent. Five records showed poorly performed pulpotomies where not all of the tissue was removed from the pulp chamber, while some other pulpotomies were well done.

One record showed local anesthesia was not administered when indicated and two records documented infiltration was used to deliver local anesthesia for treatment procedures requiring pulpal anesthesia.

All dentists interviewed demonstrated an understanding about the indications for placement of an SSC on a first primary molar with interproximal decay. Each dentist expressed a preference in placement of a multiple surface filling on primary first molars if the lesion was small or if there was a request from the parent to avoid SSCs. One Staff Dentist said the Chief Dental Officer (CDO) instructed that CSHM does not recommend that every primary first molar should receive a crown, but that the dentist should use their own professional judgment.

The Lead Dentist expressed a belief that quality of care could improve if staff members and dentists from CSHM were present more often in the clinics to observe care and provide more hands-on training.

The maximum dose of local anesthetic was not consistently entered on the Operative Procedures form (Op Sheet) prior to administering the agent.

Dentists administered appropriate local anesthesia for the procedures being performed and demonstrated excellent behavior management techniques, including slow injections, distraction, and imagery. Topical anesthetic was applied using the proper technique. Children appeared comfortable during the procedures.

Gauze shields were used inconsistently to protect the airway during the fitting and cementing of SSCs.

Overall Summary of Recommendations

The Monitor's recommendations are summarized below:

- Ensure all requested documentation is provided to the Monitor during the on-site visit.
- Perform a review to ensure all CAPs were issued and completed for all chart audit failures.
- Perform a root cause analysis to determine why there have been continuous chart audit failures in this Clinic.
- Evaluate why the CSHM IAD recommendations related to obtaining a nitrous oxide permit have not been implemented.
- Evaluate the feasibility of alternate methods for treating patients who present with acute conditions if nitrous oxide analgesia is not available.
- Ensure staff members provide adequate follow-up information and explanations for "yes" responses on the Health History form.
- Ensure staff members correctly document existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays and photographs are diagnostic and support the medical necessity for treatment provided.
- Ensure staff members take appropriate diagnostic X-rays or photographs when indicated.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure dentists address all disease and pathology appropriately on the Treatment Plan.
- Ensure staff members provide documentation to support the rationale for placement of multi-surface fillings instead of SSCs.
- Ensure CSHM CDO performs a quality of care review of patients #013 and #036 to evaluate the success of treatment and the reason for retreatment.
- Ensure dentists follow the diagnosis and treatment criteria set forth by CSHM and *AAPD Guidelines* when performing pulpotomies.
- Ensure dentists employ proper techniques when performing pulpotomies and are adequately removing all pulp tissue.
- Ensure dentists understand indications of failed pulpotomies and document any pathology or findings related to pulpotomies on the Tooth Chart.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of pulpotomies and SSCs.
- Ensure dentists administer local anesthesia according to CSHM policies.
- Ensure staff members record the method of delivery of local anesthesia and the dose of local anesthesia on the Op Sheet.
- Ensure treatment time not exceed 1 hour without adequate explanation.

[redacted] Small Smiles Dental Centers of Lynn

- Ensure the Account History Report and the patient's record accurately reflects all procedures performed.
- Ensure staff members correctly complete the Hygiene Procedures form and the Op Sheet.
- Ensure techniques are implemented to protect the airway during the fitting and cementation of SSCs and during extractions.
- Ensure the maximum dose of local anesthetic is calculated prior to administration of local anesthetic.
- Ensure clinicians understand the indications for performing pulpotomy treatments on primary teeth, specifically pulpotomies should not be performed just because the decay is half way to the pulp.
- Ensure dentists understand the indications for placement of SSC on primary teeth.

Clinic On-site Report

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management Systems, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Lynn, 319 Lynnway, Lynn, MA 01901 (Clinic). This is a follow-up visit to an on-site conducted on September 6-9, 2011. The primary scope of this review is to determine whether the recommendations contained in the Monitor's report from the previous visit have been implemented. It will also include, however, any additional findings discovered during this review.

Implementation

The OIG approved an announced on-site visit for July 11-13, 2012, at the Clinic. The Monitor notified CSHM on July 11, 2012, of the upcoming visit.

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were promptly provided and well organized. Patient observations revealed good teamwork involving the dentists and staff, and children were managed well during administration of appropriate local anesthesia.

Entrance Conference

An entrance conference was held on July 11, 2012, at approximately 3:00 p.m. The Monitor Team of [redacted], RDH, MS, [redacted], RDH, MEd, and [redacted], DDS, MS and Clinic staff members [redacted], DDS, Lead Dentist and [redacted], Office Manager and Compliance Liaison attended. An overview of the process was discussed including, point-of-contact information, intent to conduct treatment observations, and the need to interview individuals employed by the Clinic. The Monitor explained that this visit was a follow-up to the previous visit in September 2011 and would include a more focused review related to findings and recommendations stemming from that visit.

General

There were no deficiencies found during the Monitor's initial site visit with respect to the testing attributes in this section. The Monitor performed another review of the testing attributes related to personnel and notifications as required by the CIA and determined they were all met.

Review of Quality Control System

Policies and Procedures

The previous on-site visit revealed a missing *Code of Conduct Acknowledgement and Certification* form for five employees: one dentist, one hygienist, and three dental assistants. CSHM was able to provide an adequate explanation. The Compliance Liaison was able to articulate when and how she ensures these forms are completed.

During the previous on-site visit, the Clinic Coordinator supplied the Chart Documentation Guide's contents; however, it was not stored in a notebook and there was no disclaimer attached to the contents. During this on-site visit, the Monitor reviewed all manuals that remained in the Clinic and found all contained the appropriate disclaimer.

Training

The previous on-site visit revealed training documentation provided to the Monitor was incomplete and unorganized making it difficult to determine if all training was completed within the required time frames. Since then, CSHM has initiated a CE Tracking System that improves quality assurance with respect to ensuring all staff member training requirements have been met within the required time frame. The Monitor has also seen post-tests performed on many of the trainings conducted.

In response to the previous report findings related to chart documentation, the Regional Director reported the Chart Audit Update training and quiz was completed by all active employees to address recommendations made by the Monitor.

Internal Audits

In the previous report, the Monitor found CSHM did not address all significant chart audit findings in the Corrective Action Plan (CAP) issued as a result of the January 2011 failed audit. Additionally, billing issues were not refunded and re-audits were not conducted within the required timeframe.

The Monitor reviewed quarterly chart audits from October 2011 to present. The chart audit process has developed and is identifying more issues. The Clinic was audited in October 2011, and January and April 2012. Re-audits were conducted in December 2011 and March 2012 as a result of chart audit failures. The Monitor received copies of the Attestation Letters for each audit but received incomplete documentation related to all CAPs and CAP completion. All billing issues identified during the chart audits were communicated to the Clinic; however, there was no documentation to show refunds were completed for the billing issues addressed in the March 2012 chart audit results.

The October 2011 quarterly chart audit results showed the Clinic received a passing score but two of the three dentists failed the chart audit. The reason given for chart audit failure was "providing treatment without proper documentation of medical necessity." It appears a re-audit was conducted in December 2011; however, these results were not provided to the Monitor. The CAP for the October 2011 chart audit failure was not received and there was no evidence to show a CAP was completed.

Prior to the next chart audit the Clinic hired two new dentists and a Staff Dentist was terminated. The January 2012 quarterly chart audit results showed a failing score for the Clinic and one of the new dentists failed the chart audit. A re-audit of the Clinic was conducted in March 2012; however, only three dentists were included in the audit and there was no audit of one of the new dentists. The March audit scores showed the Clinic failed the re-audit. The CAPs for the January and March chart audit failures were not received and there was no evidence to show CAPs were completed.

The April 2012 quarterly chart audit showed the Clinic received another failing score. The Staff Dentist, who was not included in the March re-audit, received an automatic failure; however, after an appeal, the automatic failure was reversed but the revised score still resulted in a failing score for this dentist. Documented e-mail communications between CSHM and the Lead Dentist indicated a CAP was initiated; however, the CAP was not provided to the Monitor as requested. The e-mail communication related to the completion of the CAP indicated the Lead Dentist was going to review records and chart documentation with Clinic staff members and perform a separate review with the Staff Dentist who failed the audit. This documentation did not show the CAP was completed. An additional re-audit was in progress during the Monitor's on-site visit for the April 2012 chart audit failure.

There have been three consecutive Clinic chart audit failures. The Monitor provided a detailed list of requested items to the Clinic's Compliance Liaison, specifically requesting all quarterly chart audits, re-audits, appeals, CAPs, and documentation to show completed CAPs. Although this request was made, no CAPs were provided; therefore, the Monitor has no documentation to show any CAPs were completed for the multiple Clinic and dentist chart audit failures. While CSHM has provided significant company-wide training related to the chart audit process and chart documentation, the Clinic and newest Staff Dentist continue to receive failing scores.

CSHM's Internal Audit Department (IAD) conducted a Remediation Review in December 2011. In the report dated December 15, 2011, the following information was provided regarding an un-remediated finding: "In November 2010, IAD noted that the Center had suspended the use of nitrous oxide due to an expired facility license. Management response in January 2011 indicated that the Clinic was actively pursuing obtaining their nitrous facility license and fully expected to have the license by April 30, 2011. In a follow-up call to the facility, IAD was informed that the nitrous facility license has still not been obtained as of December 2011."

The recommendation made by IAD was: "Required training should be obtained by all Center dentists within 30 days of this report. Subsequent to the completion of training, the Center should prepare and submit the application for a nitrous oxide permit. This

form of analgesia enhances appropriate patient care by providing a higher level of comfort. All efforts should be made by the Center to obtain and maintain a nitrous permit."

During the Monitor's on-site visit it was noted that nitrous oxide was still not being used in the Clinic. When asked about the status of the nitrous oxide facility permit, the Monitor received varying responses from Clinic staff members. While auxiliary staff members believed that the Clinic was in the process of receiving the permit, the Lead Dentist expressed concern and discomfort with the administration of nitrous oxide. His reasoning included a personal lack of familiarity with the use of the agent, the scrutiny of the Board investigators entering the Clinic for inspection of the premises, and the threat of the dentists on site having their licenses in jeopardy if any negative findings are exposed Although he and other staff members had completed the required training, he has not pursued the facility permit because he did not want to use nitrous oxide or be responsible for the Clinic's facility permit; however, he did state that the Lead Dentist of Small Smiles Dental Centers of Mattapan and the co-owner of the Massachusetts Clinics was handling the nitrous re-certifications. He also disclosed that he will no longer be the Lead Dentist in the Clinic and will be transferring to work as a Staff Dentist at Small Smiles Dental Centers in Lawrence.

Two Staff Dentists reported that patients are frequently seen who would benefit from the use of nitrous oxide analgesia. The Compliance Liaison said she estimates approximately 8-10 patients per week are referred to Small Smiles Dental Centers of Lawrence or another provider because the Clinic does not have nitrous oxide. The Monitor witnessed two cases in which the dentist discussed with the parent the option of referring to an outside practice which had nitrous oxide available for their child's dental needs. One parent (patient #050) chose to have the child seen at the Lynn Clinic due to their inability to travel to another location but the other parent (patient #054) chose to seek care with another dentist. In the chart review one record (patient #042) indicated a 6-year-old patient was referred out for extraction of tooth #K because the Clinic did not have nitrous oxide availability. The patient was seen on May 1, 2012, for hygiene procedures and listed a chief complaint of pain. An abscess is visible in the X-ray dated May 1, 2012, and the Tooth Chart dated May 1, 2012, documented a buccal fistula. The patient returned to the Clinic on July 13, 2012, and still had the abscess. The Clinic prescribed an antibiotic and referred to patient to another dentist "for treatment under nitrous."

Analysis of CSHM Corrective Action

The Monitor performed an on-site visit at the Clinic on September 6-9, 2011. The report was issued on September 29, 2011.

Attachment A sets forth the verbatim CSHM responses to the Monitor's recommendations and reflects the Monitor's assessment of CSHM's implementation of the Monitor's recommendations. Through interviews, documentation review, and treatment observations, the Monitor determined that CSHM had successfully met and implemented 19 of the 29 recommendations. Six recommendations were partially met, most related to documentation issues. The Monitor concluded that two

recommendations were not implemented because no documentation supported that reoccurring chart audit findings were identified and addressed or that findings were clearly communicated and addressed in a CAP. While general training about chart documentation was provided, the Clinic and dentists are still failing the audits. The Monitor was not provided any documentation that a root cause analysis was performed to determine whether the decision to provide restorative treatment without appropriate local anesthesia is based on the needs of the patient. The Monitor also determined that its recommendation that staff members follow the *Intracoronal Restorations Documentation* policy was not implemented. Although dentists were able to articulate the policy, the record review showed dentists were not in compliance because multiple surface restorations were being performed instead of SSCs without documentation of the rationale. This has also been a repeated finding in the Clinical Risk Assessment Focus Tool (CRAFT) reports.

Interviews with staff members and dentists who were employed at the time the Monitor issued its previous report revealed knowledge of its content. The Lead Dentist reported the Senior Vice President of Operations read the report to them in October 2011. The Compliance Liaison stated she had seen the report and its contents were reviewed with her in a meeting with the Regional Director.

CSHM's Follow-up Checklist for Lynn, MA Site Visit & Desk Review Recommendations spreadsheet shows the Regional Director completed some of [redacted] assigned action items on November 2, 2011, and the remaining were completed on January 19, 2012. The only item that does not show a completion date was related to the review of percentage of crowns to fillings in the CRAFT for the next three months.

The Director of Clinical Quality Initiative and Education visited the Clinic on February 21, 2012. According to the dentists, he reviewed documentation issues related to the Health History and Tooth Chart. He performed a record review including three records per dentist. He also discussed policies and procedures associated with local anesthesia, behavior management, multiple surface fillings, and pulpotomies.

The Clinic reported the new Chief Dental Officer (CDO) has not been at this Clinic; however, the Monitor was notified by the new Chief Compliance Officer and the CDO that they were conducting an on-site visit at the Clinic beginning July 30, 2012. The Monitor discussed preliminary findings and concerns from this report with CSHM's management team when they asked for this information to aide in their visit to the Clinic.

CSHM's CRAFT Report from February 2012 indicated this Clinic was an outlier for low percentage of crowns to all restorations. It also reported that for a seven-month period (August 2011 to February 2012) the average percentage of crowns to all restorations was 10 percent. The April 2012 CRAFT Report indicated the need to continue to monitor underutilization of stainless steel crowns (SSCs).

The Monitor analyzed restorative treatment data provided by CSHM for June 2012 and found the Lead Dentist and one Staff Dentist are still outliers for underutilization of crowns and the new Staff Dentist was an outlier for overutilization of pulpotomies. The data suggests that the Lead Dentist and Staff Dentist prefer multiple surface fillings over

crowns while the new Staff Dentist performed more crowns than fillings. The data also showed a pulpotomy was completed on 60 percent of the crowns performed by the new Staff Dentist.

Complaints

In the previous report, the Monitor found it was not clear during the interviews whether staff members understood the full range of events that can be considered an adverse event. The Monitor also reported an incident that occurred with a Staff Dentist who was terminated. This finding was related to notes that were no longer a part of the patient's record and an adverse event that was not evident in the patient's record due to this missing documentation. A Quality of Care Reportable Event/Self-Disclosure Notice was sent to the dental board and the OIG on August 12, 2011; however, CSHM issued an additional notice to the dental board and the OIG on April 9, 2012, as a result of the Monitor's findings.

Recommendations

- Ensure all requested documentation is provided to the Monitor during the on-site visit.
- Perform a review to ensure all CAPs were issued and completed for all chart audit failures.
- Perform a root cause analysis to determine why there have been continuous chart audit failures in this Clinic.
- Evaluate why the CSHM IAD recommendations related to obtaining a nitrous oxide permit have not been implemented.
- Evaluate the feasibility of alternate methods for treating patients who present with acute conditions if nitrous oxide analgesia is not available.

Review of Communication System

The previous on-site report identified an incomplete Compliance Liaison quarterly report that was dated July 15, 2011. According to CSHM, the Regional Director noticed this omission during her review of the report and also noticed the same omission in other reports from her region. This topic was discussed during the Regional Director's sub-region Compliance Liaison call on August 26, 2011. Each Compliance Liaison was asked to discuss this with their Lead Dentist, Clinical Coordinator, and staff members in order to come up with a solution to prevent swallowed objects. The revised report was due by September 9, 2011. The Monitor confirmed it had no new findings related to communications systems.

There has been only one substantiated adverse event in this Clinic since the Monitor's previous report. According to CSHM's Compliance Disclosure Log, the incident was reported on June 1, 2012, by Clinical Audit who found the Lead Dentist performed treatment without consent. The investigation was closed on July 6, 2012, but the CAP remains "open." The investigative report and CAP related to this event were not provided to the Monitor. The *Center Adverse Event Log* was current and showed two

adverse events, one in 2010 and the March 2012 event. The signature sheet did not show any individuals had viewed the *Center Adverse Event Log*.

Review of Dental Record Documentation

The testing attributes related to the dental record documentation were designed to determine whether the documentation was complete and accurate, including HIPAA-related forms, medical necessity, and consent forms. A sample of 15 visits representing 15 separate patients and records was identified from the patient listing provided by CSHM, based on all Medicaid patients seen for operative visits from April 12, 2012, through July 5, 2012. The Monitor's pediatric dentist provided consultation on 14 of the 15 patient records reviewed.

This portion of the report also contains record review findings from the Monitor's pediatric dentist's observations of patient care and retrospective quality of care record review. Findings related to patients #031 to #041 resulted from the Monitor's pediatric dentist's treatment observations. Findings related to patients #046 to #054 resulted from the Monitor's quality of care review. In order to complete the retrospective quality of care record review, 10 additional records of patients who had received operative procedures and returned for post-operative X-rays were identified from a list provided by CSHM. The relevant findings from the review of the 15 visit records, 9 treatment observations, and the 11 quality of care reviews are as follows:

Health History

The Health History form in two records (patients #001 and #012) did not provide complete follow-up information to "yes" responses.

The table below provides a summary of each finding.

Health History		
Patient	**Date**	**Finding**
#001	July 5, 2012	Both "yes" and "no" responses were recorded for "ADHD (Attention Deficit Hyperactivity Disorder)" and no follow-up information was given.
#012	April 10, 2012	There was incomplete follow-up information for the "yes" response to "Asthma/Breathing Problems". Additionally, there was insufficient follow-up information regarding the "yes" response to "surgery" and "medications."

Tooth Chart

Two records (patients #010 and #036) did not show documentation of decay on the upper odontogram of the Tooth Chart.

Four records (patients #009, #010, #014, and #041) did not show documentation of existing conditions on the upper odontogram of the Tooth Chart.

In two records (patients #002 and #010) the lower odontogram did not show documentation of completed treatment.

The tables below contain a summary of the findings related to the Tooth Chart.

Decay Not Documented on the Upper Odontogram		
Patient	**Date**	**Finding**
#010	April 19, 2012	Mesial decay on tooth #T evident on X-rays dated April 19, 2012.
#036	February 20, 2012	Mesial decay on tooth #K and distal decay tooth #R, all evident on X-rays dated February 20, 2012, and charted on the Upper Odontogram dated October 14, 2011.

Existing Conditions Not Documented on the Tooth Chart		
Patient	**Date**	**Finding**
#009	January 17, 2012	Congenitally missing tooth #26, evident on X-ray dated March 23, 2011
#010	April 19, 2012	Existing occlusal amalgams on teeth #J and #K
#014	February 24, 2012	Existing mesial occlusal filling on tooth #A; existing distal occlusal filling on tooth #B
#041	May 14, 2012	Root resorption and periapical pathology on tooth #E evident on X-rays dated May 14, 2012

Completed Treatment Not Documented on the Lower Odontogram		
Patient	**Date**	**Finding**
#002	March 19, 2012	Pulpotomies performed on teeth #A and #B
#010	April 19, 2012	Pulpotomy performed on tooth #K

X-rays and Photographs

Four records (patients #002, #003, #007, and #013) contained non-diagnostic X-rays or photographs. Two records (patients #009 and #037) showed diagnostic X-rays were not taken when indicated to determine the appropriate course of treatment and/or to support the medical necessity for treatment performed.

The tables below provide a summary of each finding regarding X-rays.

Non-diagnostic X-rays or Photographs		
Patient	**Date**	**Finding**
#002	June 13, 2012	The right bitewing X-ray was non-diagnostic because of overlapping contacts on teeth #3 and #A.

[redacted] Small Smiles Dental Centers of Lynn

Non-diagnostic X-rays or Photographs		
Patient	**Date**	**Finding**
#003	March 20, 2012	The right bitewing X-ray was not diagnostic because of overlapping contacts on teeth #A and #B.
#007	March 15, 2012	The bitewing X-rays were non-diagnostic because of overlapping contacts on teeth #B, #H, #I, #J, #L, and #S.
#013	May 14, 2012	The maxillary occlusal X-ray was not diagnostic quality because it was too dark.

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#009	June 19, 2012	Because of the extent of decay on tooth #A evident on the X-rays dated January 27, 2012, a periapical X-ray was indicated to determine the appropriate course of treatment.
#037	August 22, 2011	Bitewing X-rays were not taken for the diagnosis of interproximal decay. Instead, four posterior periapical X-rays were exposed in the Operating Room (OR).

Medical Necessity

Within the records reviewed, the Monitor's pediatric dentist found two records (patients #004 and #037) did not provide radiographic evidence to support the medical necessity for treatment provided. One patient (#037) was an OR case.

The following table provides details related to each finding:

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
#004	June 12, 2012	There was no medical necessity for the distal occlusal filling on tooth #L because the X-rays dated April 26, 2012, did not show decay.
#037	August 22, 2011	There was no medical necessity for the SSCs performed on teeth #A, #B, #I, and #J because the periapical X-rays did not show decay and there was no decay documented on the Tooth Chart.

Treatment Plan

The Monitor's pediatric dentist found one record (patient #036) in which the Tooth Chart and Treatment Plan dated February 20, 2012, did not document or address radiographically demonstrable decay on the mesial of tooth #K and the distal of tooth #R. The Tooth Chart and Treatment Plan dated October 14, 2011, showed the disease

was diagnosed and treatment was planned; however, the Monitor is concerned that this decay will go untreated since it was not documented on the most recent Tooth Chart and Treatment Plan and these teeth did not receive treatment on the February 20, 2012, date of service. At the date of the Monitor's visit, this patient had not been seen since February 20, 2012.

Multiple Surface Fillings

Ten records (patients #003, #005, #008, #011, #013, #014, #031, #032, #035, and #038) did not document rationale for performing multiple surface fillings instead of SSCs.

The following table provides details related to each finding:

Multiple Surface Fillings Instead of SSCs With No Rationale		
Patient	**Date**	**Finding**
#003	June 1, 2012	Tooth #S received a distal occlusal filling and #T received a mesial occlusal filling instead of SSCs.
#005	June 7, 2012	Tooth #K received a mesial occlusal buccal filling and #L received a distal occlusal filling instead of SSCs.
#008	June 29, 2012	Tooth #S received a distal occlusal filling and #T received a mesial occlusal filling instead of SSCs.
#011	April 12, 2012	Teeth #D and #G received mesial lingual fillings and teeth #E and #F received mesial lingual distal fillings instead of SSCs.
#013	June 13, 2012	Tooth #I received a mesial lingual filling and tooth #J received a mesial occlusal lingual filling instead of SSCs.
/#014	June 29, 2012	Tooth #K received a mesial occlusal distal filling and tooth #L received a distal occlusal filling instead of SSCs.
#031	February 17, 2011	Tooth #S received a distal occlusal filling instead of an SSC.
#032	February 28, 2011	Tooth #F received a mesial incisal lingual facial filling instead of an SSC.
#035	March 9, 2011	Tooth #K received a mesial occlusal filling instead of an SSC.
#038	March 17, 2011	Tooth #S received a distal occlusal filling instead of an SSC.

Teeth Treated Multiple Times

The Monitor's pediatric dentist found 11 records (patients #003, #006, #007, #013, #031, #032, #033, #034, #035, #036, and #037) in which teeth required re-treatment after initial treatment.

The following table provides details related to each finding:

Teeth Treated Multiple Times	
Patient	**Finding**
#003	Tooth #A received a mesial occlusal amalgam and tooth #B received a distal occlusal amalgam on April 13, 2011. On April 16, 2012, both teeth #A and #B received SSCs. X-rays dated March 20, 2012, showed deep recurrent decay.
#006	Tooth #L received an occlusal amalgam on May 11, 2011, and then an SSC on January 18, 2012.
#007	Teeth #A, #D, and #F on this 5-year-old high caries risk patient were treated initially with multiple surface fillings and then pulpotomy treatments and SSCs 9 to 29 months later. Tooth #J received an occlusal buccal filling on February 25, 2010, which failed and was then replaced with another occlusal buccal filling on November 24, 2011. Tooth #T was treated with an occlusal buccal filling on February 12, 2010, which failed and was then replaced with another occlusal buccal filling on January 24, 2011.
#013	Tooth #B was treated with a pulpotomy and SSC on April 27, 2012, and then re-treated with a new SSC on May 15, 2012.
#031	Tooth #S was treated with a distal occlusal filling on December 17, 2011, and then treated with a pulpotomy and SSC 7 months later due to recurrent decay under the filling.
#032	Tooth #F was treated with a mesial incisal lingual facial filling on February 28, 2011, and then treated with an SSC on November 28, 2011, in the OR under general anesthesia.
#033	Tooth #S was treated with an occlusal amalgam on March 24, 2010, and then treated with a pulpotomy and SSC on January 18, 2012.
#034	Tooth #S was treated with a distal occlusal filling on May 1, 2009, in the OR under general anesthesia and then treated with an SSC on January 31, 2011.
#035	Tooth #K was treated with a mesial occlusal filling on February 17, 2010, which failed and was then replaced with another mesial occlusal filling on March 9, 2011.
#036	Teeth #J and #T were treated with occlusal fillings and teeth #A, #B, #I, #L, and #S were treated with sealants on April 14, 2011, and then all seven teeth were treated with SSCs in the OR on February 20, 2012.

Teeth Treated Multiple Times	
Patient	**Finding**
#037	Tooth #H was treated with a facial filling in the OR on August 22, 2011, which failed and was then replaced with another facial filling on March 27, 2012.

Other Quality of Care Issues

The post-operative X-rays in six records (patients #013, #031, #033, #038, #039, and #041) revealed quality of care issues related to fillings, pulpotomies, and SSCs. The Monitor's pediatric dentist found five teeth treated with pulpotomies in which there was incomplete removal of pulp tissues, two inadequate fillings, and one poorly fitted SSC.

The following tables provide details related to each finding:

Substandard Care		
Patient	**Date of Service**	**Finding**
#013	May 15, 2012	There was incomplete removal of pulp tissue and filling material was only in the distal portion of the crown on tooth #B visible on X-rays dated May 14, 2012.
#031	September 22, 2011	There was incomplete removal of pulp tissue on tooth #L and inadequate development of the distal occlusal box of the preparation and incomplete placement of the amalgam on tooth #S, all visible on X-rays dated March 18, 2011, and September 22, 2011.
#033	March 9, 2012	There was incomplete removal of pulp tissue on tooth #L visible on X-rays dated March 9, 2012.
#038	February 16, 2011	There was an open margin in the distal box of the restoration on tooth #S visible on X-rays dated February 16, 2011.
#039	June 20, 2012	There was incomplete removal of pulp tissue and a poorly fitted SSC on tooth #S visible on X-rays dated June 20, 2012.
#041	May 14, 2012	There was incomplete removal of pulp tissue on tooth #B visible on X-rays dated May 14, 2012.

Patient Management

Local Anesthesia

The Monitor found one record (patient #032) where local anesthesia was not administered to a 4-year-old child for a mesial incisal facial lingual filling on tooth #F. Local anesthetic was indicated due to deep decay approximating the pulp; however, the

Op Sheet dated February 28, 2011, documented it was not used. The Op sheet notes stated: "patient became uncooperative in middle – could only complete #F MIFL (illegible) NV: protective stabilization". Behavior indicators went from "3" initial to "2" response, which is consistent with behavior when the patient is experiencing pain. One record (patient #003) did not record the dose of local anesthesia on the Op sheet dated June 1, 2012, and one record (patient #033) did not document the method used to deliver local anesthesia for treatment on January 18, 2012. Additionally, the Monitor found two records (patients #006 and #039) that showed infiltration was used to achieve pulpal anesthesia in primary mandibular molars. The Op Sheet for Patient #006 noted: "patient is constantly crying and anxious!" and although initial and response behavior indicators were both "3," the deterioration of behavior of this 5-year-old patient during the treatment phase may have been an indication of the patient experiencing pain or discomfort.

The CDO's Best Practice Memo dated November 22, 2011, addressed a variety of issues related to local anesthesia and notes: "I have used **bold** font to emphasize key points." The Memo states: "**Non-use of local anesthesia is acceptable in limited instances.**" The CDO continues with "non-use of local anesthesia is most appropriate for an older patient who has experienced local anesthetic injections and who understands that the discomfort to be expected during treatment is no greater than that of receiving one or more injections for the procedure. A good example is an 8-year-old who has received previous care under local anesthetic and who requires buccal pit restorations on #19 and #30 in which you anticipate that the caries extends just beyond the DEJ. Further, to lessen the minor discomfort of preparing small pits without local anesthetic, **consider placing the patient on nitrous oxide for its analgesic effects**."

The following table provides a summary of this additional information.

Method to Deliver Local Anesthesia Not Appropriate		
Patient	**Date of Service**	**Finding**
#006	May 8, 2012	Infiltration was used for pulpotomies on teeth #S and #T instead of an inferior alveolar nerve block.
#039	February 3, 2011	Infiltration was used for a pulpotomy on tooth #S instead of an inferior alveolar nerve block.

Time Management

Two patient visits (patients #006 and #012) showed the length of treatment not in accordance with the *CSHM's Quality Assurance Protocols*. The CSHM policy indicates treatment time should not exceed 1 hour without adequate explanation or exceed 1 hour and 15 minutes for children who are 8 years old and younger.

The following table provides a summary related to these findings.

Time Management		
Patient	**Date of Service**	**Finding**
#006	May 8, 2012	Documentation for this 5-year-old patient showed

Time Management		
Patient	**Date of Service**	**Finding**
		anesthetic was administered at 10:40 a.m. and treatment on adjacent teeth #S and #T ended at 11:45 a.m. The Op Sheet recorded behavior deterioration from Initial Response "4 definitely positive," to Behavior Response "3 accepting but anxious." Op Sheet notes stated: "pt. is constantly crying/anxious!" There was no explanation for treatment time over 1 hour.
#012	May 25, 2012	Documentation for this 7-year-old patient showed anesthetic was administered at 1:20 p.m. Treatment ended at 2:36 p.m., with no breaks. Treatment time was 1 hour and 16 minutes for procedures on adjacent teeth #A and #B. Initial and Behavior response was "3, accepting but anxious." There was no explanation for the extended treatment time.

Account History

The Account History Report for two patients (patients #004 and #013) did not document all services that were performed on the audited date of service.

The following table provides details related to each finding:

Account History		
Patient	**Date**	**Finding**
#004	April 26, 2012	Sealants on teeth #I and #J incorrectly recorded and sealants on teeth #S and #T not recorded
#013	April 27, 2012	Right bitewing X-ray

Other Findings

One record (patient #037) contained a documentation error and incomplete documentation. The August 22, 2011, Operative (OR) Procedures sheet does not document that two occlusal and four periapical X-rays were exposed. Also, the dictation report from the hospital visit was not included in the chart.

Recommendations

- Ensure staff members provide adequate follow-up information and explanations for "yes" responses on the Health History form.
- Ensure staff members correctly document existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays and photographs are diagnostic and support the medical necessity for treatment provided.

- Ensure staff members take appropriate diagnostic X-rays or photographs when indicated.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure dentists address all disease and pathology appropriately on the Treatment Plan.
- Ensure staff members provide documentation to support the rationale for placement of multi-surface fillings instead of SSCs.
- Ensure CSHM CDO performs a quality of care review of patients #013 and #036 to evaluate the success of treatment and the reason for retreatment.
- Ensure dentists follow the diagnosis and treatment criteria set forth by CSHM and *AAPD Guidelines* when performing pulpotomies.
- Ensure dentists employ proper techniques when performing pulpotomies and are adequately removing all pulp tissue.
- Ensure dentists understand indications of failed pulpotomies and document any pathology or findings related to pulpotomies on the Tooth Chart.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of pulpotomies and SSCs.
- Ensure dentists administer local anesthesia according to CSHM policies.
- Ensure staff members record the method of delivery of local anesthesia and the dose of local anesthesia on the Op Sheet.
- Ensure treatment time not exceed 1 hour without adequate explanation.
- Ensure the Account History Report and the patient's record accurately reflects all procedures performed.
- Ensure staff members correctly complete the Hygiene Procedures form and the Op Sheet.

Treatment Observations, Findings, and Staff Interviews Related to Care

The treatment observation testing attributes were designed to determine if care is performed according to CSHM's policies and procedures, the *AAPD Guidelines*, and professionally recognized standards of care.

The on-site review included observations of treatments and interactions with patients, review of workspace, and review of dental records. Observation of treatment and patient interactions included observation of treatment on three patients who were receiving invasive dental treatment and nitrous oxide analgesia. The review of workspace included observation of activities in the dental hygiene and sterilization areas. Five individuals were interviewed, including the Lead Dentist, two Staff Dentists, the Clinic Coordinator, and the Compliance Liaison.

The CIA, Section III.A.2, specifies the CDO is "responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by CSHM and CSHM facilities meet the professionally recognized standards of health care." Such language directs that possessing knowledge of and following these policies are not at the discretion of the Clinic dentists and staff. The Monitor interviewed the dentists about their familiarity with the recent Best Practice e-mails, and Internal Memoranda that modify, clarify, and add to *Clinical Policies and Guidelines for CSHM Associated Clinics*. The interviews were targeted at the areas of concern identified in the September 2011 Monitor's report. Queries focused on management of the patient's behavior during administration of local anesthesia, treatment without the use of local anesthesia, (proper delivery of local anesthetic and dosage calculation), familiarity in CDO policy related to placement of SSCs versus multi-surface fillings on first primary molars, the availability of nitrous oxide for operative patients, and fluoride varnish use in the hygiene department.

- The dentists reported CSHM's Director of Clinical Quality Initiative and Education visited the Clinic in February 2012 to discuss the findings from the Monitor's previous visit and reviewed medical history, anesthesia, behavior management, and multiple surface restorations versus SSCs.
- The dentists demonstrated knowledge of proper techniques of local anesthetic during procedures and when the use of local anesthetic was indicated.
- The Monitor observed good teamwork between the dental assistants and dentists in managing patients and providing care.
- The dentists demonstrated knowledge of the indications and contraindications for pulpotomies, as well as the technique for performing them. However, one Staff Dentist expressed an understanding that a prophylactic pulpotomy should be performed if the decay was at least half way to the pulp on the X-ray, which is an incorrect understanding.
- All dentists interviewed demonstrated an understanding about the indications for placement of an SSC on a first primary molar with interproximal decay. Each dentist expressed a preference in placement of a multiple surface filling on primary first molars if the lesion was small or if there was a request from the parent to avoid SSCs. One Staff Dentist said the CDO instructed that CSHM does not recommend that every primary first molar should receive a crown, but that the dentist should use their own professional judgment.
- The Lead Dentist expressed a belief that quality of care could improve if staff members and dentists from CSHM were present more often in the clinics to observe care and provide more hands-on training.
- All dentists interviewed were able to accurately demonstrate knowledge of the changes in policy for using Protective Stabilization Devices (PSDs) and supported the change.

The Monitor also had the following relevant findings:

- The maximum dose of local anesthetic was not consistently entered on the Op Sheet prior to administering the agent.
- Dentists administered appropriate local anesthesia for the procedures being performed and demonstrated excellent behavior management techniques while administering local anesthesia, including distraction, positive reinforcement and imagery. Topical anesthetic was applied using the proper technique.
- The comfort and behavior management of several operative patients observed may have been enhanced by the use of nitrous oxide analgesia, especially during the administration of local anesthetic.
- Gauze shields were used inconsistently to protect the airway during the fitting and cementing of SSCs and during extractions.
- Fluoride varnish is being used on all patients in the hygiene department and the application of the material was performed properly.

Recommendations

- Ensure techniques are implemented to protect the airway during the fitting and cementation of SSCs and during extractions.
- Ensure the maximum dose of local anesthetic is calculated prior to administration of local anesthetic.
- Ensure clinicians understand the indications for performing pulpotomy treatments on primary teeth, specifically pulpotomies should not be performed just because the decay is half way to the pulp.
- Ensure dentists understand the indications for placement of SSC on primary teeth.

Exit Conference

The exit conference was held on July 13, 2012, at 3:00 p.m. Present at the conference were the Monitor Team of [redacted] RDH, MS, [redacted], RDH, MEd, and [redacted], DDS, MS. Clinic staff members, [redacted], Office Manager and Compliance Liaison, [redacted], DDS, Lead Dentist, and from CSHM, [redacted] Chief Compliance Officer and [redacted], Regional Manager. [redacted] from the Monitor and [redacted], CSHM's Compliance Attorney, also attended by phone. The preliminary findings discussed at the exit conference included the following:

- Staff members were welcoming and accommodating.
- The materials requested were produced in a well organized manner.
- The Compliance Liaison provided information about how she ensures all Clinic staff is up to date on training.
- The Compliance Liaison was able to articulate how she ensures all Code of Conducts are acknowledged.

- Staff members and dentists evidenced a general understanding of the Monitor's findings and recommendations from the previous visit.
- Staff members and dentists were able to articulate the new changes to the Protective Stabilization policy and indicated support for the change.
- Dentists and dental assistants demonstrated good behavior management techniques with patients.
- The Clinic has still not obtained a nitrous oxide permit. In Clinic observations and staff interviews it was revealed that some apprehensive children are referred to Small Smiles in Lawrence or other private practices that can perform the procedures with nitrous oxide.
- During treatment observations, dentists administered appropriate local anesthesia for the procedures being performed and used topical anesthetic properly.
- There was no method used to protect the airway, such as a gauze shield or rubber dam, during extractions or placement of SSCs.
- There was evidence of significant improvements in chart documentation.
- Review of records showed multiple surface fillings continue to be performed on primary teeth instead of SSCs without adequate justification.
- Pulpotomies were found with incomplete removal of pulp tissue.

[redacted] Small Smiles Dental Centers of Lynn

Attachment A

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
1	Ensure all staff members have signed the Code of Conduct.	CSHM believes that it has adequately and appropriately addressed this.	The training department will work with all Compliance Liaisons to ensure that they have all Code of Conduct acknowledgements on file. The employees in question did sign the Code of Conduct timely as required under the CIA (See Attachment A). Going forward, CSHM will remind Compliance Liaisons to verify with CSHM to obtain all signatures (including those missing at the Center level) before providing documentation to the Monitor.	Met
2	Ensure all manuals maintained in the Clinic contain the required notification.	CSHM believes that it has adequately and appropriately addressed this.	SVP of Operations advised the Center during her October 18 visit to place the Chart Documentation Guide materials into a notebook and include the proper notification that policies and procedures should not be relied upon unless verified on the intranet first. The Regional Director will review all manuals during her visit scheduled for November 3, 2011 to verify this has been completed.	Met
3	Clarify whether Best Practice E-mails and Internal Memorandum on the Intranet under the tab Chief Dental Officer constitute policy.	In process	As part of CSHM's annual review of policies and procedures, the Chief Dental Officer and Chief Compliance Officer have begun reviewing all previous Best Practice Emails and Internal Memorandums to determine which should be considered policy. Those which are deemed to be policy will be adopted into CSHM's formal policy structure. In the future, all communications will be clearly defined as policy or recommendation.	Met
4	Ensure all CSHM policies and guidelines related to patient care are clearly defined and accessible under the appropriate tabs on the intranet.	CSHM believes that it has adequately and appropriately addressed this.	During CSHM's policy and procedure trainings conducted in the summer of 2011 and to all new hires as of September 1, 2011, CSHM has provided details to ensure staff was aware of the location of the Clinical Policies and Guidelines on the intranet. However, for additional ease of locating these Guidelines, the Clinical Policies and Guidelines for CSHM Associated Clinics were moved under the Policies tab on October 7, 2011. An email was sent to all Centers on that date to notify all staff of this change.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
5	Ensure Clinic documentation of staff training is well-organized, sign-in sheets are correctly labeled, and documentation includes all covered persons working in the Clinic since the CIA.	In Process	CSHM instructed all centers to use the CE tracking software system exclusively to track all training related certifications as of September 1, 2011. As CSHM recognized that acceptance and use of the system was moderate during September, the training department required signature sheets from those centers struggling to accept the software. Since May 2011, CSHM's training department has maintained Excel based spreadsheets for each employee at each dental center that includes hyperlinks for each course to the employee's signature. The Training Department monitors all centers for timely training as required by the CIA. Prior to CSHM's transition to the CE tracking software, sign-in sheets have been standardized to include the name of the training course taken and the date of the training. The sheets are distributed by CSHM to each Center and include an up-to-date employee roster. The training department will continue to work with all Compliance Liaisons to ensure that they have all required training completed, proper course titles, and signatures in place on an ongoing basis. Going forward, CSHM will remind Compliance Liaisons to show the Monitor any electronic signatures housed in the CE Tracking Software.	Met
6	Ensure staff members are familiar with the Best Practice E-mails and Internal Memorandum that impact patient care.	In Process	Each Best Practice memo and White Paper distributed by [redacted] is available on the Chief Dental Officer tab on the intranet. The Lead Dentist will be reviewing each Best Practice memo in a morning huddle and the Office Manager will track to ensure each item is covered. All Staff will be asked during the October Compliance Liaison webinar to choose one topic from these as "Best Practice of the Day" to use during morning huddles until all topics have been reinforced.	Met
7	Ensure staff members understand the complete definition of an adverse event.	In process	CSHM began an adverse event education initiative in September. The Patient Advocate began sending weekly emails to all Centers on September 9, 2011 to share with the staff during morning huddles. Each weekly email has focused on one specific adverse event and provided examples. Each of the 12 adverse events will be highlighted in a weekly email. The Regional Director will review the Parent Notification and Adverse Event policy with all Lynn staff to reinforce what constitutes an adverse event during her site visit scheduled for November 3, 2011. [redacted] will review this topic during his site visit as well.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
8	Ensure updated forms are communicated to the Compliance Liaisons.	CSHM believes that it has adequately and appropriately addressed this.	Any changes to forms are highlighted during the monthly Compliance Liaison webinar. Each revised form is referenced with the specific change to the form emphasized as well as whether the Center may use up its existing stock or discontinue use of the old form.	Met
9	Ensure re-audits of dentists are conducted within the time frame established in the Chart Audit Policy.	CSHM believes that it has adequately and appropriately addressed this.	The Chart Audit Appeal Policy allows for 10 business days for a dentist or Center to appeal a failed audit. CSHM's intent is not to pull records during the allowable appeal period. The request for additional records was approximately 1 month after the appeal period ended which CSHM deems reasonable in light of the language in the policy. CSHM will consider the need for clarifying language during the annual review of policies and procedures as required under the CIA.	Met
10	Ensure billing issues are corrected within 15 days.	In process	CSHM's Ethics and Compliance Officer and Clinical Audit Manager have developed a tracking mechanism to ensure that billing errors discovered in the chart audit process are corrected within 15 days. As errors are discovered, each item is logged by either the Clinical Audit Manager or clinical auditors. The Center is notified and required to provide email confirmation within 15 days that steps have been taken to correct the billing and/or re-bill. Once the corrected billing has been issued by the payer, the Center is required to provide a copy of the remittance and Account History reflecting the correction. The Log provides the date the Center was notified as an additional tracking mechanism to ensure corrections are addressed within 15 days. CSHM is retrospectively reviewing this log to ensure all billing errors identified since March 2011 have been corrected.	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
11	Ensure reoccurring chart audit findings are identified and addressed.	In process	The Monitor's report references items related to documentation of existing conditions and decay on the Tooth Chart that were included both the January 2011 and April 2011 audits. While not specific to this Center, this topic has been addressed globally by CSHM. First, Chart Documentation Guides are located on the Company's intranet for staff reference. This topic was addressed during the May 2011 periodic training. Additionally, as of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. To address the recurring findings, this center will also be required to view the VOPPs specific to the Tooth Chart by November 18, 2011. A quiz covering the Tooth Chart will also be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Documentation on the Tooth Chart is also monitored through CSHM's chart audit process.	Unmet
12	Ensure chart audit findings related to medical necessity, quality of care, or billing are clearly communicated to the Clinic and are addressed in any CAP that may be issued.	CSHM believes that it has adequately and appropriately addressed this.	The format of the revised Chart Audit Tool to be implemented November 1, 2011 allows space to detail comments related to each finding individually. CSHM believes the revised format will better allow the Audit Manager to translate audit findings to CAPs as applicable.	Unmet

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
13	Ensure all questions in the Compliance Liaison Quarterly Report are answered.	CSHM believes that it has adequately and appropriately addressed this.	The Compliance Liaison submitted the Compliance Liaison Quarterly Report as required by the CIA; however, the most recent report dated July 15, 2011, did not provide a response to the question: "What measures has your center taken during the last quarter to reduce the specific adverse event of swallowed objects? (You will need to discuss with clinical staff and your lead dentist.)" The Regional Director noticed this omission during her review of the report and also noticed a large portion of the responses to this question from all Compliance Liaisons in the subregion related to what they would do if this happened rather than what steps they have taken or what they would do to prevent it. This topic was discussed during the Regional Director's sub-region Compliance Liaison call on August 26, 2011. Each CL was asked to discuss this with their Lead Dentist, Clinical Coordinator and staff to come up with what they would do to prevent it. The revised report was due by Sept. 9th.	Met
14	Ensure staff members are obtaining complete and correct information on the Acknowledgement form.	In process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training that includes proper completion of the Acknowledgement Form. Previously, this training occurred informally. The Regional Director will review this recommendation during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Proper completion of the Authorization Form is also monitored through CSHM's chart audit process.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
15	Ensure staff members are properly reviewing the patient's Health History form and documenting findings related to missing information or explanations to "yes" responses as well as obtaining the appropriate signatures.	In process	Chart Documentation Guides are located on the Company's intranet for reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPP's specific to the Health History form by November 18, 2011. A quiz covering the Health History will be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. The Health History form is also monitored through CSHM's chart audit process. Additionally, CSHM's training department is working with [redacted] to implement a training program on the Health History completion. This training will include each of the health issue concerns along with a basic definition and the dental contraindications that should be considered, what questions to ask and why it is so important in regards to the overall well-being of the patient during dental treatment. This total dental center team training will take place on November 22 and 23, 2011.	Partially Met
16	Ensure staff members are properly documenting existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart and providing additional documentation in the notes section as described in the *Patient Care Manual*.	In process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Tooth Chart by November 18, 2011. A quiz covering the Tooth Chart will also be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Documentation on the Tooth Chart is also monitored through CSHM's chart audit process.	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
17	Ensure staff members are documenting all new disease, conditions, or pathology found at subsequent appointments on the upper odontogram and/or in the notes section of the Tooth Chart as directed in the *Patient Care Manual.*	In process	Chart Documentation Guides are located on the Company's intranet for reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the voice over power points (VOPPs) specific to the Tooth Chart by November 18, 2011. A quiz covering the Tooth Chart will be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Documentation on the Tooth Chart is also monitored through CSHM's chart audit process. CSHM has also requested that the Monitor share thoughts regarding how the Dental Expert is defining "pathology found".	Partially Met
18	Ensure staff members are providing adequate documentation to support the medical necessity of all treatment provided.	In process	While CSHM believes all treatment provided was medically necessary based upon information in the record, CSHM agrees that the documentation related to these records could be improved. Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the voice over power points (VOPPs) specific to the odontogram and Tooth Chart by November 18, 2011. A quiz covering the odontogram and Tooth Chart will be administered to the staff to ensure understanding of the materials. CSHM has made documentation of medical necessity a featured topic during September's Compliance Liaison and Subregion Compliance Liaison meetings. Documentation of medical necessity was also a focus of the Q3 2011 Compliance Liaison report to assess the effectiveness of September efforts and determine whether additional training efforts are needed. [redacted] will review these records with the dentists during his follow-up visit and discuss the importance of documentation with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Documentation on the Tooth Chart is also monitored through CSHM's chart audit process.	Partially Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
19	Ensure staff members are properly completing the Hygiene Procedures form, including the topical fluoride delivery section.	In process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the voice over power points (VOPPs) specific to the Hygiene Form by November 18, 2011. A quiz covering the Hygiene Form will be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Documentation on the Hygiene Form is also monitored through CSHM's chart audit process.	Met
20	Conduct a root cause analysis to determine if the decision to provide restorative treatment without the use of appropriate local anesthesia is based on the needs of the patient.	In process	CSHM and [redacted] will conduct a root cause analysis to ensure the decision to provide restorative treatment without the use of appropriate local anesthesia is based on the needs of the patient.	Unmet

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
21	Ensure staff members are verifying that treatment provided on the Op Sheet matches the documentation on the Tooth Chart and Treatment Plan.	In process	The center will be required to view the VOPPs specific to the Op Sheet, odontogram, and Treatment Plan by November 18, 2011. A quiz covering these forms will be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. This item is also monitored through CSHM's chart audit process. However, there are appropriate scenarios where the Op Sheet, Tooth Chart and Treatment Plan will not match. This is also addressed in the response letter. As part of the adverse event education initiative, lack of consent was highlighted by the Patient Advocate in her email to all Centers to be discussed during the week of September 12, 2011 as the "adverse event of the week." Additionally, the center will be required to view the VOPPs specific to the Treatment Plan by November 18, 2011. A quiz covering the Treatment Plan will also be administered to the staff to ensure understanding of the materials. The Regional Director will review this recommendation with all Lynn staff during her site visit. [redacted] will review this topic during his site visit as well.	Met
22	Ensure staff members are obtaining consent for all treatment provided.	In process	As part of the adverse event education initiative, lack of consent was highlighted by the Patient Advocate in her email to all Centers to be discussed during the week of September 12, 2011 as the "adverse event of the week." Additionally, the center will be required to view the VOPPs specific to the Treatment Plan by November 18, 2011. A quiz covering the Treatment Plan will also be administered to the staff to ensure understanding of the materials. The Regional Director will review this recommendation with all Lynn staff during her site visit. [redacted] will review this topic during his site visit as well.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
23	Ensure staff members are following the CDO's policy related to placing SSCs on primary first molars instead of multi-surface fillings.	In Process	Fillings were completed on teeth that had existing restorations with recurrent decay instead of stainless steel crowns. [redacted] reviewed [redacted] white paper on Intracoronal Restorations during her recent visit to the Lynn Center. [redacted] will also discuss this finding and review these records with the dentists during his site visit. A rationale was not documented for the multi-surface restorations that were completed on the above patients. [redacted] reviewed the policy with the Lead Dentist during her October 18, 2011 visit and reviewed [redacted] white paper on Intracoronal Restorations. [redacted] was receptive to the discussion of treatment planning stainless steel crowns for interproximal and multi-surface caries in primary molars. [redacted] will review with an Associate Dentist who is currently on maternity leave upon her return to the Center. The remaining dentist whose treatment was reviewed during the Monitor's visit resigned as of October 14, 2011. A pedodontist is currently filling in from another center. [redacted] believes the guidance from the pedodontist is already a positive influence in the treatment philosophy with the remaining dentists. [redacted] has requested this issue be added to the CRAFT subcommittee agenda for the next three months to monitor this issue and determine if further action is necessary. [redacted] will also review this topic during his follow-up visit to the Center.	Unmet
24	Ensure staff members are properly completing the Op Sheet, including the treatment timeline at the bottom of the page.	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to Op Sheet by November 18, 2011. A quiz covering the Op Sheet will also be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates. Proper completion of the Op Sheet is also monitored through CSHM's chart audit process.	Met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
25	Ensure staff members are verifying and recording proper dates and correct date of birth on all relevant forms.	In Process	Chart Documentation Guides are located on the Company's intranet for staff reference. As of September 1, 2011 all new hires are required to take formal Chart Documentation Guide training. Previously, this training occurred informally. The center will be required to view the VOPPs specific to the Op Sheet, Health History form and Hygiene Sheet by November 18, 2011. A quiz covering these training modules will be administered to the staff to ensure understanding of the materials. [redacted] will review this recommendation during his follow-up visit and discuss its importance with the staff. The Regional Director will also reinforce this during her visit and will review records during her time at the Center to ensure proper documentation and evaluate error rates.	Met
26	Ensure the Account History Report accurately reflects the procedures performed on the date of service.	In Process	The Operative Sheet for patient #008 dated August 30, 2011, does not reflect an impression being taken as noted on the Account History. The billing will be corrected. CSHM conducted the first hour of year 2 billing training as required by the CIA the week of October 10, 2011. This training reinforced the importance of submitting accurate claims.	Met
27	Ensure staff members are not covering the most recent Tooth Chart with other forms so it will be easily available for reference or documentation.	In Process	This topic was addressed in the September Compliance Liaison webinar. The Regional Director will review this recommendation with the Center during her visit.	Met
28	Ensure maximum dose of local anesthetic is calculated prior to beginning patient care and use of local anesthetic before restorative procedures.	In Process	The Monitor's report notes that the maximum dose of local anesthetic was not calculated prior to administering local anesthetic for patients #045, #046, and #047. However, the maximum dose of local anesthetic was not calculated because it appears no local anesthetic was administered for patients #045 and #046. The maximum dose of local anesthetic was calculated, and the dose administered was below the maximum calculated dose for patient #047.	Partially met

#	Monitor's Site Visit Recommendations	CSHM's Response	Action	Met/Unmet
29	Ensure use of fluoride varnish in young children in accordance with the Best Practice Email dated April 13, 2010.	In Process	While the Chief Dental Officer has recommended the use of fluoride varnish for patients who cannot tolerate tray application for 4 minutes as a best practice, he recognizes that the use of fluoride gel in a brush-on technique is a common and accepted practice for use in young children. Quoting from Dentistry for the Child and Adolescent, ed. 9 ([redacted] "Extra caution and special application techniques are required when topical solutions, gels or foams are placed in the mouths of young children (around 4 years old and younger). The agent is usually brushed on to the teeth in small amounts and the excess is wiped away with gauze." Also from the ADA/PDR Guide to Dental Therapeutics, ed 5 (published by the American Dental Association) on page 328: "Doses of topically applied solutions, gels, foams, and varnishes are typically applied with a cotton swab, a toothbrush, a carrier, or as a rinse." As such, the Chief Dental Officer does not take exception to the quality of care provided to these patients. The Chief Dental Officer will remind the dentists in Lynn of the recommended use of fluoride varnish as a best practice during his visit.	Met

EXHIBIT 40

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
CSHM LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor

Church Street Health Management

Desk Audit
Small Smiles Dental Centers of South Bend
Mishawaka, Indiana

Deliverable #1-68

October 5, 2012

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of South Bend (Clinic), 2332 Miracle Lane, Mishawaka, IN 46545-3012.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 15 records previously reviewed by CSHM as part of its internal audit monitoring of its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of the 15 records that CSHM audited during the second quarter of 2012.

One dentist received an automatic failure by the Monitor because of lack of documentation and radiographic evidence to support the medical necessity for treatment provided. CSHM's score for the same dentist was 100 percent. The scoring differences between CSHM and the Monitor were due to findings related to under-treatment, over-treatment, medical necessity, and undiagnosed decay, existing conditions, and pathology. CSHM's auditor contacted the Director of Clinical Quality Initiatives and Training (DCQIT) for consultation on two records. Both decisions by the DCQIT required follow up with the patient; however, there was no documentation provided to the Monitor to show the Clinic attempted any follow up regarding these findings.

Eight records did not show documentation of all decay, pathology, and/or existing conditions on the Tooth Chart. CSHM reported findings in only three of the eight records.

Two records contained non-diagnostic X-rays. Three records did not have diagnostic X-rays and did not document why X-rays were not attempted. Two of the three records showed treatment was completed without diagnostic X-rays while the patient was under general anesthesia in the operating room (OR), where patient cooperation was not an issue. CSHM did not identify these findings.

The Monitor's pediatric dentist had the following findings with respect to under-treatment, over-treatment, and quality of care. Two records were identified with undiagnosed decay and pathology and another record showed risk of over-treatment with aggressive treatment planned for an adult patient with decay that appeared confined to enamel. Two records were also identified with quality of care issues related to the quality of three root canals and an interim filling performed by Dentist #1. Only one of these findings was reported by CSHM and, in that case, the Monitor identified an adjacent tooth with pathology that went unrecognized by the Clinic and CSHM.

Four records showed incorrect calculation of the Dose Calculated for Patient's Weight (DCPW) for local anesthesia. While the dose of local anesthesia administered never exceeded the maximum dose, the inaccurate calculation allowed for the possibility of patient harm. Three of the four records showed the use of Septocaine without the recognition of a maximum allowable dose. There was also no evidence to show calculation adjustments for overweight patients based on their healthy weight range. The remaining record showed an incorrect DCPW for Lidocaine based on the patient's weight. CSHM did recognize these findings; however, the Clinic was not given a specific recommendation to address this finding.

One record did not provide documentation or X-rays to support the medical necessity for the pulpotomy that was performed on tooth #K. The documentation in the patient's record did not provide a descriptive narrative and the digital photographs did not support the need for a pulpotomy on tooth #K. There was also no X-ray to determine the depth of decay. This finding resulted in an automatic failure for this dentist.

Overall Summary of Recommendations

The following recommendations are based on the Monitor's findings from the review of the 15 visit records:

- Ensure staff members review Acknowledgment forms to verify they have been completed correctly by the parent or guardian.
- Ensure staff members verify all questions are answered on the Health History form.
- Ensure staff members provide adequate and appropriate follow up documentation on all "yes" responses on the Health History form.
- Ensure staff members address the chief complaint and all findings are documented in the patient's record.
- Ensure staff members document assessment of all oral parameters related to dental trauma.
- Ensure staff members correctly document existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays are of diagnostic quality.
- Ensure staff members are aware that when pulp therapy is planned and/or performed in primary teeth, the periapical area of single rooted teeth and the furcation areas of multiple rooted teeth should be visible on pre-treatment X-rays.
- Ensure staff members acquire all necessary pre-treatment X-rays and, if not able to obtain because of patient safety factors, document sufficient rationale.
- Perform a root cause analysis to determine why X-rays are not being taken in the OR.
- Ensure staff members document rationale for not providing a fluoride treatment following a prophylaxis for a high caries risk adult patient.

- Ensure staff members review the dictated Operative Report for OR cases and correct any errors prior to placement in the patient's record.
- Ensure the X-rays for patients #002 and #014 are reviewed to determine if billing corrections related to non-diagnostic X-rays are warranted.
- Perform a root cause analysis to determine the reason for the scoring differences identified in the Monitor's report.
- Ensure the CDO or DCQIT reviews the entire record for patient #004 for the risk of under-treatment, appropriateness of the preventive and restorative plan, and the quality of care rendered.
- Ensure patient #013 is contacted to receive follow up care to address the pathology related to teeth #S and #T.
- Ensure the CDO or DCQIT reviews the record for patient #011 to evaluate over-treatment of teeth #4, #5, #12, and #13 with respect to the patient's age, lesions confined to enamel, and CSHM's policy on remineralization.
- Ensure CSHM's *Guidelines* define instances when a discretionary point deduction is warranted, criteria used to determine number of points deducted, and how to score multiple records where a provider has not adequately addressed the patient's needs in the Treatment Plan.
- Ensure the CDO or DCQIT reviews the records for patients #004 and #005 to evaluate the quality of the root canals and interim filling.
- Ensure patients #004 and #005 are monitored and extruded sealer paste is resorbed.
- Ensure the correct DCPW is calculated and documented on the OP Sheet prior to treatment and that dentists know how to adjust those doses for overweight patients.
- Ensure staff members appropriately document findings from all necessary pre-treatment X-rays and include descriptive narratives to support the medical necessity of the treatment planned.
- Ensure staff members document the rationale for placement of multiple surface fillings instead of SSCs.
- Ensure the CDO or DCQIT reviews for the appropriateness of the apparent routine post-operative administration of local anesthesia following SSC placement in the OR setting.
- Ensure dentists document assessment of the pediatric patient for the necessity of a space maintenance appliance.
- Conduct a root cause analysis to determine why nitrous oxide/oxygen analgesia is not being used with anxious patients.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of South Bend (Clinic), 2332 Miracle Lane, Mishawaka, IN 46545.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of South Bend. On July 31, 2012, the Monitor notified CSHM's Compliance Officer by e-mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from CSHM on August 1, 2012. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the second quarter of 2012
  - E-mail to the Clinic with results for the second-quarter audit
  - Second-quarter chart audit tool spreadsheet
- Blank audit tool used to conduct the chart audit, which included guidelines to respond to the questions *(Guidelines)*
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by the Director, Clinical Audit Review prior to conducting audits; Auditor has received ongoing supervision by Director, Clinical Audit Review
  - Training reference tools used
    - *The CBC Chart Audit Policy*
    - *The Chart Documentation Guide*
    - *Clinical Policies and Guidelines for CSHM Affiliated Dental Centers*
    - *Quality Assurance Protocols and Guidelines for Dental Centers Policy*
    - White paper dated February 2012 titled *"Indirect Pulp Therapy"*

- White paper dated June 2012 titled *"Antibiotics"*

CSHM initially requested the Clinic's charts on June 5, 2012, and the documents were received on June 11, 2012. A licensed dental hygienist completed the chart audit on August 2, 2012. CSHM indicated the Clinic and the three dentists passed the chart audit. The DCQIT reviewed two of the 15 records for this chart audit.

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the second quarter of 2012 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating its criteria. The Monitor's pediatric dentist provided consultation on 13 of 15 records reviewed.

Review of CSHM Chart Audit

Fifteen records were reviewed for the three audited dentists following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the *Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services*. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentists. CSHM issued a passing score for the Clinic and the three dentists. While the Monitor issued passing scores for the Clinic and two dentists, the remaining dentist received an automatic failure because of lack of documentation and radiographic evidence to support the medical necessity for treatment. The Monitor also identified instances of under-treatment and over-treatment that resulted in lower scores for the Clinic and passing dentists.

	Monitor Score	CSHM Score
Clinic Score	**93.5 %**	**97.6%**
Dentist #1	Automatic Failure	100%
Dentist #2	93%	95.1%
Dentist #3	95.2 %	95.4%

The following tables summarize findings pertaining to the records for the dentists. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The column titled "CSHM's Findings" records the verbatim findings reported by CSHM in the Clinic's chart audit spreadsheet. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the following tables.

[redacted]

Dentist #1

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	The Monitor scored this question as "n/a" since there were no X-rays; however, CSHM's auditor scored the question as "yes" indicating X-rays were present and of diagnostic quality. As a result of a question from the Monitor, the Director of Clinical Audit Review determined CSHM's auditors' answer was incorrect and additional training to decrease scoring errors was initiated as a result of this finding.	
#3	This patient was 3 years, 10 months old and was treated in the OR. There was no indication that X-rays were attempted or explanation as to why. Clinical photographs were available for this patient, but photographs in place of X-rays are appropriate in the Clinic only when diagnostic X-rays cannot be acquired because of an uncooperative patient.	
#10	According to the Monitor's pediatric dentist, the digital photographs and documentation in the patient's record did not support the medical necessity for the pulpotomy performed on tooth #K. This finding resulted in automatic failure.	

[redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#12	The Health History and Hygiene Procedures forms dated April 10, 2012, documented the chief complaint as "cavities, tooth not coming in from 2 month extraction;" however, documentation did not show that the chief complaint was explored or addressed and there was no periapical X-ray or photograph taken of the mandibular anterior teeth.	
#47	There was no descriptive narrative indicating the need for a pulpotomy on tooth #K, and there was no X-ray taken to determine the depth of decay.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	Pathology in primary anterior teeth occurs at the apex; however, the maxillary occlusal X-ray is elongated and apices of teeth #E and #F are not visible. Therefore, the Monitor found the maxillary occlusal X-ray was non-diagnostic.	
#15	Tooth #M did not receive treatment on May 9, 2012, the audited date of service. According to the Account History Report, the Tooth Chart, and the OR Procedures form, tooth #H received a single surface (mesial) filling. Since this was not a multiple surface filling, the rationale for placement of a crown was not needed and the Monitor entered "n/a" for this question.	A mesial restoration was done on tooth # M an explanation was not provided as to why a crown was not utilized. DOS 5/9/2012

[redacted]

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#58	The maxillary anterior X-ray was billed, but the apices were not visible on teeth #D, #E, #F, and #G. The size of the lesions on these teeth would indicate a need to see the periapical area.	
#68	Documentation on the dictated Operative Report dated May 9, 2012, noted tooth #H received a "mesial facial resin filling." According to the Account History Report, the Tooth Chart, and the OR Procedures form, tooth #H received a single surface (mesial) filling. The documentation error on the dictated Operative Report was not corrected.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#3	This patient was 2 years, 2 months old and there was no indication that X-rays were attempted. This child's second molars were unerupted and all tooth surfaces could be visualized for smooth surface caries; however, diagnostic X-rays were necessary for the anterior teeth receiving pulpotomies to rule out pathology and to assess the status of roots of these very carious teeth. In addition, X-rays would have been valuable in exploring the cause of tooth mobility, as noted on the Tooth Chart dated March 21, 2012, in such a young patient. Photographs in place of X-rays are appropriate in the Clinic only when diagnostic X-rays cannot be acquired because of an uncooperative patient.	

[redacted]

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	Rationale was not documented to explain why multiple surface composite fillings were performed on teeth #O, #P, and #Q instead of stainless steel crowns (SSCs) for such a young patient whose cooperation in the office would be marginal if replacement or repair was necessary in the next year.	
#68	Documentation on the dictated Operative Report dated May 2, 2012, noted that tooth #B was treated with a pulpotomy and SSC and also received a "facial resin filling." According to the Tooth Chart dated March 21, 2012, tooth #P received a facial resin filling, not tooth #B. The documentation error on the dictated Operative Report was not corrected.	

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist found undiagnosed radiographically demonstrable decay on the distal of tooth #5, distal of tooth #11, mesial of tooth #12, mesial of tooth #14, mesial of tooth #18, mesial and distal of tooth #19, and distal of tooth #29. These findings were not recorded on the Tooth Chart or included in the Treatment Plan.	
#8	Tooth #29 received an occlusal amalgam filling on the audited date of service and the radiographically demonstrable distal decay remained untreated.	

[redacted]

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#16	The Monitor's pediatric dentist noted that this patient demonstrated a virulent and aggressive form of decay that demanded a holistic approach to managing the disease and restoring the mouth. According to the Account History Report, other teeth were treated at subsequent appointments by Dentist #1 and Dentist #2 and decay remained untreated. There was no evidence that the providers recognized the seriousness of the disease or planned an aggressive preventive program to control the disease process.	
#54	The Monitor's pediatric dentist noted concerns with the quality of the root canals performed on teeth #18 and #30 and the interim filling performed on tooth #30. The post-operative X-rays showed the filling material extended beyond the apices of teeth #18 and #30; and a poorly performed interim restoration on tooth #30 that had questionable abilities to maintain the requisite seal until the final restoration was placed.	
#71	The distal occlusal composite filling completed on tooth #30 was not documented on the lower odontogram.	
#73	Because of the significant amount of decay that went undiagnosed, the Monitor's pediatric dentist issued a five-point discretionary point deduction on question #73 for Dentist #2 who performed the exam and developed the Treatment Plan.	

[redacted]

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist found abnormal spacing between teeth #20 and #21 and an unusual appearance of the interproximal bone on the bite-wing and panoramic X-rays dated January 23, 2012. Also, there was a noted lack of symmetry in the eruption pattern of the mandibular second premolars, with tooth #20 demonstrating delayed eruption compared to its contra-lateral tooth. There was no evidence the abnormal spacing and appearance of the interproximal bone or delayed eruption of tooth #20 were identified and planned for further exploration for etiology or treatment.	
#54	The Monitor's pediatric dentist noted concerns with the quality of the root canal performed on tooth #30. The post-operative X-ray showed the filling material extended beyond the apices.	

Dentist #2

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#21	The Operative Procedures form (Op Sheet) recorded the Dose Calculated for Patient's Weight (DCPW) of Septocaine for this patient as 8.44 when CSHM's Local Anesthetic Calculation Chart shows the maximum DCPW for Septocaine as 6.9.	The correct DCPW of Septocaine is 6.9. This was not documented.

[redacted]

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#3	No reason was given why X-rays were not taken for this new patient. The orthodontic referral letter showed X-rays were not included with the letter.	
#6	The Tooth Chart contained only the patient's name and did not document existing conditions on the upper odontogram. The new patient was referred from the patient's orthodontist for the extraction of primary teeth; however, there was no explanation for not taking X-rays or for not performing a complete examination. According to the *Chart Documentation Guide*, all new patients should have a completed Tooth Chart documenting all existing conditions on the upper odontogram.	
#71	The extraction of teeth #C, #H, #K, #L, #S, and #T were not documented on the lower odontogram of the Tooth Chart.	Completed extracrions [sic] of teeth #s C,H,K,L,S and T are not documented on the bottom of the [sic]

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist agrees with the DCQIT's assessment and also agrees with the benefit of a panoramic X-ray for further evaluation of this area of concern.	Per [DCQIT], "The roots of #18 have an unusual appearance. The radiopacity in that area could reflect unusual root shape, a third root, or some other developmental anomaly. The mesial root of #31 also has an unusual appearance. I suggest that the center place a note in the patient's record to consider taking a PA of #18 at their next opportunity to determine whether further evaluation and treatment is necessary."

[redacted]

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#21	The Op Sheet recorded the DCPW of Lidocaine for this patient as 7.9 when CSHM's Local Anesthetic Calculation Chart shows the DCPW as 7.2.	The correct DCPW is 7.2. This was not documented.

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist noted an existing distal overhang on tooth #4 as seen in the X-rays dated April 20, 2012. There was no documentation indicating this was identified or planned for treatment. Based upon the documentation the Monitor reviewed, the filling did not appear to have been performed in the Clinic.	
#21	The Op Sheet recorded the DCPW of Septocaine for this patient as 9.3 when CSHM's Local Anesthetic Calculation Chart shows the maximum DCPW for Septocaine as 6.9.	The correct DCPW for septocaine is 6.9. This was not documented.
#26	The Health History form dated April 20, 2012, did not show "yes" or "no" was marked for pregnancy or autism.	
#27	There was no follow up explanation for the patient's history of epilepsy and seizures documented on the Health History form dated April 20, 2012. There was also no reference to the Medical Consult form dated April 18, 2012. A more complete explanation was documented on the Hygiene Procedures form dated April 20, 2012.	

[redacted]

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#70	The Hygiene Procedures form dated April 20, 2012, did not document rationale for why a special needs adult patient with a high caries risk did not receive a fluoride treatment following a prophylaxis. The Monitor agreed with CSHM's finding; however, CSHM's auditor only noted "adult patient" as the rationale for scoring this question as "no" and did not provide clear communication to the Clinic regarding the significance of the finding.	Adult patient

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#12	The Monitor's pediatric dentist noted incomplete evaluation following the patient's complaint of "couple loose ones (teeth)" on the Health History form dated May 18, 2012. The Tooth Chart also documented that the patient boxes and was advised to wear a mouthguard. The Hygiene Procedures form documented: "no loose teeth noted" in the diagnosis section. A complete review of the history of trauma events was indicated including inquiry as to when the teeth were loose (if not now), the symptoms the patient experienced with the loose teeth, the X-rays reviewed for pathology, and a notation for future follow up. There was no documentation indicating a thorough trauma assessment was conducted.	

[redacted]

Dentist #3

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#16	This question was a non-scoring question and asked: "Is it acceptable to NOT pass on results of this chart audit to the Patient Advocate and the CDO for a broader review as it relates to systemic overtreatment/undertreatment issues?" The Monitor's pediatric dentist found the treatment planned for teeth #4, #5, #12, and #13 to be aggressive for lesions that were radiographically confined to enamel in a 34 year-old patient with teeth that had been erupted for 20 years.	
#21	The OP Sheet recorded the DCPW of Septocaine for this patient as 15.2 when CSHM's Local Anesthetic Calculation Chart shows the maximum DCPW for Septocaine as 6.9.	The correct maximum DCPW for Septocaine is 6.9
#73	Dentist #2 developed the Treatment Plan for this case; however, the Monitor did not add a point deduction because the Guidelines did not provide clear criteria for the discretionary point deduction process, and a five-point deduction had already been issued to this provider for the Treatment Plan related to patient #004.	

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
	No findings.	

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist agreed with the findings related to tooth #S, but also noticed there was no documentation on the Tooth Chart or Treatment Plan to address the furcation radiolucency on tooth #T that was evident on the bitewing X-ray dated May 25, 2012. This finding would indicate the need for an additional periapical X-ray to view the apices of #T to determine if the permanent tooth bud is involved.	Per [DCQIT], "S has internal resorption. Unless I'm missing something obvious, I don't see that it is planned for treatment. It does have a restoration which is what I think is charted on the upper odontogram (black?). #S is probably asymptomatic, but the internal resorption should have been charted on the upper odontogram. I suggest that the center recall this patient and assess the status of #S and whether it should be extracted. The mesial root will fracture during the extraction; it should be left in place an allowed to resorb. The dark areas on #B and I are, I believe, anatomical findings."
#8	The Monitor's pediatric dentist agreed with this finding but also noted the Treatment Plan did not address the pathology associated with tooth #T.	Per [redacted] #S has internal resorption. Unless I'm missing something obvious, I don't see that it is planned for treatment. It does have a restoration which is what I think is charted on the upper odontogram (black?). #S is probably asymptomatic, but the internal resorption should have been charted on the upper odontogram. I suggest that the center recall this patient and assess the status of #S and whether it should be extracted. The mesial root will fracture during the extraction; it should be left in place an allowed to resorb. "I would deduct 3 points from the dentist who did the treatment plan for not recognizing the condition and charting it on the odontogram, and not planning treatment for #S.

[redacted]

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	The Monitor's pediatric dentist noted the bitewing X-rays are non-diagnostic due to overlapping contacts between the teeth; thus, the proximal surfaces of teeth #A, #B, #K, #L, #S, and #T could not be evaluated for decay.	
#6	There was no documentation to show the panoramic X-ray dated May 25, 2012, was read and interpreted.	
#23	No finding.	Per [DCQIT], "non use of local anesthesia is ok in this case."
#58	The bitewing X-rays were billed even though they were non-diagnostic due to overlapping contacts of the teeth.	
#61	The individual completing the Acknowledgment of Receipt of Privacy Practices (Acknowledgment) form did not document their relationship to the patient.	Relationship to the patient is not documented.

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Tooth Chart dated May 10, 2012, did not document the internal resorption on tooth #I. The Account History Report showed tooth #19 received a sealant in 2009, but the Tooth Chart did not document an existing sealant or the need to redo the sealant.	

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#45	The Monitor scored this question "n/a" since the audited date of service was May 10, 2012; and the OP Sheet for May 3, 2012, when the sealants were placed, was not included in the requested documents. This Op Sheet, most likely, documented the rationale for sealant placement.	The sealants are documented on the account history and the lower odontogram. The "deep grooves is not circled on the hygiene sheet dos 5/3/2012

Summary

Below is a summary of the Monitor's findings from the 15 records reviewed:

Consents and Acknowledgments

One record (patient #014) contained an Acknowledgment form that was not completed correctly. The person completing the Acknowledgment form for the patient did not include their relationship to the patient.

Health History

One record (patient #009) contained an incomplete Health History. The record did not document answers for questions regarding pregnancy and autism. There was also no explanation for the patient's history of epilepsy and seizures and no reference to the Medical Consult form dated April 18, 2012.

Chief Complaint

Two records (patients #001 and #010) did not document that the chief complaint was explored and addressed.

- Patient #001 – The chief complaint was stated as "tooth not coming in from 2 month extraction" and there were no clinical notes or X-rays taken to address this concern.
- Patient #010 – The patient's chief complaint was stated as "couple loose ones (teeth)" with a history of boxing. The Monitor's pediatric dentist noted incomplete evaluation of the complaint and no documentation indicating a thorough trauma assessment was completed.

Tooth Chart

Eight records (patients #004, #005, #007, #008, #009, #013, #014, and #015) did not document all decay, pathology, and/or existing conditions on the Tooth Chart.

- Patient #004 – There was no documentation of the radiographically demonstrable decay on the distal of tooth #5, distal of tooth #11, mesial of tooth #12, mesial of tooth #14, mesial of tooth #18, mesial and distal of tooth #19, and distal of tooth #29.

- Patient #005 – There was no documentation of the abnormal spacing and appearance of the interproximal bone or delayed eruption of tooth #20. These findings were not identified and planned for further exploration for etiology or treatment.
- Patient #007 – The Tooth Chart contained only the patient's name and did not record the date of the exam or existing conditions.
- Patient #008 – There was no documentation of the radiopacity apical to tooth #18 and the need for further evaluation and a periapical X-ray.
- Patient #009 – There was no documentation of the radiographically evident distal overhang on the existing filling on tooth #4.
- Patient #013 – There was no documentation noting the radiographically evident internal resorption noted on tooth #S and the furcation radiolucency on tooth #T.
- Patient #014 – There was no documentation showing the panoramic X-ray was read and interpreted.
- Patient #015 – There was no documentation noting the radiographically evident internal resorption on tooth #I.

Two records (patients #004 and #007) did not show documentation of completed treatment on the lower odontogram of the Tooth Chart.

- Patient #004 – Distal occlusal composite filling completed on tooth #30.
- Patient #007 – Extraction of teeth #C, #H, #K, #L, #S, and #T.

X-rays

Two records (patients #002 and #014) contained non-diagnostic X-rays.

- Patient #002 – The maxillary occlusal X-ray was non-diagnostic because of elongation and the inability to see the apices of teeth #E and #F.
- Patient #014 – The bitewing X-rays were non-diagnostic because of overlapping contacts.

Three records (patients #001, #003, and #007) did not document why X-rays were not attempted. Two of the three records (patients #001 and #003) showed treatment without diagnostic X-rays while the patient was under general anesthesia in the OR, where patient cooperation was not an issue. The following details pertain to these findings:

- Patients #001 and #003 – There was no documentation indicating why X-rays were not attempted in the Clinic and OR settings and treatment was completed without the diagnostic value of X-rays. Also, X-rays would have been valuable in exploring the cause of tooth mobility for patient #003, as noted on the Tooth Chart dated March 21, 2012, which is atypical in such a young patient.
- Patient #007 – There was no documentation indicating why X-rays were not taken for this new patient. The orthodontic referral letter showed X-rays were not included with the letter.

Hygiene Procedures

One record (patient #009) did not document rationale for why a special needs adult patient with a high caries risk did not receive a fluoride treatment following a prophylaxis. The Monitor agreed with CSHM's finding; however, CSHM's auditor noted "adult patient" as the only rationale for scoring this question as "no" and did not provide clear communication to the Clinic regarding the significance of the finding.

Operative Report

Two of the three OR cases (patients #002 and #003) contained documentation errors on the dictated Operative Report. The following provides a summary of each:

- Patient #002 – Documentation on the dictated Operative Report showed tooth #H received a "mesial facial resin filling;" however, the OR Procedures form, lower odontogram of the Tooth Chart, and the Account History Report indicated tooth #H received a single surface filling involving only the mesial surface.
- Patient #003 – Documentation on the dictated Operative Report noted that tooth #B received an SSC and pulpotomy, and a facial resin filling. According to the Tooth chart dated March 21, 2012, tooth #P received a facial resin filling, not tooth #B. The error was not corrected on the dictated Operative Report.

Account History Report

The Account History Report for two records (patients #002 and #014) showed billing for X-rays that were non-diagnostic.

Other Scoring Differences

Three records (patients #001, #002, and #015) showed scoring differences between the Monitor and CSHM's auditor. The following details are related to those findings:

- Patient #001 – The Monitor scored question #1 as "n/a" since there were no X-rays; however, CSHM's auditor scored the question as "yes" indicating X-rays were present and of diagnostic quality. The remaining X-ray questions were also scored by CSHM's auditor as if there were X-rays.
- Patient #002 – The Monitor scored question #15 as "n/a" per the *Guidelines* since there was no documentation on the Account History Report, the Tooth Chart, and the OR Procedures form indicating that tooth #H received a multiple surface filling. CSHM's auditor scored the question "yes" and stated: "a mesial restoration was done on tooth #M an explanation was not provided as to why a crown was not utilized." Tooth #M did not receive treatment on May 9, 2012, the audited date of service.
- Patient #015 – The Monitor scored question #45 as "n/a" per the *Guidelines* since the audited date of service was May 10, 2012, and the OP Sheet for May 3, 2012, when the sealants were placed, was not included in the requested documents. This Op Sheet, most likely, documented the rationale for sealant placement. CSHM's auditor scored the question "no" indicating "the sealants are documented on the account history and the lower odontogram. The 'deep grooves' is not circled on the hygiene sheet dos 5/3/2012."

Treatment Issues

Under-Treatment

Two records (patients #004 and #013) showed planned treatment that did not adequately address the patient needs and showed instances of under-treatment with respect to the care provided in the Clinic. The following details pertain to these findings:

- Patient #004 – The Monitor's pediatric dentist found undiagnosed radiographically demonstrable decay on the distal of tooth #5, distal of tooth #11, mesial of tooth #12, mesial of tooth #14, mesial of tooth #18, mesial and distal of tooth #19, and distal of tooth #29. Tooth #29 received an occlusal amalgam filling on the audited date of service, and the radiographically demonstrable distal decay remained untreated. The Monitor's pediatric dentist noted that this patient demonstrated a virulent and aggressive form of decay that demanded a holistic approach to managing the disease and restoring the mouth. There was no evidence that the providers recognized the seriousness of the disease or planned an aggressive preventive program to control the disease process. Because of these findings, both the audited Dentist (Dentist #1) and the Dentist (Dentist #2) who developed the Treatment Plan were penalized.
- Patient #013 – Pathology evident on the X-ray of teeth #S and #T went undiagnosed and was not addressed in the Treatment Plan developed by Dentist #3. The DCQIT provided consultation related to the unrecognized internal resorption on tooth #S and indicated a need for the Clinic to follow up with the patient; however, CSHM's auditor and the DCQIT did not provide any finding related to the unrecognized furcation radiolucency associated with tooth #T.

Over-Treatment

One record (patient #011) had planned treatment that showed risk of over-treatment. The following details pertain to this finding:

- Patient #011 – There was no documentation to support the aggressive treatment planned on teeth #4, #5, #12, and #13 for lesions that were radiographically confined to enamel in a 34 year-old patient with teeth that had been erupted for 20 years. Dentist #2 developed the Treatment Plan for this case; however, the Monitor did not add a point deduction because the *Guidelines* did not provide clear criteria for the discretionary point deduction process, and a five-point deduction had already been issued to this provider for the Treatment Plan related to patient #004.

Quality of Care

Two records (patients #004 and #005) showed quality of care issues related to three root canals performed by Dentist #1. The following details are related to these findings:

- Patient #004 – The Monitor's pediatric dentist noted concerns with the quality of the root canal performed on teeth #18 and #30 and the interim filling performed on tooth #30. The post-operative X-rays showed the filling material extended beyond the apices of teeth #18 and #30, and a poorly performed interim

restoration on tooth #30 with questionable abilities to maintain the requisite seal until the final restoration was placed.

- Patient #005 – The Monitor's pediatric dentist noted concerns with the quality of the root canal performed on tooth #30. The post-operative X-ray showed the filling material extended beyond the apices.

Local Anesthesia

Four records (patients #006, #008, #009, and #011) showed incorrect calculation of the DCPW for local anesthesia. While the dose of local anesthesia administered to each of these patients never exceeded the maximum dose, the inaccurate calculation allowed for the possibility of patient harm. Three of the four records (patients #006, #009, and #011) showed the use of Septocaine without the recognition of a total maximum allowable dose of 6.9 carpules, regardless of patient weight or age. There was also no evidence of calculation adjustments for overweight patients based on their healthy weight range. The remaining record (patient #008) showed an incorrect DCPW was calculated for Lidocaine based on the patient's weight.

Medical Necessity

One record (patient #001) did not provide documentation or X-rays to support the medical necessity for the pulpotomy that was performed on tooth #K. The documentation in the patient's record did not provide a descriptive narrative and the digital photographs did not support the need for a pulpotomy on tooth #K. There was also no X-ray to determine the depth of decay. These findings were captured in questions #10 and #47 of CSHM's Audit Tool.

Multiple Surface Fillings

One record (patient #003) did not document the rationale for placement of multiple surface fillings instead of SSCs. This 2-year-old received full mouth rehabilitation in the OR where multiple surface composite fillings were performed on teeth #O, #P, and #Q. The Monitor's pediatric dentist's primary concerns were related to the success rate of fillings versus SSCs in these small teeth in such a young patient and the patient's cooperation in the office if replacement or repair was necessary in the next year.

Observations

Upon review of the 15 records, the Monitor had the following observations:

Three OR cases (patients #001, #002, and #003) were reviewed and showed routine post-operative administration of local anesthesia as stated in the dictated report "following dental restorations, local anesthetic was administered as follows 1.0 carpule of 2% lidocaine with epinephrine infiltrated buccally to all teeth restored with crowns." According to the Monitor's pediatric dentist, administration of local anesthesia in the OR is appropriate following extractions that would be painful when the child awakens. The records for patients #001 and #002 indicated no treatment that involved extraction of teeth. The dictated Operative Report dated May 2, 2012, for the patient #003 indicated this patient received local anesthesia with buccal infiltration following the placement of crowns, but local anesthesia was not administered where extractions occurred.

The record for patient #013 showed placement of a fixed unilateral space maintainer on the audited date of service, May 25, 2012, without documentation indicating a thorough workup. The Monitor's pediatric dentist noted there was no indication that an assessment of this patient's occlusal status or spacing issues was done to justify the necessity of a space maintainer for tooth #L.

The Monitor reviewed one record (patient #014) where local anesthesia was not administered for occlusal fillings performed on teeth #A and #J. This record was reviewed by the DCQIT with the determination that this was acceptable in this case. The Op Sheet noted "very minimal caries" and local anesthesia was not necessary. The records did not reflect behavior by the patient that was consistent with pain. The Monitor is concerned the fillings performed without local anesthesia were shallow and not placed into dentin.

Three of 15 records reviewed documented treatment performed in the OR. Of the remaining 12 records, 8 (patients #004, #006, #008, #009, #011, #013, #014, and #015) did not show nitrous oxide/oxygen analgesia was administered for anxious patients. With the exception of one patient, (patient #013), behavior for these patients was noted as "positive, accepting but anxious." The behavior recorded for patient #013 was "negative, patient reluctant to treatment." The Monitor's pediatric dentist is concerned that nitrous oxide/oxygen analgesia is not being utilized when it could be beneficial for patient comfort during operative treatment.

Recommendations

The following recommendations are based on the Monitor's findings from review of the 15 visit records:

- Ensure staff members review Acknowledgment forms to verify they have been completed correctly by the parent or guardian.
- Ensure staff members verify all questions are answered on the Health History form.
- Ensure staff members provide adequate and appropriate follow up documentation on all "yes" responses on the Health History form.
- Ensure staff members address the chief complaint and all findings are documented in the patient's record.
- Ensure staff members document assessment of all oral parameters related to dental trauma.
- Ensure staff members correctly document existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays are of diagnostic quality.
- Ensure staff members are aware that when pulp therapy is planned and/or performed in primary teeth, the periapical area of single rooted teeth and the furcation areas of multiple rooted teeth should be visible on pre-treatment X-rays.

- Ensure staff members acquire all necessary pre-treatment X-rays and, if not able to obtain because of patient safety factors, document sufficient rationale.
- Perform a root cause analysis to determine why X-rays are not being taken in the OR.
- Ensure staff members document rationale for not providing a fluoride treatment following a prophylaxis for a high caries risk adult patient.
- Ensure staff members review the dictated Operative Report for OR cases and correct any errors prior to placement in the patient's record.
- Ensure the X-rays for patients #002 and #014 are reviewed to determine if billing corrections related to non-diagnostic X-rays are warranted.
- Perform a root cause analysis to determine the reason for the scoring differences identified in the Monitor's report.
- Ensure the CDO or DCQIT reviews the entire record for patient #004 for the risk of under-treatment, appropriateness of the preventive and restorative plan, and the quality of care rendered.
- Ensure patient #013 is contacted to receive follow up care to address the pathology related to teeth #S and #T.
- Ensure the CDO or DCQIT reviews the record for patient #011 to evaluate over-treatment of teeth #4, #5, #12, and #13 with respect to the patient's age, lesions confined to enamel, and CSHM's policy on remineralization.
- Ensure CSHM's *Guidelines* define instances when a discretionary point deduction is warranted, criteria used to determine number of points deducted, and how to score multiple records where a provider has not adequately addressed the patient's needs in the Treatment Plan.
- Ensure the CDO or DCQIT reviews the records for patients #004 and #005 to evaluate the quality of the root canals and interim filling.
- Ensure patients #004 and #005 are monitored and extruded sealer paste is resorbed.
- Ensure the correct DCPW is calculated and documented on the OP Sheet prior to treatment and that dentists know how to adjust those doses for overweight patients.
- Ensure staff members appropriately document findings from all necessary pre-treatment X-rays and include descriptive narratives to support the medical necessity of the treatment planned.
- Ensure staff members document the rationale for placement of multiple surface fillings instead of SSCs.
- Ensure the CDO or DCQIT reviews for the appropriateness of the apparent routine post-operative administration of local anesthesia following SSC placement in the OR setting.
- Ensure dentists document assessment of the pediatric patient for the necessity of a space maintenance appliance.

- Conduct a root cause analysis to determine why nitrous oxide/oxygen analgesia is not being used with anxious patients.

EXHIBIT 41

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Chief Compliance Officer
CSHM LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor

CSHM LLC

Clinic Report
Colorado Springs, CO

Deliverable #1-73

November 15, 2012

Executive Summary

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dentistry for Children, 2859 E. Fountain Blvd. Colorado Springs, CO 80910 (Clinic).

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Patient observations revealed good teamwork involving the dentists and staff, and children were managed well during administration of local anesthesia.

Overall Summary of Critical Findings and Observations

The critical findings and observations from the Monitor's visit are as follows:

With respect to the Tooth Chart, 4 records did not show documentation of decay and 12 records did not record all existing conditions.

The Monitor found non-diagnostic X-rays in 5 records and evidence of under-utilization of diagnostic X-rays in 12 records. Of these 12 records, 4 showed treatment was completed without diagnostic X-rays while the patient was under general anesthesia in the operating room (OR), where patient cooperation was not an issue.

The Monitor noted a trend related to treatment provided without diagnostic X-rays and found five records did not provide documentation and/or radiographic evidence to support the medical necessity for treatment.

The Monitor noticed a trend with respect to under-utilization of SSCs and found five records did not document rationale for performing multiple surface fillings instead of SSCs.

Three records showed treatment was provided without documented consent.

Two records contained incomplete documentation with no explanation for leaving teeth with noted decay untreated.

The Monitor's pediatric dentist observed a patient being treated with an SSC on tooth #I without X-rays or photographs.

Nitrous oxide was used appropriately, but one expanded duty dental assistant (EDDA) said she did not know she was supposed to titrate the administration in 10 percent increments.

Gauze shields were used by the EDDA during fitting of SSCs. They were not used by the Associate Dentist during the fitting of a band and loop space maintainer.

Overall Summary of Recommendations

Set forth below is a summary of the report's recommendations:

- Ensure Compliance Liaisons have a plan to allow the Monitor prompt access to the Clinic upon arrival if the Compliance Liaison is not available.
- Ensure CSHM communicates to the Monitor any changes with respect to Clinic office hours.
- Ensure the *Code of Ethics* is signed by each employee within the required time frames.
- Ensure the Monitor is supplied with a complete list of Clinic employees.
- Ensure quarterly chart audits are performed.
- Ensure the Clinic is notified of chart audit results in a timely manner.
- Ensure the Monitor is supplied with copies of all CAPs and documentation to show their completion.
- Ensure the Monitor receives the Chart Audit Tool spreadsheet for each quarterly chart audit.
- Ensure staff members verify the Acknowledgement form is completed correctly and stored in each patient record.
- Ensure staff members provide adequate follow-up information and explanations for "yes" responses on the Health History form.
- Ensure staff members correctly document existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays are stored in a manner where they are easy to locate and review.
- Ensure X-rays are clearly labeled with date of exposure and patient identification.
- Ensure staff members document the interpretation of all X-rays.
- Ensure staff members acquire all necessary pre-treatment X-rays and, if not able to obtain because of patient safety factors, document sufficient rationale.
- Perform a root cause analysis to determine why X-rays are not being taken in the OR.
- Ensure X-rays are diagnostic and support the medical necessity for treatment provided.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.

- Ensure dentists recognize and address all disease and pathology on the Treatment Plan.
- Ensure staff members provide documentation to support the rationale for placement of multiple surface fillings instead of SSCs.
- Ensure the Nitrous Oxide Consent Form is signed by the dentist.
- Ensure the records for patients #003, #007, and #016 are reviewed to determine if treatment was performed without consent.
- Ensure the Questions for Affirmed Health History Issues form includes relevant questions to provide sufficient follow-up to heart murmur.
- Ensure the dictated Operative Report and all X-rays or photographs taken in the OR are stored in the patient's Clinic record.
- Ensure staff members provide adequate, legible documentation related to trauma and chief complaints.
- Ensure a Clinical Coordinator is hired.
- Ensure X-ray capabilities are provided in the OR to take X-rays of patients receiving treatment in the OR.
- Ensure photographs are taken when child behavior precludes obtaining X-rays.
- Ensure all those who administer nitrous oxide know to titrate administration in 10 percent increments and do so.
- Ensure gauze shields are used to protect the patient's airway when fitting SSCs and bands.

Clinic On-site Report

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dentistry for Children, 2859 E. Fountain Blvd. Colorado Springs, CO 80910 (Clinic).

Implementation

The OIG approved an unannounced on-site visit for October 23-26, 2012, at the Clinic. The Monitor notified the Chief Compliance Officer (CCO), via voicemail prior to arrival at the Clinic on October 23, 2012. Since the CCO was unable to be reached, the Monitor attempted to contact the Compliance Attorney via the phone number recorded on the most current list of compliance committee members; however, the phone number was not in service. Upon arrival at the Clinic, the Monitor team found the Clinic was selected as part of a group of clinics to test new office hours beginning August 13, 2012.

Because of the new office hours, the Office Manager/Compliance Liaison was on lunch and the Front Office Assistant asked that the team wait for her return prior to entering the Clinic; therefore, the Monitor was unable to start the on-site when planned. Also, because the Clinic would be closed Friday morning, the Monitor had to make an unexpected adjustment to the schedule in order to conduct the exit conference at a time when the Lead Dentist could participate. The Clinic's Compliance Liaison went on leave shortly after the entrance conference; however, the Office Manager/Compliance Liaison from the Denver Clinic came to assist the Monitor with document requests during the visit. After expressing concerns regarding our site visit schedule, the Denver Compliance Liaison told the Monitor she had spoken with her Regional Director who approved a plan to open the Clinic on Friday morning to better accommodate the Monitor's schedule. The Monitor accepted the offer and was able to acquire the requested documents as planned.

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Patient observations revealed good teamwork involving the dentists and staff, and children were managed well during administration of local anesthesia.

Entrance Conference

An entrance conference was held on October 23, 2012, at approximately 3:00 p.m. The Monitor Team of [redacted] CDA, RDH, [redacted], RDH, MS, and [redacted], DDS, MSD attended. Clinic staff members [redacted], Lead Dentist, [redacted], Office Manager/Compliance Liaison, and [redacted] Assistant Office Manager also attended. An overview of the process was discussed, including the point of contact information, the intent to conduct treatment observations, and the need to interview individuals employed by the Clinic.

General

The testing attributes in this section are designed to ensure that the required personnel and notifications are present in the Clinic as required by the CIA and CSHM policies and procedures. The relevant findings are as follows:

- The Clinic had a designated Compliance Liaison, as required by the CIA, Section III.A.3.
- Two posters were displayed in the waiting room titled *The Small Smiles Pledge to Children, Families & Communities* (one in English and one in Spanish). The posters contained content as required in the CIA, Section III.A.4, to reflect "CSHM's commitment to ensuring that all dental services and items provided meet professionally recognized standards of care." As required by the CIA, Section III.B.2.m, both posters included contact information for filing or registering a complaint with the parent compliance hotline, the appropriate State Dental Board, and the OIG.
- A sign in the waiting room, written in English and Spanish, indicated that parents have a right to accompany their child in the treatment area.
- Current licenses and certificates as appropriate were displayed for all dentists, dental hygienists, and dental assistants.
- An *Ethics and Compliance Hotline* poster, with a toll-free phone number, was displayed in the employee break room. The poster indicated callers may choose to remain anonymous when calling and there would be no retribution toward anyone who reported a suspected violation in good faith, as required by the CIA, Section III.F. It also included the phone number for the appropriate State Dental Board.
- A current *Quality of Care Dashboard* was posted in the break room.
- A list of current compliance committee members was in the break room, as required by CSHM's *Code of Ethics and Business Conduct (Code of Ethics)*.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) signs and forms were written in English and Spanish.
- Documentation was supplied to support the List of Excluded Individuals and Entities (LEIE), and Excluded Parties List System (EPLS) databases were checked. The Monitor chose five active employees from the list of employees

provided by the Clinic. Documentation indicated the LEIE and EPLS were checked for all five active employees within required time frames.

Review of Quality Control System

The testing attributes in this section are designed to determine whether the clinical policies and procedures are up to date and distributed; whether the *Code of Ethics* is signed by each employee; whether required training is conducted; whether internal audits are performed; whether the Clinic provides a timely and appropriate response to any internal audit findings or other indicators of quality of care issues; and how complaints are handled at the Clinic level.

Policies and Procedures

The CIA, Section III.B, requires a code of conduct and specific policies and procedures be developed and implemented. Recently, CSHM changed its process to an electronic format for the most recent policies, procedures, and forms. The relevant findings are as follows:

- Using the list of employees supplied by CSHM, the Monitor was able to verify each employee signed the acknowledgment and certification related to CSHM's *Code of Ethics* within the required time frames except for five employees. One of those employees signed the *Code of Ethics* 6 months after the hire date. The remaining four employees with signed *Code of Ethics* were not on the employee list provided by CSHM; therefore, the Monitor could not verify hire dates to determine whether the *Code of Ethics* was signed within the appropriate time frames.
- The Compliance Liaison reported that all manuals are now located on the CSHM intranet and were not maintained in the office, with the exception of the Office Manager Manual, Clinic Coordinators Manual, and Infection Control Manual, which appropriately contained the required notification that printed policies and procedures should not be relied on unless it was first verified on the CSHM intranet site.
- The Compliance Liaison was familiar with the *Policy and Procedure Development* policy issued on March 1, 2011. She evidenced good knowledge of new policies.
- The Compliance Liaison was questioned about revised policies and how she determined they have been changed. She stated changes made to an existing policy, procedure, or form were communicated to her by e-mail and reviewed in the monthly compliance liaison meetings.
- Staff members reported that new or revised policies or procedures were discussed during morning huddles.
- Staff members generally evidenced good knowledge of the policies and procedures used in their daily work.
- Staff members were able to articulate that updates are found on the intranet.

- The Compliance Liaison was able to identify recent form changes. All forms used in the Clinic were up to date.
- Generally, staff members said they had good quality dental materials and supplies in the Clinic.

Training

CSHM uses a Continuing Education (CE) Tracking System to ensure all employees meet training requirements. The Monitor reviewed the CE Tracking System data for five active clinical employees to verify all training requirements were completed. The CIA, Section III.C.1, requires 2 hours of general training related to the CIA requirements and CSHM's Compliance Program. This training must be performed within 90 days of the effective date or 90 days after becoming a "covered person," whichever is later. Three hours of "Clinic Quality Training" are required for each "Clinical Quality Covered Person." This training must be delivered within 10 days after the start of employment or within 90 days after the effective date, whichever is later, and an additional 2 hours each year, thereafter. Periodic training is also required on an as-needed basis but at least semi-annually and for a minimum of 2 hours annually.

All training requirements were verified by reviewing the CSHM CE Tracking System database. After review, the Monitor determined all training requirements had been met for the five randomly selected, active, clinical employees.

Internal Audits

The CIA, Section III.B.2, requires CSHM to install measures designed "to promote the delivery of patient items or services at CSHM and CSHM facilities that meet professionally recognized standards of health care, including but not limited to appropriate documentation of dental records, including radiographs or digital photos consistent with professional recognized standards of health care." One of the required policies is a periodic audit of clinical quality. CSHM has developed a *Chart Audit Policy* that governs its process for chart audits. The relevant findings follow:

- CSHM policy requires each Associated Dental Center to receive four quarterly chart reviews consisting of five patient records per dentist. The Clinic underwent a quarterly audit in February, May, August, and November 2010; February, May, August, and November 2011; and May and August 2012. The Clinic and all dentists passed all audits in 2010. In 2011, the Clinic and all dentists passed all the audits except the November audit. As a result of the failed November 2011 audit, the Clinic was re-audited in January 2012. The Clinic underwent two regular quarterly audits in May and August 2012. Due to a re-audit it appears the Clinic missed its regularly scheduled February 2012 chart audit.
- The *Attestation Letter for Chart Review (Attestation Letter)* was provided for all audits beginning February 2010.
- The Clinic did not receive the November 2011 chart audit results until February 1, 2012. The Clinic and all three dentists failed the audit, one dentist with an automatic failure. A Corrective Action Plan (CAP) was issued and documentation showed the CAP, which included correction of billing errors, was completed. As a

result of the failed audit, the Clinic was re-audited in January 2012. All dentists passed the re-audit; however, the Clinic failed the re-audit with a score of 85 percent. A CAP was issued and documentation showed the CAP was completed. As a result of the failed re-audit, the Clinic was again re-audited in March 2012. The Clinic and one dentist passed the re-audit while one dentist failed with an automatic failure. Documentation showed a CAP was issued; however, the Monitor did not receive a copy of the CAP or proof of its completion. Billing errors were identified and documentation showed billing errors were corrected.

- The Clinic and one of the two dentists failed the May 2012 audit. Billing errors were identified and documentation showed the errors were corrected. A CAP was issued; however, the Monitor was not provided documentation of completion of the CAP. As a result of the failed audit, the Clinic was re-audited in July 2012. The Clinic and all dentists passed the July 2012 re-audit. Billing errors were identified and documentation showed the billing errors were corrected.
- The Clinic and all dentists passed the August 2012 audit. Therefore, a CAP was not required. No billing errors were identified in the audit.
- The Monitor did not receive the Chart Audit Tool spreadsheet as requested and, therefore, could not determine if all findings were addressed and appropriate CAPs and/or recommendations made to the Clinic.

Complaints

The CIA, Section III.B.2.g, requires that "compliance issues are promptly and appropriately investigated" and, if substantiated, that CSHM implement "effective and timely corrective action plans" and monitor compliance with such plans. The CIA, Section III.D, also requires that a disclosure program be established which includes a mechanism to enable individuals to disclose any issues anonymously. Finally, the CIA, Section III.A.4, requires the creation of a parent compliance hotline. Two CSHM policies address these complaints: Disclosure Program and Policy, and Patient Advocate Policy and Procedure. The relevant findings follow:

- Staff members interviewed indicated if they received a complaint from a parent, they would report it to the Compliance Liaison. The Compliance Liaison indicated she would report it to the Patient Advocate.
- Staff members expressed confidence in reporting quality of care concerns to the Clinic management team.
- Staff members were able to identify examples of adverse events.
- Complaints come from parents using a variety of mechanisms. They are in response to follow-up calls to the "Net Promoter Score System (NPS) Survey," center comment cards, CSHM comment line, e-mails from the website, and feedback during a Clinic visit.
- Four individuals provided feedback via the parent comment line. Three of the complaints concerned long wait times and unprofessional staff behavior, parent accompaniment, and confusing paperwork. In the other complaint, the caller requested information about an extraction but left no contact information for

follow up. For all complaints, there was documentation of follow-up when possible and, where appropriate, CAPs including staff counseling.

- One parent complaint came to the Patient Advocate regarding negative publicity she saw about the Clinic. Two parent complaints came from calls to the Office Manager/Compliance Liaison who reported the complaints to the Patient Advocate. One of those complaints concerned a parent who saw negative publicity about possible side effects of amalgam fillings. The other complaint was in reference to potential quality of care concerns about the need for extraction of a tooth 3 months after placement of a stainless steel crown (SSC). Another complaint through the *SmileFactor* comments regarded retention of a root tip following extraction of a tooth. Additionally, another complaint came from the website regarding whether pediatric or general dentists treated patients in the Clinic. In each case, there was follow up by the Patient Advocate, Patient Advocate Coordinator, and/or the Chief Dental Officer (CDO). Where appropriate, CAPs were initiated and their completion documented.
- There were seven substantiated adverse events with respect to this Clinic including five in 2010, one in 2011, and one in 2012. Two adverse events related to injuries from chemicals during treatment. The other adverse events related to parasthesia, treatment without proper consent, X-rays taken on the wrong patient, a tooth lodged in the sinus during extraction, and a bur lodged in a tooth during treatment. Documentation showed all reported adverse events were investigated. CAPs were initiated and completed for all substantiated adverse events.
- Seven employee complaints were communicated through exit interviews. Four employee complaints were received via the Ethics Hotline. All complaints were investigated. No compliance or quality of care issues were found; however, a CAP was issued for one complaint and documentation showed the CAP was completed.
- While on-site, the Monitor received a complaint that records were being removed and hidden in a desk drawer and storage unit. The Monitor received all records requested. CSHM investigated this complaint in the Monitor's presence and was unable to substantiate that records were being removed and hidden.

Recommendations

- Ensure Compliance Liaisons have a plan to allow the Monitor prompt access to the Clinic upon arrival if the Compliance Liaison is not available.
- Ensure CSHM communicates to the Monitor any changes with respect to Clinic office hours.
- Ensure the *Code of Ethics* is signed by each employee within the required time frames.
- Ensure the Monitor is supplied with a complete list of Clinic employees.
- Ensure quarterly chart audits are performed.
- Ensure the Clinic is notified of chart audit results in a timely manner.

- Ensure the Monitor is supplied with copies of all CAPs and documentation to show their completion.
- Ensure the Monitor receives the Chart Audit Tool spreadsheet for each quarterly chart audit.

Review of Communication System

The testing attributes related to the communication system are designed to determine whether the communication system is effective. The CIA, Section III.E.I, states the Monitor shall determine whether the "communication system is effective, allowing for accurate information, decisions, and results of decisions to be transmitted to the proper individuals in a timely fashion." The relevant findings follow:

- The Compliance Liaison submitted compliance reports quarterly as required by the CIA, Section III.A.2. The Monitor noted that the Compliance Liaison Quarterly Report – 2nd Quarter 2012, which would typically be submitted in July, was submitted on October 23, 2012. The Office Manager/Compliance Liaison from the Denver Clinic explained the home office had only recently requested the 2nd quarter reports and had told the Compliance Liaisons a request for the 3rd quarter report would be requested within days.
- The Monitor asked the Compliance Liaison to describe her role and responsibilities. She reported her role is to inform and update the staff members of new and revised policies and procedures; monitor quality of care; and report adverse events.
- Staff members interviewed articulated the existence of the employee hotline and that complaints could be made anonymously. Staff members did not express reluctance in using the hotline if needed.
- Staff members participated in "morning huddles," which include discussions of new or revised policies and procedures and announcements of upcoming webinars.

The CIA, Section III.B.2.m, requires CSHM to design measures to collect reports relating to patient care incidents, injuries, abuse, neglect, and to inform patients when a substantiated incident of patient harm occurs at the facility. The CIA, Section III.B.2.10, requires a policy related to parental accompaniment. CSHM policies allow patients, parents, and guardians to provide feedback using the NPS Survey completed at the end of the visit. The survey asks the responder whether he or she can be contacted.

Communication between the Clinic and patients, parents, and guardians is also facilitated by preprinted parent comment cards, a parent hotline, e-mails, and the option to report issues to a staff member. CSHM's *Parent Notification and Adverse Events* policy is designed to inform patients, parents, and legal guardians of substantiated incidents of patient harm. In addition, CSHM's *Parent Absence/Presence Policy* is designed to ensure parents and guardians have a right to accompany children into treatment. The relevant findings are as follows:

- The NPS Survey was available at the checkout desk. The response rate as of October 20, 2012, indicated the Clinic had a year-to-date response rate of 89 percent.
  - The *SmileFactor Snapshot* documents the results of the NPS Survey. The month-to-date score as of October 20, 2012, was 84 percent with a year-to-date score of 88 percent.
- A sign informed parents of their right to accompany the child into the treatment rooms.
- The Clinic had a *Center Adverse Event Log* that documented seven adverse events reported at the Clinic. This was consistent with CSHM's Comprehensive Compliance Disclosure Log. Notification of the log's existence is located on the Health History form. The *Adverse Event Disclosure Log* indicates four individuals asked to review the *Center Adverse Event Log.*
- Staff members interviewed were aware of the translation service.

The CIA, Section III.B.2.11, requires a policy on informed consent. Treatment plans are the basis for obtaining informed consent. As noted in the CSHM policy on *Informed Consent*, part of informed consent includes understanding the alternatives to the proposed treatment. CSHM has indicated its policy does not require dentists to present treatment plans. The CDO's "Protective Stabilization and Treatment Planning" white paper, dated March 2009, sets forth concerns about allowing dental assistants to present treatment plans. It cites "complaints that parents generate regarding misunderstandings over their child's care, or over what they perceive to be a lack of communication with the dentists who planned and provided the treatment." The CDO quotes from an article published in *Pediatric Dentistry*, the peer-reviewed, official journal of the American Academy of Pediatric Dentistry (AAPD), in which an attorney states: "The task of obtaining informed consent should not be delegated to an auxiliary, but should be that of the pediatric dentist." (Pediatr Dent 1995; 17:0-97). The CDO then states: "It is incumbent on the Small Smiles dentist to be part of the treatment plan presentation, to answer the parent's questions, and provide explanations that the dental assistant may have difficulty doing."

Furthermore, in the training prepared by the CDO titled "Treatment Planning for Small Smiles Patients," he states that staff "[m]ay give *preliminary* presentation of treatment plan," but "[s]taff cannot obtain consent- must be done by doctor" [emphasis in original]. Recent CDO training indicates that treatment plans may be done by dentists or "[T]rained staff." The presentation is considered "preliminary" until the "dentist stops by to ensure that any questions the parent may have are answered" and the parent should not sign the treatment plan until this opportunity is presented. The training also indicates it is best, but not essential, that the dentist be present when the parent signs the treatment plan.

- Staff members were able to articulate the correct policy for when consent is required.

- Staff members interviewed reported that dentists, dental hygienists, and dental assistants present the treatment plan to the parent and obtain consent.

Review of Dental Record Documentation

The testing attributes related to the dental record documentation are designed to determine whether the documentation is complete and accurate, including HIPAA-related forms, medical necessity, and consent forms. Findings related to patients #001 to #030 represent a sample of 30 visits representing 30 separate patients and records identified from the patient listing provided by CSHM, based on all Medicaid patients seen for operative visits from July 30, 2012, through October 22, 2012. The Monitor's pediatric dentist provided consultation on 25 of the 30 patient records reviewed.

Of the four dentists included in the Monitor's 30-record review, one is no longer employed by CSHM and two are new employees. The majority of the quality of care issues identified by the Monitor's pediatric dentist were associated with services provided by a dentist who is no longer employed with CSHM; therefore, quality of care findings related to patients #022 – #027 and #031 – #041 will be summarized in a separate report to be issued on November 21, 2012. With the removal of the six records reviewed for the terminated dentist, the findings in this report relate to only 24 visit records.

The Monitor conducts a retrospective quality of care record review by selecting records of patients who have received operative procedures and have returned for post-operative X-rays. These records are identified from a list provided by CSHM and are subject to specific testing attributes used to evaluate the quality of pulpotomies, SSCs, and other restorations over time; however, the two new dentists have not been employed long enough to complete a quality of care record review. Also, the new Lead Dentist had not started seeing patients for operative procedures at the time of the site visit; therefore, the Monitor was unable to perform a complete record review for this provider.

The relevant findings from the review of the 24 visit records follow:

HIPPA Form

The Monitor was unable to find an Acknowledgment of Receipt of Notice of Privacy Practices (Acknowledgement) form in one record (patient #007). Two records (patients #001 and #009) contained incomplete Acknowledgement forms.

Health History

The Health History form in five records (patients #001, #002, #003, #009, and #020) did not show answers for all questions or provide complete follow-up information to all "yes" responses.

The table below provides a summary of each finding.

Health History		
Patient	**Date**	**Finding**
#001	September 4, 2012	The Questions for Affirmed Health History Issues form did not address the "yes" response to ADHD.
#002	September 25, 2012	There was no explanation for the "yes" response to allergies.
#003	August 10, 2012	There was lack of follow-up information regarding the "yes" response to "Asthma/Breathing Problems" or "ADHD."
#009	September 21, 2012	There was lack of follow-up information regarding the "yes" response for "ADHD," "Asthma/Breathing Problems," and "has the patient had surgery."
#020	July 16, 2012	There was lack of follow-up information regarding the "yes" response to "Asthma/Breathing problems."

Tooth Chart

Four records (patients #003, #017, #018, and #020) did not show documentation of decay on the upper odontogram of the Tooth Chart.

Existing conditions were not recorded on the upper odontogram of the Tooth Chart in 12 records (patients #001, #002, #006, #007, #008, #009, #011, #014, #015, #019, #020, and #028).

In three records (patients #006, #012, and #018), the lower odontogram did not show documentation of completed treatment.

The table below contains a summary of these findings.

Decay Not Documented on the Upper Odontogram		
Patient	**Date**	**Finding**
#003	August 10, 2012	Mesial decay on tooth #T
#017	October 1, 2012	Decay on teeth #B, #D, #E, #F, #G, and #R
#018	September 17, 2012	Decay on tooth #B
#020	July 30, 2012	Decay on the mesial of tooth #K, distal of tooth #S, and mesial of tooth #T

Existing Conditions Not Documented on the Tooth Chart		
Patient	**Date**	**Finding**
#001	September 4, 2012	Existing teeth #K, #R, and #T; pulpotomy and internal resorption on tooth #T
#002	September 25, 2012	SSC on tooth #G
#006	September 26, 2012	Crowns on teeth #A, #D, #E, #F, #G; distal filling on tooth #C
#007	September 26, 2012	Missing filling on tooth #I
#008	September 12, 2012	Fillings on teeth #A, #B, #I, #J, #S, and #T
#009	September 21, 2012	Pulpotomies on teeth #E, #F, and #G
#011	October 9, 2012	Oversized SSC and distal residual cement on tooth #I; fillings on teeth #S, #T, and #J
#014	September 17, 2012	Fillings on teeth #S, #T, #K, and #L; distal lingual filling on tooth #E
#015	August 9, 2012	Distal occlusal filling on tooth #B; facial fillings on teeth #G and #H
#019	August 13, 2012	Pulpotomy on tooth #T; SSCs on teeth #E, #F, #G, #S, and #T
#020	July 30, 2012	Failing pulpotomy, internal resorption, and furcation radiolucency on tooth #L; oversized crowns with overhangs on teeth #A and #B; residual cement or dental materials distal of tooth #I and mesial of tooth #J
#028	May 22, 2012	Trauma and fractures to teeth #9 and #24

Completed Treatment Not Documented on the Lower Odontogram		
Patient	**Date**	**Finding**
#006	September 26, 2012	Pulpotomy on tooth #T
#012	July 11, 2012	Mesial incisal distal facial lingual filling on tooth #D
#018	September 17, 2012	Facial filling on tooth #G; facial filling on tooth #H marked in error

X-rays and Photographs

Older X-rays were stored in coin envelopes and were not in X-ray mounts making them hard to review. Some X-rays were loose in the record and not stored in an envelope with other X-rays. Two bitewing X-rays taken on March 16, 2012, were missing from the record of patient #009. X-rays in two records (patients #001 and #003) were not clearly

labeled with the date of service or patient's date of birth. Only one record (patient #003) did not show documentation of the panoramic X-ray dated August 10, 2012.

The Monitor found non-diagnostic X-rays in five records (patients #005, #010, #012, #013, and #014) and evidence of under-utilization of diagnostic X-rays in 12 records (patients #006, #007, #008, #009, #011, #012, #014, #015, #016, #017, #018, and #020). Of these 12 records, 4 (patients #016, #017, #018, and #020) showed treatment was completed without diagnostic X-rays while the patient was under general anesthesia in the operating room (OR), where patient cooperation was not an issue.

The tables below provide a summary of each finding regarding X-rays.

Non-diagnostic X-rays or Photographs		
Patient	**Date**	**Finding**
#005	September 14, 2012	The right bitewing X-ray because of overlapping contacts of teeth #A and #B.
#010	August 3, 2012	The left bitewing X-ray because of overlapping contacts of teeth #I and #J.
#012	July 11, 2012	The right and left bitewing X-rays because of overlapping contacts of teeth #A and #B, and #I and #J.
#013	September 14, 2012	The right bitewing X-ray because of overlapping contacts of teeth #A and #B.
#014	September 17, 2012	The right and left bitewing X-rays because the full crowns and interproximal contacts for maxillary molars were not visible.

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#006	September 26, 2012	Bitewing X-rays were warranted at the hygiene appointment because of patient's high caries risk and an anterior occlusal X-ray was warranted to evaluate the crowns on maxillary anterior teeth; however, none were taken. Furthermore, X-rays used to develop the treatment plan were 6 months old.
#007	October 11, 2012	The Tooth Chart dated September 26, 2012, documented "not possible to get X-rays" on the 2-year-old patient; however, there was no reason recorded for not taking photographs.

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#008	September 12, 2012	Due to the extent of mesial decay on tooth #J, a periapical X-ray was warranted to determine appropriate course of treatment. The Tooth Chart showed teeth #D, #E, and #F were missing, tooth #9 present, and all first permanent molars were erupted; however, the initial examination of the 8-year-old patient was performed without a maxillary occlusal X-ray and panoramic X-ray.
#009	March 16, 2012 and September 21, 2012	Maxillary occlusal X-rays were warranted for diagnosis of decay on March 16, 2012, and at the 6-month recall appointment for evaluation of pulpotomies and SSCs performed on teeth #E, #F, and #G.
#011	October 9, 2012	A periapical X-ray was warranted to evaluate the poor fitting SSC and pulpotomy on tooth #I, and maxillary occlusal X-rays were warranted to evaluate existing anterior restorations.
#012	September 25, 2012	A maxillary occlusal X-ray was warranted to evaluate the health of tooth #D and the course of treatment for its lost crown.
#014	September 24, 2012	A diagnostic bitewing X-ray was warranted prior to treatment of teeth #A and #B to support the medical necessity for the SSCs.
#015	September 20, 2012	A maxillary occlusal X-ray was warranted to determine the extent of decay on teeth #D, #E, and #F, and the eruption pattern of successor permanent teeth prior to formulating a treatment plan.
#016	October 15, 2012	The Hygiene Procedures form dated April 16, 2012, noted "not due" as the reason X-rays were not taken. The child was diagnosed with interproximal decay at that time without new X-rays. The X-rays used to diagnose and treatment plan were 1 year old. New bitewing X-rays were warranted on this high caries risk patient. Additionally, the patient had congenitally missing and supernumerary anterior teeth which needed evaluation.
#017	October 1, 2012	Due to extensive decay, which was treatment planned for the OR, X-rays or photographs were warranted; however, none were taken.

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#018	September 17, 2012	The 3-year-old patient was treated in the OR. Due to extent of decay and inability to view the furcations, periapical X-rays were warranted for teeth #B and #I. Due to decay on teeth #D and #G, a maxillary occlusal X-ray was also warranted.
#020	July 16, 2012	The Hygiene Procedures form stated diagnostic X-rays were not taken because they were "not needed." X-rays dated January 9, 2012, showed evidence of abscess on tooth #L and interproximal decay on teeth #K, #S, and #T. New bitewing X-rays and a maxillary occlusal were warranted prior to treatment in the OR to evaluate progression of disease and health of teeth with existing pulpotomies and SSCs.

Medical Necessity

The Monitor noted a trend related to treatment provided without diagnostic X-rays and found five records (patients #007, #012, #013, #016, and #017) did not provide documentation and/or radiographic evidence to support the medical necessity for treatment.

The following table provides details related to each finding:

No Documentation to Support Medical Necessity		
Patient	**Date of Service**	**Finding**
#007	October 11, 2012	There were no X-rays or photographs to support the medical necessity for the pulpotomies and SSCs performed on teeth #A and #B.
#012	September 25, 2012	There was insufficient documentation and no X-ray to support the medical necessity for replacing a missing crown with a four-surface filling on tooth #D.
#013	October 5, 2012	A non-diagnostic X-ray was used to support the medical necessity for the SSC performed on tooth #B.
#016	October 15, 2012	There were no current X-rays to support the medical necessity for treatment provided to this 5-year-old patient in the OR.

No Documentation to Support Medical Necessity		
Patient	**Date of Service**	**Finding**
#017	October 1, 2012	There were no X-rays or photographs to support the medical necessity for treatment in the OR on teeth #B, #D, #E, #F, #G, and #R, and no documentation of decay on the upper odontogram of the Tooth Chart.

Treatment Plan

The Monitor's pediatric dentist found two records (patients #011 and #020) in which the Treatment Plan did not adequately address decay or pathology evident on diagnostic X-rays.

The following table provides details related to each finding:

Treatment Plan Did Not Address Patient's Needs		
Patient	**Date**	**Finding**
#011	October 9, 2012	The radiographically evident fractured distal surface of tooth #L
#020	July 16, 2012	The residual dental materials on the interproximal of teeth #I and #J

Multiple Surface Fillings

The Monitor noticed a trend with respect to under-utilization of SSCs and found five records (patients #006, #010, #012, #015, and #021) did not document rationale for performing multiple surface fillings instead of SSCs.

The following table provides details related to each finding:

Multiple Surface Fillings Instead of SSCs With No Rationale		
Patient	**Date**	**Finding**
#006	October 10, 2012	Tooth #R
#010	September 11, 2012	Teeth #I, #J, and #L
#012	September 25, 2012	Tooth #D
#015	September 20, 2012	Teeth #D, #E, and #F
#021	August 13, 2012	Teeth #E and #F

Teeth Treated Multiple Times

The Monitor's pediatric dentist found one patient record (patient #016) that showed multiple treatment to the same tooth within a short time frame. This patient was treated by a Pediatric Dentist who is currently employed with CSHM. In this case, a supernumerary tooth (tooth #G) was treated with an SSC in the OR. The SSC came off

the same day and was re-cemented in the Clinic. The next day the patient returned to the Clinic for re-cementation of the lost crown; however, the tooth was extracted.

Nitrous Oxide Analgesia

In two records (patients #007 and #008), the Nitrous Oxide form was not signed by the dentist.

Potential Adverse Events

Three records (patients #003, #007, and #016) showed treatment was provided without documented consent.

The following table provides details related to each finding.

Potential Adverse Events Identified		
Patient	**Date**	**Finding**
#003	October 18, 2012	The Treatment Plan proposed a filling for tooth #T; however, it was treated with an SSC without proper written consent.
#007	September 26, 2012	The Monitor was unable to determine the relationship of person who authorized consent for treatment to the patient. It appeared an unauthorized person signed the Treatment Plan and consented to treatment.
#016	October 16, 2012	There was no consent documented for the extraction of supernumerary tooth #G.

Other Findings

Two records (patients #017 and #021) contained incomplete documentation with no explanation for leaving teeth with noted decay untreated. Upon evaluation of the Affirmed Health History Issues form for patient #014, the Monitor noted that the form did not include whether the patient was under the care of a cardiologist or the type of heart murmur diagnosed. In the remaining record (patient #018) there was no documentation to show the chief complaint was addressed.

The following table provides details related to each finding.

Other Findings		
Patient	**Date**	**Finding**
#014	September 17, 2012	Follow-up questions for the "yes" response to "Heart Murmur" were answered on the Questions for Affirmed Health History Issues form; however, the Questions for Affirmed Health History Issues form did not include questions to identify if the patient was under the care of a cardiologist or the type of heart murmur diagnosed.

Other Findings		
Patient	**Date**	**Finding**
#017	October 1, 2012	The dictated Operative Report from the hospital of the OR case was missing from the patient record. Additionally, the upper odontogram of the Tooth Chart dated October 1, 2012, documented facial decay on tooth #P and the lower odontogram documented an error on tooth #P. Tooth #P was not treated in the OR on October 1, 2012. Because there was no X-ray of tooth #P and the documentation was incomplete, the Monitor could not determine if it was appropriate not to treat tooth #P at the time of the OR visit.
#018	July 25, 2012	There was no documentation that the chief complaint noted on the Hygiene Procedures form, which stated "cavities, she says her mouth is really hurting," was addressed.
#021	August 13, 2012	The patient was treated in the OR; however, the distal decay on teeth #E and #F, which was evident on the X-rays dated June 28, 2012, and included in the Treatment Plan dated June 28, 2012, was left untreated without explanation.

Recommendations

- Ensure staff members verify the Acknowledgement form is completed correctly and stored in each patient record.
- Ensure staff members provide adequate follow-up information and explanations for "yes" responses on the Health History form.
- Ensure staff members correctly document existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays are stored in a manner where they are easy to locate and review.
- Ensure X-rays are clearly labeled with date of exposure and patient identification.
- Ensure staff members document the interpretation of all X-rays.
- Ensure staff members acquire all necessary pre-treatment X-rays and, if not able to obtain because of patient safety factors, document sufficient rationale.
- Perform a root cause analysis to determine why X-rays are not being taken in the OR.
- Ensure X-rays are diagnostic and support the medical necessity for treatment provided.

- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure dentists recognize and address all disease and pathology on the Treatment Plan.
- Ensure staff members provide documentation to support the rationale for placement of multiple surface fillings instead of SSCs.
- Ensure the Nitrous Oxide Consent Form is signed by the dentist.
- Ensure the records for patients #003, #007, and #016 are reviewed to determine if treatment was performed without consent.
- Ensure the Questions for Affirmed Health History Issues form includes relevant questions to provide sufficient follow-up to heart murmur.
- Ensure the dictated Operative Report and all X-rays or photographs taken in the OR are stored in the patient's Clinic record.
- Ensure staff members provide adequate, legible documentation related to trauma and chief complaints.

Treatment Observations, Findings, and Staff Interviews Related to Care

The treatment observation testing attributes are designed to determine whether care is performed according to CSHM's policies and procedures, the *AAPD Guidelines*, and professionally recognized standards of care.

The on-site review included observations of treatments and interactions with patients, review of workspace, review of dental records, and interviews with dentists and selected staff. Observation of treatment and patient interactions included observation of treatment on three patients. Two of these patients received invasive dental treatment involving local anesthesia and nitrous oxide/oxygen analgesia.

The review of workspace included observation of activities in the dental hygiene and sterilization areas.

Seven individuals were interviewed, including the Lead Dentist, one Staff Dentist, the Compliance Liaison, the Assistant Office Manager, two dental assistants, and a dental hygienist. The CIA, Section III.A.2, specifies the CDO is "responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by CSHM and CSHM facilities meet the professionally recognized standards of health care." Such language directs that possessing knowledge of and following these policies are not at the discretion of the Clinic dentists and staff. The Monitor interviewed the dentists about their familiarity with the recent Best Practice E-mails and Internal Memoranda that modify, clarify, and add to *Clinical Policies and Guidelines for CSHM Associated Clinics*.

- Both Dentists had recently attended the New Dentist Training and demonstrated a good level of familiarity with the CDO's Best Practice E-mails and Internal Memoranda.

- The Associate Dentist was able to describe the indications and technique for a primary tooth pulpotomy.

The Monitor also had the following relevant findings:

- Appropriate techniques to administer local anesthesia were demonstrated for the procedures being performed.
- The Restorative Dentistry Checklist was completed prior to beginning patient treatment, and the maximum dose of local anesthesia was calculated prior to administering the agent for one patient.
- Dentists and staff demonstrated a good team approach to behavior management techniques.
- The protective stabilization device (PSD) is rarely used in this Clinic. The Colorado Practice Act requires special training and certification for dentists to use PSDs, and the dentists in this facility are not currently certified. Both doctors are scheduled to take the training in November.
- The dental hygienist is allowed to administer local anesthesia, and reported she anesthetized most of the previous Lead Dentist's operative patients.
- The dental hygienist reported that either she or one of the doctors examines every patient in the hygiene bay for the presence of calculus and the need for her to provide scaling to remove it.
- This Clinic does not have a Clinical Coordinator but efforts are underway to hire an individual to fill this position.
- Colorado Practice Act authorizes expanded duty dental assistants (EDDAs), and they are allowed to administer and monitor nitrous oxide inhalation analgesia, place restorations, fit SSCs, perform coronal polishing, and place sealants and topical fluoride. There are EDDAs working with the doctors during patient care in this facility.
- The Associate Dentist reported the previous Lead Dentist did not like SSCs and did not use them, preferring to place multi-surface amalgams instead. The Monitor's review of records has shown this to be true, with many primary teeth demonstrating multi-surface decay treated with multi-surface amalgams instead of the SSCs specified in CSHM policy.
- The new Associate Dentist completed New Dentist Training in July, and he reported it was comprised of a large amount of information delivered over a short period of time, primarily in a lecture format without typodont exercises or interactive components.
- The new Associate Dentist, who graduated dental school in May 2012, was in the Clinic as the only dentist for about a month when the newly hired Lead Dentist failed to appear. There were extended employee absences due to illness and a sense of working shorthanded. In spite of having to work in the hygiene bay and provide operative procedures simultaneously, the Clinic income stayed level during this month.

- Employees interviewed expressed concern about reduced numbers of patients over the past year. Some of the previous dentists referred difficult patients out, and many did not continue as patients once their referred treatment was completed. Also, there are more pediatric dentists in the area, increasing competition. Several individuals expressed concern the Clinic was difficult to find, and Clinic location could be a component in reduced numbers of new patients.
- This Clinic has the ability to refer difficult patients for treatment in the OR by one of the Pueblo Center dentists who comes twice a month. There were no X-ray capabilities in the OR, and patients who did not have X-rays in the center before going to the OR were treated without X-rays. This is problematic, because subjecting a patient to general anesthesia increases the risk for morbidity and/or mortality. All necessary diagnostic tools should be available to ensure the treatment provided is thorough and appropriate. X-rays are one of the most important diagnostic tools a dentist has, and to provide treatment in the OR without X-rays is practicing outside of the standard of care.
- A patient (#048) was treated with an SSC on tooth #I without X-rays or photographs. The treating dentist expressed concern he had not received proper mentoring by the previous Lead Dentist and did not know he should take photographs when he could not obtain an X-ray. He agreed to do so in the future.
- Nitrous oxide was used appropriately, but one EDDA said she did not know she was supposed to titrate the administration in 10 percent increments.
- Gauze shields were used by the EDDA during fitting of SSCs on patient #046. They were not used by the Associate Dentist during the fitting of the band and loop space maintainer on patient #045.

Recommendations

- Ensure a Clinical Coordinator is hired.
- Ensure X-ray capabilities are provided in the OR to take X-rays of patients receiving treatment in the OR.
- Ensure photographs are taken when child behavior precludes obtaining X-rays.
- Ensure all those who administer nitrous oxide know to titrate administration in 10 percent increments and do so.
- Ensure gauze shields are used to protect the patient's airway when fitting SSCs and bands.

Exit Conference

The exit conference was held on October 25, 2012, at approximately 5:45 p.m. Present at the conference were the Monitor Team of [redacted] CDA, RDH, [redacted], RDH, MS, and [redacted], DDS, MDS; [redacted], Lead Dentist, and [redacted] CCO, (via telephone) also attended. The preliminary findings discussed at the exit conference included the following:

- Staff members were welcoming and accommodating.

- Generally, staff members interviewed said they had good quality dental materials and supplies in the Clinic.
- Staff members interviewed were knowledgeable of the existence of the hotline and did not express reluctance in using it.
- Staff members interviewed were knowledgeable of the translation service.
- The Compliance Liaison reported that all manuals are now located on the CSHM intranet and are not maintained in the office, with the exception of the Office Manager Manual, Clinic Coordinators Manual, and Infection Control Manual, which appropriately contained the disclaimer form.
- The Compliance Liaison demonstrated familiarity with the process for informing staff members of new and revised policies and procedures.
- Local anesthesia, appropriate for procedures being performed, was administered using good techniques to ameliorate the painful sensation, including proper use of topical anesthetic.
- The restorative dentistry checklist was completed prior to patient treatment.
- Nitrous was used appropriately.
- Older X-rays were stored in coin envelopes and were not in X-ray mounts making them hard to review. Some X-rays were loose in the record and not stored in an envelope with other X-rays. The Clinic was unable to locate X-rays for a specific date of service for one patient.
- *FDA/ADA Guidelines* for acquiring X-rays according to caries risk were not followed and there was evidence of under-utilization of X-rays.
- OR cases were reviewed that contained no X-rays or photographs to support the medical necessity for treatment provided under general anesthesia.

EXHIBIT 42

[redacted] Small Smiles Dental Centers of Akron

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Chief Compliance Officer
CSHM LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor
CSHM LLC

Clinic Report
Akron, OH

Deliverable #1-60

June 21, 2012

[redacted] Small Smiles Dental Centers of Akron

Executive Summary

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Akron, 881-883 East Exchange Street, Akron, OH 44306 (Clinic).

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were provided in a timely manner and were well organized; however, not all materials were provided while on-site. Patient observations revealed good teamwork involving the dentists and staff, and children were managed well during administration of appropriate local anesthesia.

Overall Summary of Critical Findings and Observations

The critical findings and observations from the Monitor's visit are as follows:

The List of Excluded Individuals and Entities (LEIE) and Excluded Parties List System (EPLS) databases were not checked prior to date of hire for three of five active employees that the Monitor chose from the list of employees provided by the Clinic.

Staff members interviewed generally evidenced good knowledge of the policies and procedures. The Clinic has posted the policies on the walls around the Clinic and attempts to facilitate understanding of the policies by creating games, such as crossword puzzles. The Clinic also instituted its own chart documentation training program by creating a patient chart reflecting numerous errors that staff members were challenged to find.

CSHM reported they could not verify completion of all Corrective Action Plan (CAP) items associated with four quarterly chart audits.

There was no documentation provided to verify the completion of a CAP associated with two adverse events in 2011, both related to swallowed crowns.

Staff members interviewed were knowledgeable of the existence of the hotline and did not express reluctance in using it. Review of complaints revealed use of the hotline.

The Lead Dentist raised a concern to the Chief Dental Officer (CDO) about the quality of care being rendered by a staff dentist and it was not initially reported to the Chief Compliance Officer or the Patient Advocate and therefore it was not investigated as a quality of care complaint until after the staff dentist left.

The Health History form in nine records did not document complete follow-up information to "yes" responses.

Documentation on the Tooth Chart was inconsistent with inadequate documentation of decay found in ten records. Seventeen records did not show documentation of existing conditions on the Tooth Chart and six records did not document completed treatment on the lower odontogram.

With respect to X-rays, three records contained non-diagnostic X-rays or photographs. Fourteen records showed diagnostic X-rays were not taken when indicated to determine the appropriate course of treatment and/or to support the medical necessity for treatment performed. Two records did not document rationale for X-rays taken outside of *Food and Drug Administration/American Dental Association (FDA/ADA) Guidelines* and six records did not document interpretation of X-rays.

Within the records reviewed, the Monitor's pediatric dentist found 16 records did not provide radiographic evidence to support the medical necessity for treatment provided. Seven of these records showed pulpotomies were performed on teeth where X-rays did not show decay half way into the pulp. An additional seven records revealed pulpotomies and Stainless Steel Crowns (SSCs) were performed on teeth where X-rays showed evidence of abscess or root resorption. The remaining four records did not have X-rays to support the medical necessity for the treatment provided.

The Monitor's pediatric dentist found seven records in which the Treatment Plan did not adequately address decay or pathology evident on diagnostic X-rays.

The Monitor's pediatric dentist found three records in which teeth were treated with pulpotomies and SSCs and then extracted within a year of initial treatment.

The post-operative X-rays in eight records revealed quality of care issues related to pulpotomies and SSCs. The Monitor's pediatric dentist found a total of eight teeth treated with pulpotomies in which there was incomplete removal of pulp tissues, three SSCs with residual cement, and one poor fitting SSC. In addition, four records showed pulpotomies were performed on teeth that had radiographic evidence of pathology or were near exfoliation.

With respect to patient management, the Monitor found two patient visits where neither local anesthesia nor nitrous oxide analgesia were administered for fillings performed on primary teeth in children who were younger than 7 years old. One record did not show consent or proper documentation related to use of active stabilization. Two of ten patient visits showed a protective stabilization device (PSD) was used for non-emergent treatment and another two patient visits showed poor time management, which may have attributed to the patient's behavior.

Nitrous oxide analgesia was administered in only 4 of the 30 patient visits reviewed. All 4 records documented both the initial and working concentrations of nitrous were administered at 30 percent documentation and did not show nitrous oxide was titrated in 10 percent increments as described in the *AAPD Guidelines for the use of Nitrous Oxide for Pediatric Dental Patients.*

The Account History Report for six patients did not document all services that were performed on the audited date of service and one Account History Report showed billing for a pulpotomy that was not performed. Three Account History Reports did not document use of Behavior Management, which allows CSHM to track and monitor the use of the PSD.

Maximum dose of local anesthesia was not consistently entered on the Operative Procedures form (Op sheet) prior to administering the agent.

The number of dental assistants certified to monitor nitrous oxide analgesia may be impacting the use of the agent. Specifically, not all dental assistants are certified, and when the agent was used, it was sometimes necessary to reassign dental assistants to ensure a certified assistant was present in the room during the procedure. The Monitor observed this reassignment process and time delay it caused.

The Restorative Dentistry checklist was not consistently completed prior to beginning patient treatment.

Overall Summary of Recommendations

Set forth below is a summary of the report's recommendations:

- Ensure LEIE and EPLS databases are checked within the required timeframes.
- Ensure all requested documents are provided to the Monitor on-site when available.
- Ensure *Code of Conduct* is signed by all employees within the required timeframes.
- Ensure all paper manuals maintained in the Clinic contain the required notification that printed policies and procedures should not be relied on unless first verified on the CSHM intranet site.
- Evaluate staff members' suggestion to determine whether a hands-on component to training is beneficial.
- Ensure documentation of completion of CAPs associated with all failed quarterly chart audits, adverse events, and parent/patient complaints.
- Ensure confirmation of all billing error corrections identified in Chart Audits.
- Ensure completion of all CAPs associated with the CSHM report of their site visit.
- Ensure rubber dams are properly utilized in the Clinic.
- Ensure the recipients of the exit interviews provide the interviews to the compliance department when compliance issues are raised, and it is done in a timely fashion.
- Evaluate why the CCO determined a high volume of crowns and pulpotomies by a staff dentist was considered a billing issue based upon comparison to peers when the Lead Dentist had provided numerous communications related to the overtreatment by this staff dentist and at least one of these communications included a copy to the CCO.

- Evaluate processes for when the CDO, Regional Manager, Senior Vice-President, and other CSHM management is required to report quality of care issues being brought to their attention and ensure such issues are included on the Compliance Disclosure Log.
- Perform a root cause analysis to determine why the Clinic's *SmileFactor Snapshot* scores are below the company average.
- Ensure staff members are verifying an Acknowledgement form is completed for each patient or record.
- Ensure staff members are verifying correct completion of the Authorization form.
- Ensure staff members are providing adequate follow-up information and explanations for "yes" responses on the Health History form.
- Ensure staff members are correctly documenting existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays and photographs are diagnostic and support the medical necessity for treatment provided.
- Ensure staff members are correctly labeling X-rays with the date of exposure and patient identification.
- Ensure staff members take appropriate diagnostic X-rays or photographs when indicated.
- Ensure staff members document rationale for X-rays taken outside of *FDA/ADA Guidelines*.
- Ensure staff members document the interpretation of all X-rays taken.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure dentists are addressing all disease and pathology appropriately on the Treatment Plan.
- Ensure staff members provide documentation to support the rationale for placement of multi-surface fillings instead of SSCs.
- Ensure dentists follow the diagnosis and treatment criteria set forth by CSHM and *AAPD Guidelines* when performing pulpotomies.
- Ensure dentists employ proper techniques when performing pulpotomies and are adequately removing all pulp tissue.
- Ensure dentists understand indications of failed pulpotomies and document any pathology or findings related to pulpotomies on the Tooth Chart.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of pulpotomies and SSCs.
- Ensure dentists are administering local anesthesia when indicated and performing an assessment to determine effectiveness of local anesthesia.

- Ensure consent for active stabilization is obtained.
- Ensure dentists are following the *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* with respect to stabilization and when to refer a patient to a specialist.
- Ensure dentists administer nitrous oxide/oxygen analgesia in accordance with *AAPD Guidelines,* including documentation of proper titration.
- Perform a root cause analysis of why patients are sitting in the operatory for extended time before being seen.
- Ensure the Account History Report and the patient's record accurately reflects all procedures performed.
- Ensure the billing error for patient #055 is corrected.
- Ensure staff members provide adequate information related to trauma and chief complaints.
- Ensure procedures performed by an EFDA are clearly documented on the Op Sheet.
- Ensure staff members are correctly completing the Op Sheet and properly documenting error corrections.
- Ensure the maximum dose of local anesthetic is calculated prior to administration of local anesthetic.
- Evaluate whether nitrous oxide is contraindicated for patients with a diagnosis of ADHD.
- Ensure the Restorative Dentistry checklist is completed prior to onset of patient care.

Clinic On-site Report

Introduction

The Office of Inspector General (OIG) and CSHM LLC(CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its review of Small Smiles Dental Centers of Akron, 881-883 East Exchange Street, Akron, OH 44306 (Clinic).

Implementation

The OIG approved an unannounced on-site visit to be conducted from May 16-18, 2012, at the Clinic. The Monitor notified [redacted], then Chief Compliance Officer, on May 16, 2012, prior to arriving on-site.

Overall Impressions

Staff members welcomed and accommodated the Monitor. Personnel were available for interviews. The Clinic was well-kept. Requested materials were provided in a timely manner and were well organized; however, not all materials were provided while on-site. Patient observations revealed good teamwork involving the dentists and staff, and children were managed well during administration of appropriate local anesthesia.

Entrance Conference

An entrance conference was held on May 16, 2012, at approximately 8:30 a.m. The Monitor Team of [redacted] CDA, RDH, [redacted] RDH, [redacted] DDS, MSD, and [redacted], DDS, MS, attended. Clinic staff members [redacted], DDS, Lead Dentist, [redacted], Clinical Coordinator, and [redacted] Office Manager and Compliance Liaison, also attended. An overview of the process was discussed, including the point of contact information, the intent to conduct treatment observations, and the need to interview individuals employed by the Clinic.

General

The testing attributes in this section are designed to ensure that the required personnel and notifications are present in the Clinic as required by the CIA and CSHM policies and procedures. The relevant findings are as follows:

- The Clinic has a designated Compliance Liaison, as required by the CIA, Section III.A.3.
- Two posters are displayed in the waiting room titled *The Small Smiles Pledge to Children, Families & Communities* (one in English and one in Spanish). The

posters contained content as required in the CIA, Section III.A.4, to reflect "CSHM's commitment to ensuring that all dental services and items provided meet professionally recognized standards of care." As required by the CIA, Section III.B.2.m, both posters included contact information for filing or registering a complaint with the parent compliance hotline, the appropriate State Dental Board, and the OIG.

- A sign in the waiting room, written in English and Spanish, indicates that parents have a right to accompany their child in the treatment area.
- Current licenses are displayed for all dentists and dental hygienists and expanded-function dental assistants (EFDAs).
- An *Ethics and Compliance Hotline* poster, with a toll-free phone number, is displayed in the employee break room. The poster indicates callers may choose to remain anonymous when calling and there will be no retribution toward anyone who reports a suspected violation in good faith, as required by the CIA, Section III.F. It also includes the phone number for the appropriate State Dental Board.
- A current *Quality of Care Dashboard* was posted in the break room.
- A list of current compliance committee members was in the break room, as required by CSHM's *Code of Ethics and Business Conduct (Code of Ethics)*.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) signs and forms are written in English and Spanish.
- Documentation was supplied to support the List of Excluded Individuals and Entities (LEIE) and Excluded Parties List System (EPLS) databases were checked. The Monitor chose five active employees from the list of employees provided by the Clinic. Documentation indicated the LEIE and EPLS were checked after the date of hire for three of the five active employees.

Recommendations

- Ensure LEIE and EPLS databases are checked within the required timeframes.

Review of Quality Control System

The testing attributes in this section are designed to determine whether the clinical policies and procedures are up-to-date and distributed; whether the *Code of Ethics* has been signed by each employee; whether required training has been conducted; whether internal audits were performed; whether the Clinic provided a timely and appropriate response to any internal audit findings or other indicators of quality of care issues; and how complaints were handled at the Clinic level. The Monitor did not receive all requested documentation while on site. Following a post-visit evaluation, a letter requesting the missing documentation was forwarded to CSHM.

Policies and Procedures

The CIA, Section III.B, requires a code of conduct and specific policies and procedures be developed and implemented. Recently, CSHM changed its process to an electronic

format for the most recent policies, procedures, and forms. The relevant findings are as follows:

- Using the list of employees supplied by CSHM, the Monitor reviewed acknowledgements and certifications related to CSHM's *Code of Ethics* for five randomly selected employees. For 2010, it was determined three employees were hired prior to October 2009 and signed the *Code of Ethics* on February 9, 2010, which was not within the required time frame. One employee did not sign the *Code of Ethics* within 30 days of hire in 2011. All employees signed the *Code of Ethics* within 30 days of revisions in 2012.
- The following paper manuals were maintained in the Clinic. Two of the manuals, as identified below, did not contain the required notification that printed policies and procedures should not be relied on unless it is first verified on the CSHM intranet site.
  - *Office Manager's Manual*
  - *Infection Control Manual*
  - *Clinical Coordinator's Manual*
  - *Policy and Procedures for FORBA Associated Dental Centers* – No disclaimer
  - *Best Practice White Papers and Internal Memos* – No disclaimer
- The Compliance Liaison was familiar with the *Policy and Procedure Development* policy issued on March 1, 2011. She evidenced good knowledge of new policies.
- The Compliance Liaison was questioned about revised policies and how she determines how they have been changed. She stated changes made to an existing policy, procedure, or forms are communicated to her by e-mail and reviewed in the monthly compliance liaison meetings.
- The staff members reported new or revised policies or procedures are discussed during the morning huddles held each day.
- Staff members interviewed generally evidenced good knowledge of the policies and procedures they use in their daily work.
- Staff members were able to articulate that updates are found on the intranet.
- The Compliance Liaison was able to identify recent form changes. All forms used in the Clinic are up-to-date.
- CSHM has created a new form titled *Health History Issues Questions*, which provides a standardized manner for following up to "yes" questions on the Health History form. The form is dated April 3, 2012. A dental hygienist reported the front desk reviewed the Health History form using the new questions and then the hygienists and dentists review the Health History form in the back office.
- The Clinic has posted the policies on the walls around the Clinic and attempts to facilitate understanding of the policies by creating games, such as crossword puzzles.

Training

CSHM recently incorporated a Continuing Education (CE) Tracking System to ensure all employee training requirements have been met. In the past, training documentation has been unorganized and signature sheets were used for training verification. This new system provides a more organized and reliable approach to tracking employee training. As a result of this change, the Monitor reviewed the training signature sheets and the CE Tracking System data for five active clinical employees to verify all training requirements were completed.

The CIA, Section III.C.1, requires 2 hours of general training related to the CIA requirements and CSHM's Compliance Program. This training must be performed within 90 days of the effective date or 90 days after becoming a "covered person," whichever is later. Three hours of "Clinic Quality Training" are required for each "Clinical Quality Covered Person." This training must be delivered within 10 days after the start of employment or within 90 days after the effective date, whichever is later, and an additional 2 hours each year, thereafter. Periodic training is also required on an as-needed basis but at least semi-annually and for a minimum of 2 hours annually.

Initial Training and 2010 Periodic Training requirements were verified while on-site in the Clinic by reviewing training signature sheets. The Compliance Liaison reported she created a form to verify initial training for one employee, hired January 17, 2011, because CSHM was in transition from using sign-in sheets to the CE tracking system. The form was signed June 13, 2011. The Compliance Liaison stated the training occurred prior to that date though she did not know the exact date; however, for documentation purposes, she created the form on June 13, 2011. The 2011 training requirements were verified by reviewing the CSHM CE Tracking System data. The 2012 training requirements were verified by reviewing the CSHM CE Tracking System data. After review the Monitor determined all training requirements had been met for the five active clinical employees.

The Clinic instituted its own chart documentation training program by creating a patient chart reflecting numerous errors. Staff members were asked to find these errors with the person finding the most errors receiving a gift card. There was a tie, and both staff members won a gift card. The results of this exercise allowed the Clinic to identify those staff members who required additional training.

Two staff members interviewed reported they would prefer more hands-on training.

Internal Audits

The CIA, Section III.B.2, requires CSHM to install measures designed "to promote the delivery of patient items or services at CSHM and CSHM facilities that meet professionally recognized standards of health care, including but not limited to appropriate documentation of dental records, including radiographs or digital photos consistent with professional recognized standards of health care." One of the required policies is a periodic audit of clinical quality. CSHM has developed a *Chart Audit Policy* that governs the process for chart audits by CSHM. The relevant findings are as follows:

- CSHM policy requires each Associated Dental Center to receive four quarterly chart reviews consisting of five patient records per dentist. The Monitor requested all chart audits from January 15, 2010, to present. The Clinic underwent an audit in March, June, September, and December 2010; March, June, August, and November 2011; and March 2012. The Clinic passed all audits with the exception of its June 2011 audit, August 2011 re-audit, and November 2011 audit.
- The *Attestation Letter for Chart Review (Attestation Letter)* was provided for all audits.
- The Clinic received an overall score of 90 percent or higher for each of the audits completed in 2010; therefore, no Corrective Action Plan (CAP) was required for the Clinic.
- All dentists passed each quarterly chart audit for 2010 with the exception of one dentist who failed the September audit. Supplemental information provided to the Monitor stated "CSHM could not verify CAP completion regarding this audit." Billing errors were identified in the 2010 audits and the Monitor was able to confirm the billing errors were corrected
- The Clinic received an overall score of 91 percent for the audit completed in March 2011; therefore, no Corrective Action Plan (CAP) was required for the Clinic.
- All dentists passed the March 2011 quarterly chart audit. Billing errors were identified and the Monitor was able to confirm the billing errors were corrected.
- The Clinic received an overall score of 86 percent for the June 2011 chart audit. A CAP was issued; however, the documentation provided to the Monitor did not demonstrate that all aspects of the CAP had been completed.
- Five of the six dentists failed the June 2011 chart audit, two with automatic failures. A CAP was issued and completed. Billing errors were identified. The Monitor was able to confirm billing errors were corrected with the exception of one patient. The Account History Report (AHR) showed CSHM requested the billing error correction on June 4, 2012, which was after the Monitor had requested supplemental documentation to confirm billing errors.
- The Clinic received an overall score of 89 percent for the re-audit conducted for August 2011. A CAP was issued. Supplemental information provided to the Monitor stated "CSHM could not verify CAP completion regarding this audit."
- Two of the four dentists failed the August 2011 re-audit, one with automatic failure. A CAP was issued. Following an appeal, the scores remained the same. Supplemental information provided to the Monitor stated "CSHM could not verify CAP completion regarding this audit." The Monitor was able to confirm the identified billing errors were corrected.
- The Monitor was not supplied with any document to support another re-audit was conducted in response to the failure noted in the August 2011 re-audit.

- Documentation indicated the September 2011 quarterly audit was cancelled; however, no documentation was supplied that provided an explanation for this decision.
- The Clinic received an overall score of 85 percent for the November 2011 audit. A CAP was issued; however, the Monitor did not receive a copy of the CAP. Supplemental information provided to the Monitor stated "CSHM could not verify CAP completion regarding this audit."
- Two dentists failed the November 2011 audit, one with an automatic failure. A CAP was issued; however, supplemental information provided to the Monitor stated "CSHM could not verify CAP completion regarding this audit." Billing errors were identified and the Monitor was able to confirm the errors were corrected.
- The Clinic received an overall score of 98 percent for the audit conducted for December 2011; therefore, no Corrective Action Plan (CAP) was required for the Clinic.
- All dentists passed the December 2011 quarterly chart audit. Billing errors were identified and the Monitor was able to confirm the billing errors were corrected.
- The Clinic received a passing score of 94.02 percent for the March 2012 chart audit; therefore, no CAP was required for the Clinic.
- All dentists except one passed the March 2012 audit. A CAP was issued; however, due to an appeal the CAP had not been completed at the time of the Monitor's visit. Billing errors were identified. The Monitor could not confirm billing errors were corrected because, at the time of the Monitor's visit, billing error corrections had been requested but not received.

From January 31 – February 1, 2012, CSHM conducted its first "combined Clinical, HR, and Compliance on-site visit upon receiving feedback that CSHM should be conducting more compliance site visits." The visit included chart reviews, observations of care, interviews, and educational sessions. The draft report was not finalized until June 4, 2012, and contains CAPs for the Clinic. The Clinic's response to the CAPs is not due until July 6, 2012, and thus, is not evaluated as part of this report. Some notable findings included:

- There were medically unnecessary services identified and directions provided to refund.
- Local anesthesia was not documented in several charts reviewed.
- Additional detail was provided related to the quality of care issues the Lead Dentist identified relating to a previous staff dentist (which is more fully discussed below). CSHM recognized it "should have been more proactive in responding to the Lead Dentist's concern with respect to an Associate Dentist's treatment patterns."
- There were concerns identified that the front office was not functioning smoothly. Suggestions were provided to assist with issues. The Monitor also observed the Office Manager functioning in multiple roles; however, the Office Manager

explained there were a number of new employees, which required her to function in multiple roles.

- CSHM's Audit Manager was directed to provide to the Compliance Liaison the rationale for not conducting a September, 2011 chart audit.

Complaints

The CIA, Section III.B.2.g, requires that "compliance issues are promptly and appropriately investigated" and, if substantiated, that CSHM implement "effective and timely corrective action plans" and monitor compliance with such plans. The CIA, Section III.D, also requires the establishment of a disclosure program that includes a mechanism to enable individuals to disclose any issues anonymously. Finally, the CIA, Section III.A.4, requires the creation of a parent compliance hotline. Two CSHM policies address these complaints: Disclosure Program and Policy and Patient Advocate Policy and Procedure. The relevant findings are as follows:

- Staff members interviewed indicated if they received a complaint from a parent, they would report it to the Compliance Liaison. The Compliance Liaison reported she would report it to the Patient Advocate.
- Staff members were able to identify some adverse events.
- Complaints are received from parents using a variety of mechanisms. They are in response to follow-up calls to the "Net Promoter Score System (NPS) Survey," from center comment cards, e-mails from the website, and feedback during a Clinic visit.
- Twenty-five individuals provided feedback. The majority of complaints were related to unprofessional or rude staff members. For every complaint, there was documentation of follow-up and, where appropriate, staff counseling. The Monitor was unable to verify completion of CAPs associated with two complaints from 2010 and one complaint from 2011.
- There have been 14 substantiated adverse events with respect to this Clinic. Eight adverse events related to swallowed objects, three related to cuts, one related to treatment of the wrong tooth, and one lacked proper consent.
- Most CAPs related to swallowed objects instructed the Lead Dentist to counsel the staff dentist on how to protect the airway. The CAP dated May 19, 2011, states, however, the Lead Dentist was to counsel the treating dentist on protecting the airway, including the use of rubber dams. On June 14, 2011, the Lead Dentist responded to CSHM stating "all doctors are now aware that they are to use rubber dams when trying on anterior crowns to protect the airways." On July 21, 2011, the Compliance Liaison submitted her quarterly report responding to a question about what measures this center has taken to reduce the incidences of swallowed objects, to which the Compliance Liaison responded "implemented the use of rubber dam and 4x4 cotton gauze for all patients??????" In addition, one of the recommendations from the CSHM site visit stated the Clinic needed to "[e]nsure that a rubber dam is used for all root canal procedures and that all staff are aware of this directive. During the

Monitor's site visit, interviews and patient observations revealed rubber dams are not routinely used in this Clinic.

- The Monitor was unable to verify the completion of the CAPs for two 2011 adverse events, both related to swallowed crowns.
- There were 10 employee complaints that were communicated through a comment card, e-mails, exit interviews, an anonymous call, and a hotline call. All had investigative reports and one is still open. One exit interview from a staff dentist fax stamped August 2, 2010, was not provided to the compliance department until May 17, 2011. The exit interview indicated the staff dentist was aware of instances of patient harm "[b]ut the Dr. and Lead dentist follow Small Smiles protocols." Efforts to contact the dentist were unsuccessful.
- The Lead Dentist expressed a concern about the quality of care rendered by a new staff dentist hired in May, 2011. This is more fully discussed below in the Review of Communication System section.

Recommendations

- Ensure all requested documents are provided to the Monitor on-site when available.
- Ensure *Code of Conduct* is signed by all employees within the required timeframes.
- Ensure all paper manuals maintained in the Clinic contain the required notification that printed policies and procedures should not be relied on unless first verified on the CSHM intranet site.
- Evaluate staff members' suggestion to determine whether a hands-on component to training is beneficial.
- Ensure documentation of completion of CAPs associated with all failed quarterly chart audits, adverse events, and parent/patient complaints.
- Ensure confirmation of all billing error corrections identified in Chart Audits.
- Ensure completion of all CAPs associated with the CSHM report of their site visit.
- Ensure rubber dams are properly utilized in the Clinic.
- Ensure the recipients of the exit interviews provide the interviews to the compliance department when compliance issues are raised, and it is done in a timely fashion.

Review of Communication System

The testing attributes related to the communication system were designed to determine whether the communication system is effective. The CIA, Section III.E.I, states the Monitor shall determine whether the "communication system is effective, allowing for accurate information, decisions, and results of decisions to be transmitted to the proper individuals in a timely fashion." The relevant findings are as follows:

- The Compliance Liaison submitted compliance reports quarterly as required by the CIA, Section III.A.2.

- The Monitor asked the Compliance Liaison to describe her role and responsibilities. She reported her role is to inform and update the staff members of new and revised policies and procedures; report adverse events, participate in Compliance Liaison meetings
- Staff members interviewed articulated the existence of the employee hotline and that complaints can be made anonymously.
- Staff members participate in daily "morning huddles," which include discussions of new or revised policies and procedures and announcements of upcoming webinars.

As noted above, the Lead Dentist expressed concern to CSHM about the quality of care rendered by one of her staff dentists. The following sets forth the nature of the communications and the responses from CSHM. Notably, CSHM required the Lead Dentist to manage a situation related to quality of care concerns, without intervention from CSHM management. Despite many communications from the Lead Dentist throughout 2011, CSHM did not log this issue into the Compliance Log until January, 2012.

- The Lead Dentist first expressed her concerns in May 2011. In response, the Senior Vice-President of Operations provided her with a structure to assess the care provided, which included review of patient care and patient records over a 3-week period. At the conclusion, the Lead Dentist reported her findings, which stated "I do not have many concerns about [the staff dentist's] ability to perform dentistry . . . My concern stems for potential over zealous treatment at times . . . I will continue to monitor and document any behaviors that seem inconsistent with our guidelines, as I assure you I would do with any provider. I do feel that [the staff dentist] is able to be managed and I welcome any suggestions or input from you."
- On September 16, 2011, after discussing the matter with the new Senior Vice-President for Operations, the Lead Dentist e-mailed the then Chief Dental Officer (CDO) to express concerns that the staff dentist was overtreating. Specifically, she stated she reviewed charts and "every tooth prepared for a crown received a pulpotomy." The response from the CDO was to tell the Lead Dentist to address the concerns with the dentist as this was the Lead Dentist's responsibility and he invited her to submit charts if she thought it of value.
- Soon thereafter, the staff dentist submitted her 90-day notice of resignation to be effective in December, 2011. Another complaint was forwarded to the Senior Vice-President of Operations on November 16, 2011, stating that while the number of pulpotomies had decreased for a while, they had now increased again, and the "assistants claim that she is not giving enough time for anesthetic to work," and "not using enough anesthetic in each area in order to do more work." The Lead Dentist indicated the dentist will "remain on hygiene until we are able to address the issues and come to an agreement." The Regional Manger stated she would support the Lead Dentist's decision. Another e-mail that day

from the Lead Dentist reported the conversation with the staff dentist and her statement that "[s]he does not feel like she does too many pulpotomies." The next day the Lead Dentist sent another e-mail to the Senior Vice-President with a copy to the Regional Manager requesting them to "consider letting her go" earlier than her stated resignation date, as the Lead Dentist believes the staff dentist is "purposely using poor decision making behavior."

- On November 23, 2011, the Lead Dentist indicated she was providing "cases of concern" to the CDO. The Senior Vice-President of Operations asked the Lead Dentist to share her concerns with the CDO and the Patient Advocate in an e-mail with her plan of action. The Lead Dentist complied, reiterating her concerns from the November 16, 2012, e-mail. The Patient Advocate responded indicating that charts should be sent to the CDO for review. The Chief Compliance Officer (CCO) was included in the response from the Patient Advocate. The dentist left the Clinic on December 2, 2011.
- On January 23, 2012, the CCO added an inquiry to the Compliance Disclosure Log stating "[i]n preparing response letter to OIG, discovered irregularity regarding certain procedures completed by [staff dentist] (former dentist) at Akron. Appears to be very high volume of crowns and pulpotomies as compared to peers. Concerned there could be duplicate billing."
- The Monitor queried the CCO about why she believed this was a duplicate billing issue and she responded it seemed to be an "outlier among outliers."

The CIA, Section III.B.2.m, requires CSHM to design measures to collect reports relating to patient care incidents, injuries, abuse, neglect, and to inform patients when a substantiated incident of patient harm occurs at the facility. The CIA, Section III.B.2.10, requires a policy related to parental accompaniment. CSHM policies allow patients, parents, and guardians to provide feedback using the NPS Survey completed at the end of the visit. The survey asks the person completing it whether he or she can be contacted. Communication between the Clinic and patients, parents, and guardians is also facilitated by preprinted Parent Comment Cards, a parent hotline, e-mails, and the option to report issues to a staff member. CSHM's *Parent Notification and Adverse Events* policy is designed to inform patients, parents, and legal guardians of substantiated incidents of patient harm. In addition, CSHM's *Parent Absence/Presence Policy* is designed to ensure parents and guardians have a right to accompany children into treatment. The relevant findings are as follows:

- The NPS Survey is available at the checkout desk. The response rate as of May 25, 2012, indicated the Clinic had a year-to-date response rate of 90 percent.
- Preprinted Parent Comment Cards, written in English and Spanish, were available to the parents at the checkout desk.
- A sign informs parents of their right to accompany the child into the treatment rooms. The April 2012 *Smile Factor Snapshot*, which records the results based on Clinic-level criteria from the "NPS parent survey," indicates 80 percent of the respondents were aware they could accompany their child during treatment and 60 percent chose to accompany their child during treatment.

- The *Smile Factor Snapshot* also rates the Clinic on other factors, such as ease of scheduling, cleanliness, staff demeanor, wait time, and explanation of paperwork and procedures. The February 2012 *Smile Factor Snapshot* showed the Clinic scored below company average for "front desk cheerful and friendly," "clinical staff explained procedures well," "follow up occurred for questions/outcome," "dentist was cheerful and friendly," and "other clinical staff were cheerful and friendly." The March 2012 *Smile Factor Snapshot* showed the Clinic below the company average in all areas. The April 2012 *Smile Factor Snapshot* showed the Clinic scored below company average for "ease of scheduling," "front desk cheerful and friendly," "follow up occurred for questions/outcome," and "other clinical staff cheerful and friendly."
- The Clinic has a *Center Adverse Event Log* that documented 14 adverse events reported at this Clinic. This is consistent with the Patient Advocate Tracking Report. Notification of the log's existence is located on the Health History form. The *Adverse Event Disclosure Log* indicates no individuals have asked to review the *Center Adverse Event Log.*
- Staff members interviewed were aware of the translation service and have used the service in the past.

The CIA, Section III.B.2.11, requires a policy on informed consent. Treatment plans are the basis for obtaining informed consent. As noted in the CSHM policy on *Informed Consent*, part of informed consent includes understanding the alternatives to the proposed treatment. CSHM has indicated its policy does not require dentists to present treatment plans. The CDO's "Protective Stabilization and Treatment Planning" white paper, dated March 2009, sets forth concerns about allowing dental assistants to present treatment plans.

It cites "complaints that parents generate regarding misunderstandings over their child's care, or over what they perceive to be a lack of communication with the dentists who planned and provided the treatment." The CDO quotes from an article published in *Pediatric Dentistry*, the peer-reviewed, official journal of the American Academy of Pediatric Dentistry (AAPD), in which an attorney states: "The task of obtaining informed consent should not be delegated to an auxiliary, but should be that of the pediatric dentist." (Pediatr Dent 1995; 17:0-97).

The CDO then states: "It is incumbent on the Small Smiles dentist to be part of the treatment plan presentation, to answer the parent's questions, and provide explanations that the dental assistant may have difficulty doing." Furthermore, in the training prepared by the CDO titled "Treatment Planning for Small Smiles Patients," he states that staff "[m]ay give *preliminary* presentation of treatment plan," but "[s]taff cannot obtain consent- must be done by doctor" [emphasis in original]. Recent CDO training indicates that treatment plans may be done by dentists or "[T]rained staff." The presentation is considered "preliminary" until the "dentist stops by to ensure that any questions the parent may have are answered" and the parent should not sign the treatment plan until this opportunity is presented. In addition, the training indicates it is

best, but not essential, that the dentist be present when the parent signs the treatment plan.

- Staff members were able to articulate the correct policy for when consent is required.
- Staff members interviewed reported that dental assistants usually present the treatment plan to the parent and obtain consent; however, sometimes the dental hygienist and dentist performed this function.

Recommendations

- Evaluate why the CCO determined a high volume of crowns and pulpotomies by a staff dentist was considered a billing issue based upon comparison to peers when the Lead Dentist had provided numerous communications related to the overtreatment by this staff dentist and at least one of these communications included a copy to the CCO.
- Evaluate processes for when the CDO, Regional Manager, Senior Vice-President, and other CSHM management is required to report quality of care issues being brought to their attention and ensure such issues are included on the Compliance Disclosure Log.
- Perform a root cause analysis to determine why the Clinic's *SmileFactor Snapshot* scores are below the company average.

Review of Dental Record Documentation

The testing attributes related to the dental record documentation were designed to determine whether the documentation was complete and accurate, including HIPAA-related forms, medical necessity, and consent forms. A sample of 30 visits representing 30 separate patients and records was identified from the patient listing provided by CSHM, based on all Medicaid patients seen for operative visits from March 2, 2012, through May 14, 2012. The Monitor's pediatric dentist provided consultation on 30 of the 30 patient records reviewed.

This portion of the report also contains additional record review findings from the Monitor's pediatric dentist's observations of patient care and retrospective quality of care record review. Findings related to patients #031 to #039 are a result of the Monitor's pediatric dentist's treatment observations. Findings related to patients #046 to #057 are a result of the Monitor's quality of care review. In order to complete the retrospective quality of care record review, 12 additional records of patients who had received operative procedures and returned for post-operative X-rays were identified from a list provided by CSHM. The relevant findings from the review of the 30 visit records, 9 treatment observations, and the 12 quality of care review are as follows:

Acknowledgement and Authorization Forms

Two records (patients #013 and #030) did not contain a completed Acknowledgement of Receipt of Notice of Privacy Practice (Acknowledgement) form for the patient of record.

Three records (patients #010, #029, and #030) contained Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian (Authorization) forms that were not completed correctly.

Health History

The Health History form in nine records (patients #003, #007, #008, #010, #013, #014, #015, #018, and #031) did not provide complete follow-up information to "yes" responses. The majority of the findings were related to follow-up questions regarding a positive history of asthma/breathing problems.

The table below provides a summary of each finding.

Health History		
Patient	**Date**	**Finding**
#003	March 2, 2012	There was lack of follow-up information regarding the "yes" response to "asthma/breathing problems."
#007	April 3, 2012	There was lack of follow-up information regarding the "yes" response to "asthma/breathing problems."
#008	January 6, 2012	There was lack of follow-up information regarding the "yes" response to "asthma/breathing problems."
#010	March 7, 2012	There was lack of follow-up information for the "yes" response to "Anemia", Allergies, or "Disabilities/ Special Needs."
#013	April 16, 2012	There was lack of follow-up information for the "yes" response of "Ibuprobin" to the question regarding allergy to medication.
#014	April 24, 2012	There was lack of follow-up information regarding the "yes" response to "asthma/breathing problems."
#015	January 3, 2011	The Health History form incorrectly documented the date as January 3, 2011, instead of January 3, 2012. Additionally, there was lack of follow up information regarding the "yes" response to "asthma/breathing problems."
#018	September 23, 2011	There was lack of follow-up information regarding the reason the patient was taking "non-aspirin."
#031	May 15, 2012	There were no details documented for the patient's reported heart murmur.

Tooth Chart

Ten records (patients #001, #002, #004, #015, #021, #023, #025, #028, #030, and #047) did not show documentation of decay on the upper odontogram of the Tooth Chart.

Seventeen records (patients #001, #005, #009, #010, #013, #014, #017, #019, #020, #023, #025, #030, #048, #049, #050, #051, and #053) did not show documentation of existing conditions on the upper odontogram of the Tooth Chart.

In six records (patients #015, #017, #021, #022, #023, and #024), the lower odontogram did not show documentation of completed treatment.

The tables below contain a summary of the findings related to the Tooth Chart.

Decay Not Documented on the Upper Odontogram		
Patient	**Date**	**Finding**
#001	February 10, 2012	Buccal decay on tooth #30
#002	April 24, 2012	Radiographically demonstrable decay on the mesial of teeth #B and #I evident on X-rays dated April 24, 2012
#004	April 20, 2012	Decay on teeth #19 and #L
#015	January 3, 2012	Decay on teeth #D, #F, and #G
#021	April 9, 2012	Radiographically demonstrable mesial decay on tooth #T evident on X-rays dated April 10, 2012
#023	April 30, 2012	Upper odontogram not completed
#025	April 20, 2012	Radiographically demonstrable decay on tooth #S evident on X-rays dated April 20, 2012
#028	April 10, 2012	Radiographically demonstrable decay on tooth #T evident on X-rays dated April 10, 2012
#030	April 5, 2012	Distal decay on teeth #B and #I and distal decay on tooth #I, all evident on X-rays dated April 5, 2012
#047	March 18, 2011	Mesial decay on tooth #E evident on X-rays dated March 18, 2011, and no notation of plans to monitor lesion because tooth would be lost soon

Existing Conditions Not Documented on the Tooth Chart		
Patient	**Date**	**Finding**
#001	February 10, 2012	Existing teeth, pulpotomies and SSCs on teeth #K and #L; occlusal fillings in teeth #J and #19; incomplete removal of pulpal tissue in teeth #K and #L, which received pulpotomies on July 21, 2011; and possible abscess on tooth #L, all evident on X-rays dated February 10, 2012
#005	April 24, 2012	Distal root resorption on tooth #S evident on X-rays dated April 24, 2012
#009	April 12, 2012	Existing occlusal filling on tooth #A
#010	March 8, 2012	Abscess on tooth #S evident on X-rays dated March 8, 2012, and occlusal filling on tooth #K
#013	April 16, 2012	Abnormal root resorption of teeth #C and #H due to crowding evident on X-ray dated April 16, 2012

[redacted] Small Smiles Dental Centers of Akron

Existing Conditions Not Documented on the Tooth Chart		
Patient	**Date**	**Finding**
#014	April 24, 2012	Pulpotomy on tooth #I or the pulpotomy and SSC on tooth #H
#017	January 12, 2012	Existing pulpotomy and SSC on tooth #B; pulpotomies on teeth #K and #S; failing pulpotomy on tooth #K, evident on X-rays dated January 12, 2012
#019	March 19, 2012	Furcation radiolucency on tooth #S, evident on the X-rays dated March 19, 2012
#020	February 3, 2012	Existing pulpotomy on tooth #L
#023	April 30, 2012	Upper odontogram not completed; no tooth letters/numbers circled to document existing teeth
#025	April 20, 2012	Pulpotomy and internal resorption on the mesial root of tooth #L; abscess on tooth #S, all evident on X-rays dated April 20, 2012
#030	April 5, 2012	Pulpotomies on teeth #A, #K, #L, and #T; incomplete removal of pulp tissue on tooth #T, evident on X-rays dated April 5, 2012
#048	October 27, 2011	Failed pulpotomy on tooth #S evident on X-rays dated October 27, 2011
#049	February 23, 2012	Radiographically demonstrable abscess of tooth #B evident on X-rays dated February 23, 2012
#050	March 19, 2012	Radiographically demonstrable abscess of tooth #T evident on X-rays dated March 19, 2012
#051	October 25, 2011	Radiographically demonstrable internal resorption on tooth #S evident on X-rays dated October 25, 2011
#053	March 3, 2012	Extensive premature root resorption indicating possible pulpotomy failure in tooth #B evident on X-rays dated March 3, 2012

Completed Treatment Not Documented on the Lower Odontogram		
Patient	**Date**	**Finding**
#015	January 3, 2012	Mesial, incisal, lingual, facial restorations performed on teeth #D, #,F and #G
#017	January 12, 2012	SSCs performed on teeth #I and #L
#021	April 9, 2012	Pulpotomies performed on teeth #E and #F
#022	April 24, 2012	Pulpotomy performed on tooth #I
#023	April 30, 2012	Pulpotomies performed on teeth #A and #T
#024	April 11, 2012	Pulpotomy performed on tooth #I

[redacted] Small Smiles Dental Centers of Akron

X-rays and Photographs

Three records (patients #012, #016, and #018) contained non-diagnostic X-rays or photographs. Four records (patients #014, #015, #025, and #027) contained incorrectly labeled X-rays. Fourteen records (patients #002, #004, #007, #009, #014, #018, #019, #021, #023, #028, #030, #050, #056, and #057) showed diagnostic X-rays were not taken when indicated to determine the appropriate course of treatment and/or support the medical necessity for treatment performed. Two records (patients #018 and #020) did not document rationale for X-rays taken outside of *Food and Drug Administration/American Dental Association (FDA/ADA) Guidelines,* and six records (patients #005, #009, #010, #013, #018, and #020) did not document interpretation of X-rays.

The tables below provide a summary of each finding regarding X-rays.

Non-diagnostic X-rays or Photographs		
Patient	**Date**	**Finding**
#012	December 2, 2012	The right bitewing X-ray was non-diagnostic because of overlapping contacts of teeth #A and #B.
#016	April 12, 2012	The photograph was not of diagnostic quality to assess the size of the decay on teeth #E and #F which received SSCs with resin windows.
#018	September 23, 2011	The right bitewing X-ray was not diagnostic because of the overlapping contact on the distal of tooth #S.

Incorrectly Labeled X-rays		
Patient	**Date**	**Finding**
#014	April 24, 2012	Duplicate X-rays provided to Monitor for patient #014 were labeled as if they belonged to patient #015.
#015	January 3, 2012	Duplicate X-rays provided to Monitor for patient #015 were labeled as if they belonged to patient #014.
#025	April 20, 2012	There was no date of service recorded on the original X-rays; however, the duplicate X-rays provided to the Monitor were dated correctly.
#027	April 18, 2012	There was no date of service recorded on the original X-rays; however, the duplicate X-rays provided to the Monitor were dated correctly.

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#002	May 3, 2012	Extent of decay on tooth #B and inability to see the furcation in the bitewing X-ray dated April 24, 2012, warranted a periapical X-ray of #B to evaluate the presence or absence of abscess and appropriateness of the pulpotomy performed.

[redacted] Small Smiles Dental Centers of Akron

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#004	May 1, 2012	Extent of decay on tooth #B and presence of sinus tract/swelling warranted a periapical X-ray to evaluate the appropriateness of the pulpotomy performed on tooth #B and the extraction of tooth #A.
#007	April 30, 2012	Only occlusal decay was recorded on the Tooth Chart for tooth #B, which received an SSC; an X-ray or photo was indicated to support the treatment.
#009	April 26, 2012	Extent of decay on tooth #J and inability to see the furcation in the bitewing X-ray dated April 12, 2012, warranted a periapical X-ray of #J to evaluate the presence or absence of abscess and appropriateness of the pulpotomy performed.
#014	April 24, 2012	Extent of decay and restorations visible on X-rays dated November 12, 2010, for teeth #C, #D, and #H and documentation of existing decay on these teeth on the tooth chart dated April 24, 2012, warranted an anterior occlusal X-ray of these teeth before planning treatment. The diagnosis of over retention and planned extraction of tooth #I warranted a periapical X-ray to confirm the diagnosis. The existing bitewing did not show root structure of #I or the permanent successor. Based on the amount of root structure visible on the mandibular first primary molars, a diagnosis of over retention is unlikely and without substantiation with the existing X-rays.
#018	April 13, 2012	Fillings placed in teeth #A, #J, #K, #L, and #T on April 13, 2012, used X-rays dated September 23, 2011, to support the medical necessity for treatment. These X-rays were more than 6 months old, and new X-rays were indicated.
#019	April 6, 2012	Extent of decay on tooth #S and inability to fully visualize the furcation, which appeared to be suspicious for rarefaction in X-rays dated March 19, 2012, warranted a periapical X-ray to evaluate the appropriateness of the pulpotomy performed on tooth #S.

[redacted] Small Smiles Dental Centers of Akron

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#021	May 11, 2012	Extent of decay on teeth #E and #F and its approximation to the pulp warranted a diagnostic upper anterior occlusal X-ray to evaluate the appropriateness of the pulpotomies performed on teeth #E and #F.
#023	April 30, 2012 and May 16, 2012	Extent of decay on teeth #A and #J and inability to see the furcation in the bitewing X-ray dated April 30, 2012, warranted periapical X-rays to evaluate the appropriateness of the pulpotomies performed on teeth #A and #J.
#028	April 10, 2012	Extent of decay on teeth #B and #L and inability to see the furcation in the bitewing X-ray dated April 10, 2012, warranted periapical X-rays to evaluate the appropriateness of the pulpotomy performed on tooth #L and the pulpotomy treatment planned for tooth #B.
#030	April 5, 2012	Photographs of sinus tracts on the upper right and left buccal mucosa are not a replacement for periapical X-rays of the suspected teeth to verify the source of the infection. In addition, periapical X-rays are important diagnostic aids prior to extraction of multi-rooted teeth. Patient #30 was 9 years old and fully cooperative for obtaining X-rays.
#050	September 12, 2011	Extent of decay on tooth #I was half-way to the pulp. The furcation of tooth #I was not visible on the bitewing X-ray dated September 12, 2011, and a periapical X-ray was warranted to justify the extraction of tooth #I.
#056	August 17, 2011	Extent of decay on tooth #L and inability to see the furcation in the bitewing X-ray dated August 17, 2011, warranted a periapical X-ray to evaluate the appropriateness of the pulpotomy performed on tooth #L.

[redacted] Small Smiles Dental Centers of Akron

Diagnostic X-rays Not Taken When Indicated		
Patient	**Date of Service**	**Finding**
#057	March 8, 2011 and September 28, 2011	Extent of decay on tooth #S and inability to see the furcation in the bitewing X-ray dated October 11, 2011, warranted a new periapical X-ray to evaluate the appropriateness of the pulpotomy performed on tooth #S on March 8, 2011, five months later. Pulpotomies should be evaluated every 6 months to determine their success. Follow-up X-rays should have been taken at the recall appointment on September 28, 2011, to evaluate the success of the pulpotomy.

No Documented Rationale for X-rays		
Patient	**Date**	**Finding**
#018	September 23, 2011	Panoramic X-ray taken prior to the eruption of the first permanent molars
#020	February 3, 2012	Periapical X-ray taken of tooth #J

No Interpretation of X-rays		
Patient	**Date**	**Finding**
#005	April 24, 2012	Panoramic X-ray
#009	April 12, 2012	Panoramic X-ray
#010	March 8, 2012	Panoramic X-ray
#013	April 16, 2012	Panoramic X-ray
#018	September 23, 2011	Panoramic X-ray
#020	February 3, 2012	Periapical X-ray of tooth #J

Medical Necessity

Within the records reviewed, the Monitor's pediatric dentist found 16 records (patients #004, #007, #010, #015, #019, #046, #047, #049, #050, #051, #052, #053, #054, #055, #056, and #057) did not provide radiographic evidence to support the medical necessity for treatment provided. Seven of these records (patients #046, #047, #049, #050, #051, #053, and #055) showed pulpotomies were performed on teeth where X-rays did not show decay half way to the pulp. An additional seven records (patients #004, #010, #019, #052, #054, #056, and #057) revealed pulpotomies and SSCs were performed on teeth where X-rays showed evidence of abscess or root resorption. The remaining four records (patients #004, #007, #015, and #050) did not have X-rays to support the medical necessity for the treatment provided.

The following table provides details related to each finding:

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
#004	May 1, 2012	There was no periapical X-ray to support the medical necessity for the extraction of tooth #A and pulpotomy and SSC performed on tooth #B. A photograph showed a purulent sinus tract in the upper right buccal mucosa in the vicinity of tooth #A. A bitewing X-ray dated April 20, 2012, showed very large decay approximating the pulp in tooth #B and less well demarked decay in the occlusal of tooth #A. The furcation of neither tooth was visible. It was unclear which tooth was the cause of the infection demonstrated by the sinus tact. A periapical X-ray was warranted to demonstrate the bone loss expected with the development of a sinus tract. Tooth #A was extracted and tooth #B received a pulpotomy. It was possible both teeth needed to be extracted or only tooth #B needed to be extracted. More diagnostic information was needed to make an accurate decision of correct treatment.
#007	April 30, 2012	There were no diagnostic X-rays to support the medical necessity for the SSC performed on tooth #B.
#010	April 19, 2012	There was no medical necessity for the pulpotomy and SSC placed on tooth #S because the X-ray revealed an abscess and root resorption.
#015	May 2, 2012	There was no medical necessity for the mesial incisal lingual facial fillings placed in teeth #D, #F, and #G, because the periapical X-ray taken of tooth #E on May 2, 2012, could not be found in the patient's record and there was no documentation of decay on the tooth chart dated January 3, 2012.
#019	April 6, 2012	There was no medical necessity for the pulpotomy and SSC placed on tooth #S because the X-ray dated March 19, 2012, showed a radiolucency in the furcation of tooth #S.
#046	July 1, 2011	There was no medical necessity for the pulpotomies performed on teeth #A and #J because the X-rays dated July 1, 2011, did not show decay half way to the pulp.
#047	March 18, 2011	There was no medical necessity for the pulpotomy performed on tooth #K because the X-rays dated

[redacted] Small Smiles Dental Centers of Akron

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
		March 18, 2011, did not show decay half way to the pulp.
#049	August 8, 2011	There was no medical necessity for the pulpotomy performed on tooth #A because the X-rays dated August 8, 2011, did not show decay half way to the pulp.
#050	September 12, 2011	There was no medical necessity for the pulpotomy performed on tooth #J because the X-rays dated September 12, 2011, did not show decay half way to the pulp. There was no medical necessity for the extraction of tooth #I because there were no notes on the Tooth Chart or Op Sheet and no supporting radiographic evidence.
#051	April 27, 2011	There was no medical necessity for the pulpotomy performed on tooth #I because the X-rays dated April 18, 2011, were non-diagnostic to determine the amount of decay in tooth #I.
#052	November 7, 2011	There was no medical necessity for the pulpotomy and SSC performed on tooth #I because the X-rays dated November 4, 2011, showed tooth #I was near exfoliation with very little root remaining. This was further evidenced by tooth #I becoming loose and being extracted only 3.5 months later.
#053	August 30, 2011	There was no medical necessity for the pulpotomies performed on teeth #B and #L because the X-rays dated August 30, 2011, did not show decay half way to the pulp.
#054	March 31, 2011	There was no medical necessity for the pulpotomy and SSC performed on tooth #A because the X-rays dated March 31, 2011, did not show decay half way to the pulp, and all remaining primary molars were in late stages of exfoliation. Tooth #A exfoliated before the 6-month recall following the pulpotomy and SSC.
#055	April 6, 2011	There was no medical necessity for the pulpotomy performed on tooth #B because the X-rays dated January 4, 2011, did not show decay half way to the pulp.
#056	August 17, 2011	There was no medical necessity for the pulpotomy and SSC performed on tooth #L because the X-rays dated August 17, 2011, showed a very large lesion

No Medical Necessity For Treatment Performed		
Patient	**Date of Service**	**Finding**
		and possible abscess on tooth #L. Tooth #L was extracted on February 22, 2012, seven months after receiving a pulpotomy and SSC. Therefore, it is possible tooth #L was already necrotic on August 17, 2011, but no periapical X-ray was taken to rule out an abscess and support the medical necessity for the pulpotomy and SSC.
#057	March 8, 2011	There was no medical necessity for the pulpotomy and SSC performed on tooth #S on March 8, 2011, because the X-rays dated October 11, 2010, were 5 months old. A periapical X-ray of tooth #S to rule out progression of the lesion to necrosis of the pulp was not taken prior to performing a pulpotomy. The patient experienced pain and an emergency extraction of tooth #S on January 12, 2012, only 9 months after the pulpotomy and SSC.

Treatment Plan

The Monitor's pediatric dentist found seven records (patients #010, #013, #015, #018, #025, #029, and #030) in which the Treatment Plan did not adequately address decay or pathology evident on diagnostic X-rays.

The following table provides details related to each finding:

Treatment Plan Did Not Address Patient's Needs		
Patient	**Treatment Plan Date**	**Finding**
#010	March 8, 2012	Tooth #S had a radiographically demonstrable abscess which was treatment planned for pulpotomy and SSC instead of pulpectomy or extraction.
#013	April 16, 2012	The abnormal root resorption on tooth #C was not documented or addressed.
#015	May 2, 2012	The radiographically demonstrable decay on teeth #A, #L, and #S was not documented or addressed. The Tooth Chart dated January 3, 2012, states: "caries free" and there was no plan for the treatment of this decay despite evidence of radiographically demonstrable decay on the bitewing X-rays dated January 3, 2012.
#018	April 13, 2012	The radiographically demonstrable decay on the distal of tooth #R was not documented or addressed.
#025	April 20, 2012	The internal resorption on the mesial root of tooth #L was not documented or addressed.

[redacted]

Treatment Plan Did Not Address Patient's Needs		
Patient	**Treatment Plan Date**	**Finding**
#029	April 11, 2012	The radiographically demonstrable decay on teeth #E and #F was not documented or addressed.
#030	April 5, 2012	The radiographically demonstrable distal decay on tooth #B was not documented or addressed.

Multiple Surface Fillings

Two records (patients #015 and #018) did not document rationale for performing multiple surface fillings instead of SSCs.

The following table provides details related to each finding:

Multiple Surface Fillings Instead of SSCs With No Rationale		
Patient	**Date**	**Finding**
#015	May 2, 2012	Teeth #D, #F, and #G received mesial, incisal, lingual, and facial composite restorations instead of SSCs.
#018	April 13, 2012	Tooth #L received a distal, occlusal filling instead of an SSC.

Teeth Treated Multiple Times

The Monitor's pediatric dentist found three records (patients #052, #056, and #057) in which teeth were treated with pulpotomies and SSCs and then extracted within a year of initial treatment.

The following table provides details related to each finding:

Teeth Treated Multiple Times	
Patient	**Finding**
#052	Tooth #I was near exfoliation but was treated on November 7, 2011, with a pulpotomy and SSC and then extracted on February 23, 2012, due to a "loose cap."
#056	Tooth #L was treated on August 17, 2011, with a pulpotomy and SSC and then extracted on February 22, 2012, due to an abscess.
#057	Tooth #S was treated on March 8, 2011, with a pulpotomy and SSC and then extracted on January 12, 2012, due to an abscess.

Other Quality of Care Issues

The post-operative X-rays in eight records (patients #001, #017, #029, #046, #047, #049, #050, and #053) revealed quality of care issues related to untreated decay, pulpotomies, and SSCs. The Monitor's pediatric dentist found a total of eight teeth treated with pulpotomies in which there was incomplete removal of pulp tissues, three SSCs with residual cement, and one poor fitting SSC.

Four records (patients #010, #019, #052, and #054) showed pulpotomies were performed on teeth that had radiographic evidence of pathology or were near exfoliation.

The following tables provide details related to each finding:

Substandard Care		
Patient	**Date of Service**	**Finding**
#001	July 21, 2011	The bitewing X-rays dated February 10, 2012, revealed incomplete removal of pulp tissue on teeth #K and #L and it appeared the chambers were barely entered. The X-rays also showed an abscess may be forming in the furcation of tooth #L indicating a failing pulpotomy.
#017	March 15, 2010	There was residual cement on the distal of tooth #K and the mesial of both teeth #B and #S visible on X-rays dated January 12, 2012, and on X-rays taken in 2010.
#029	November 23, 2011	Decay on the mesial of tooth #E and the mesial and distal of tooth #F, evident on the X-rays dated November 17, 2011, and which appear more advanced on the X-rays dated April 11, 2012, has been left untreated. Facial composites were performed on teeth #E, #F, and #H on November 23, 2011, indicating the patient returned for treatment. The lower odontogram of the Tooth Chart dated November 17, 2011, indicated teeth #E and #F were treatment planned for crowns, which were not performed, and there was no explanation for the failure to treat as planned. In addition, the Treatment Plan dated April 11, 2012, still did not address the interproximal decay on teeth #E and #F.
#046	July 1, 2011	There was incomplete removal of pulp tissue on teeth #A and #J visible on X-rays dated April 18, 2012.
#047	March 18, 2011	There was incomplete removal of pulp tissue on tooth #K visible on X-rays dated September 28, 2011, and March 30, 2012.
#049	August 8, 2011	There was incomplete removal of pulp tissue on tooth #A visible on X-rays dated February 23, 2012.
#050	September 12, 2011	There was incomplete removal of pulp tissue and a poorly fitted SSC on tooth #S visible on X-rays dated March 19, 2012.
#053	August 30, 2011	There was incomplete removal of pulp tissue on tooth #L visible on X-rays dated March 8, 2012.

Pulpotomies Performed Outside AAPD Guidelines		
Patient	**Date**	**Finding**
#010	April 19, 2012	Tooth #S was treated with a pulpotomy and SSC; however, the X-rays dated March 8, 2012, revealed abscess, root resorption, periapical radiolucency, and radicular bone loss.
#019	April 6, 2012	Tooth #S was treated with a pulpotomy and SSC; however, the X-rays dated March 19, 2012, showed tooth #S had a furcation radiolucency.
#052	November 7, 2011	Tooth #I was treated with a pulpotomy and SSC; however X-rays dated November 4, 2011, showed very little root remaining and tooth #I was near exfoliation. Tooth #I was extracted on February 23, 2012 due to "loose cap."
#054	March 31, 2011	Tooth #A was treated with a pulpotomy and SSC; however X-rays dated March 31, 2011, showed very little root remaining and tooth #A was near exfoliation.

Patient Management

Local Anesthesia

The Monitor found two patient visits (patients #015 and #018) where neither local anesthesia nor nitrous oxide analgesia were administered for fillings performed on primary teeth in children who were younger than 7 years old.

The CDO's Best Practice Memo dated November 22, 2011, addressed a variety of issues related to local anesthesia and notes: "I have used **bold** font to emphasize key points." The Memo states: "**Non-use of local anesthesia is acceptable in limited instances.**" The CDO continues with "non-use of local anesthesia is most appropriate for an older patient who has experienced local anesthetic injections and who understands that the discomfort to be expected during treatment is no greater than that of receiving one or more injections for the procedure. A good example is an 8-year-old who has received previous care under local anesthetic and who requires buccal pit restorations on #19 and #30 in which you anticipate that the caries extends just beyond the DEJ. Further, to lessen the minor discomfort of preparing small pits without local anesthetic, **consider placing the patient on nitrous oxide for its analgesic effects**."

The following table provides a summary of this additional information.

No Local Anesthesia		
Patient	**Date of Service**	**Finding**
#015	May 2, 2012	Local anesthesia was indicated for the multiple surface fillings placed in teeth #D, #F, and #G; however, the Op Sheet documented it was not used.
#018	April 13, 2012	Local anesthetic was indicated for the occlusal

[redacted] Small Smiles Dental Centers of Akron

No Local Anesthesia		
Patient	**Date of Service**	**Finding**
		fillings placed in teeth #A, #J, #K, and #T, and the distal occlusal filling placed in tooth #L; however, the Op Sheet documented it was not used.

Protective Stabilization

One record (patient #012) did not show consent or proper documentation regarding use of active stabilization. The Op Sheet dated May 14, 2012, documented active stabilization was utilized; however, there was no consent form and no documentation of what type active stabilization was used or who was involved with the active stabilization.

Within the records reviewed, ten patient visits (patients #002, #007, #011, #016, #019, #025, #027, #028, #029, and #056) were identified in which a protective stabilization device (PSD) or papoose board was used. Two of the ten patient visits (patients #007 and #016) showed a PSD was used for non-emergent treatment. Two patient visits (patients #019 and #027) showed poor time management which may have attributed to the patient's behavior.

The following table provides a summary related to these findings.

PSD used for Non-Emergent Treatment		
Patient	**Date of Service**	**Finding**
#007	April 30, 2012	Tooth #B was treated with an SSC with no X-ray or photograph taken to evaluate whether the treatment was emergent. Additionally, tooth #B did not receive a pulpotomy, which indicates the decay was not deep enough to be emergent. The record did not include any other documentation to support why the PSD was used.
#016	April 26, 2012	Teeth #E and #F received SSCs with resin windows, and the photograph dated April 12, 2012, did not show lesions that would indicate an emergent nature for the treatment and use of the PSD. The record did not include any other documentation to support why the PSD was used.

Time Management		
Patient	**Date of Service**	**Finding**
#019	April 6, 2012	Documentation for this 4-year-old patient showed she was seated in the operatory chair at 10:48 a.m., nitrous oxide was started at 11:20 a.m., and anesthetic was started almost an hour after initial seating at 11:43 a.m. Nitrous oxide was stopped at 12:00 p.m. because the patient began to cry. Treatment was started at 12:07 p.m. and then the

Time Management		
Patient	**Date of Service**	**Finding**
		patient was placed in a PSD at 12:20 p.m. Treatment ended at 12:42 p.m. The time of day and length of time the patient was in the operatory may have been a contributing factor to the patient's behavior. Better time management with this young child may have eliminated the need for use of the PSD.
#027	April 18, 2012	This 4-year-old patient was in the chair for almost 50 minutes before anesthesia was administered. The time of day and length of time the patient was in the operatory may have been a contributing factor to the patient's behavior. The total time the patient was in the operatory was almost 2 hours. A PSD was used to treat three front teeth due to pain. The Consent for Protective Stabilization form states: "patient fought entire time."

Nitrous Oxide

Nitrous oxide analgesia was administered in 4 of the 30 patient visits reviewed (patients #005, #019, #025, and #026). All 4 records documented both the initial and working concentrations of nitrous were administered at 30 percent. Therefore, the documentation did not show nitrous oxide was titrated in 10 percent increments as described in the *AAPD Guidelines for the use of Nitrous Oxide for Pediatric Dental Patients.* (Pediatr Dent 2011-2012; 33 (special issue): 181-84.

Account History

The Account History Report for six patients (patients #002, #005, #017, # 021, #025, and #030) did not document all services that were performed on the audited date of service and one Account History Report (patient #055) showed billing for a pulpotomy that was not performed. Three Account History Reports (patients #002, #021, and #025) did not document use of Behavior Management, which allows CSHM to track and monitor the use of the PSD.

The following table provides details related to each finding:

Account History		
Patient	**Date**	**Finding**
#002	May 3, 2012	The Account History did not document the use of Behavior Management.
#005	May 1, 2012	The Account History Report did not document the use of nitrous oxide.
#017	January 12, 2012	The Account History Report did not document the panoramic X-ray.

[redacted] Small Smiles Dental Centers of Akron

Account History		
Patient	**Date**	**Finding**
#021	May 11, 2012	The Account History Report did not document the use of Behavior Management.
#025	April 24, 2012	The Account History Report did not document the use of nitrous oxide or Behavior Management.
#030	April 11, 2012	The Account History Report did not document delivery of the space maintainers to hold the spaces for teeth #4, #12, and #20.
#055	April 6, 2011	X-rays dated December 12, 2011, showed no pulpotomy was performed on tooth #A; however, the Account History Report showed a pulpotomy was billed for tooth #A on April 6, 2011.

Other Findings

Two records (patients #015 and #023) contained documentation errors or incomplete documentation with respect to a chief complaint.

The following table provides details related to each finding.

Other Findings		
Patient	**Date**	**Finding**
#015	May 2, 2012	The Hygiene Procedures form shows a limited oral exam was performed on May 2, 2012, and documented the chief complaint as: "cap came off [with] tooth E." Additional notes stated "upon exam and X-ray #E evulsed. Interproximal decay noted." There were no other details recorded on the Hygiene Procedures form or Tooth Chart regarding how or when tooth #E was evulsed.
#023	April 30, 2012	The Op Sheet did not have the "Y" or "N" circled to indicate if an EFDA helped with the placement of fillings performed on teeth #3 and #30. Documentation did not record use of a precautionary isolation method or proper notation of error corrections with respect to time changes made at the bottom of the form.

Recommendations

- Ensure staff members are verifying an Acknowledgement form is completed for each patient or record.
- Ensure staff members are verifying correct completion of the Authorization form.
- Ensure staff members are providing adequate follow-up information and explanations for "yes" responses on the Health History form.

- Ensure staff members are correctly documenting existing conditions, decay, restorations, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure X-rays and photographs are diagnostic and support the medical necessity for treatment provided.
- Ensure staff members are correctly labeling X-rays with the date of exposure and patient identification.
- Ensure staff members take appropriate diagnostic X-rays or photographs when indicated.
- Ensure staff members document rationale for X-rays taken outside of *FDA/ADA Guidelines*.
- Ensure staff members document the interpretation of all X-rays taken.
- Ensure staff members provide radiographic evidence and/or documentation to support the medical necessity for treatment provided.
- Ensure dentists are addressing all disease and pathology appropriately on the Treatment Plan.
- Ensure staff members provide documentation to support the rationale for placement of multi-surface fillings instead of SSCs.
- Ensure dentists follow the diagnosis and treatment criteria set forth by CSHM and *AAPD Guidelines* when performing pulpotomies.
- Ensure dentists employ proper techniques when performing pulpotomies and are adequately removing all pulp tissue.
- Ensure dentists understand indications of failed pulpotomies and document any pathology or findings related to pulpotomies on the Tooth Chart.
- Ensure staff members provide treatments within professionally recognized standards of care, with special emphasis on the quality of pulpotomies and SSCs.
- Ensure dentists are administering local anesthesia when indicated and performing an assessment to determine effectiveness of local anesthesia.
- Ensure consent for active stabilization is obtained.
- Ensure dentists are following the *Quality Assurance Protocols and Guidelines for Dental Centers for Whom CSHM Provides Management Services* with respect to stabilization and when to refer a patient to a specialist.
- Ensure dentists administer nitrous oxide/oxygen analgesia in accordance with *AAPD Guidelines,* including documentation of proper titration.
- Perform a root cause analysis of why patients are sitting in the operatory for extended time before being seen.
- Ensure the Account History Report and the patient's record accurately reflects all procedures performed.
- Ensure the billing error for patient #055 is corrected.

- Ensure staff members provide adequate information related to trauma and chief complaints.
- Ensure procedures performed by an EFDA are clearly documented on the Op Sheet.
- Ensure staff members are correctly completing the Op Sheet and properly documenting error corrections.

Treatment Observations, Findings, and Staff Interviews Related to Care

The treatment observation testing attributes were designed to determine whether care was performed in accordance with CSHM's policies and procedures, the *AAPD Guidelines*, and professionally recognized standards of care.

The on-site review included observations of treatments and interactions with patients, review of workspace, and review of dental records and interviews with dentists and selected staff. Observation of treatment and patient interactions included observation of treatment on nine patients. Eight of these patients received invasive dental treatment involving local anesthesia, four of whom also received nitrous oxide/oxygen analgesia. One patient who also received nitrous oxide/oxygen analgesia became so uncooperative that treatment was aborted before local anesthesia was administered. One patient was also observed receiving sealants by a dental assistant. The review of workspace included observation of activities in the dental hygiene and sterilization areas. Seven individuals were interviewed, including the Lead Dentist, two Staff Dentists, the Compliance Liaison, the Clinical Coordinator, a dental assistant, and a dental hygienist. The CIA, Section III.A.2, specifies the CDO is "responsible for developing and implementing policies and procedures that ensure that the services and items provided to patients by CSHM and CSHM facilities meet the professionally recognized standards of health care." Such language directs that possessing knowledge of and following these policies are not at the discretion of the Clinic dentists and staff. The Monitor interviewed the dentists about their familiarity with the recent Best Practice E-mails and Internal Memoranda that modify, clarify, and add to *Clinical Policies and Guidelines for CSHM Associated Clinics*.

- All dentists demonstrated a good-to-moderate level of familiarity with the CDO's Best Practice E-mails and Internal Memoranda.
- All individuals interviewed were able to accurately demonstrate knowledge of the recent changes in policy for the use of PSDs and generally supported the change.

The Monitor also had the following relevant findings:

- Dentists used appropriate techniques to administer local anesthesia for the procedures they were performing and demonstrated proper use of topical anesthetic.
- Dentists used good techniques to ameliorate the pain associated with the administration of local anesthesia, and patients tolerated the procedure well.

- Proper sized mouth props were used, and patients appeared comfortable.
- Maximum dose of local anesthesia was not consistently entered on the Op sheet prior to administering the agent.
- The number of dental assistants certified to monitor nitrous oxide analgesia may be impacting the use of the agent. Specifically, not all dental assistants are certified, and when the agent was used, it was sometimes necessary to reassign dental assistants to ensure a certified assistant was present in the room during the procedure. The Monitor observed this reassignment process and time delay it caused.
- One staff dentist reported she did not use nitrous oxide for patients with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) because she was informed by the Clinic Coordinator that it was contraindicated.
- Dentists demonstrated knowledge of the indications, technique, and criteria for success over time for pulpotomies in primary teeth.
- Gauze shields were used to protect the patients' airways during the fitting of SSCs.
- The Restorative Dentistry checklist was not consistently completed prior to beginning patient treatment.
- The Monitor observed an EFDA placing sealants using proper technique.
- The clinic is using a new product for fluoride varnish that is specifically intended for use as a fluoride varnish and can be dispensed in three doses, .25 ml; .4 ml; or .5 ml, depending on the patient's age and weight.

Recommendations

- Ensure the maximum dose of local anesthetic is calculated prior to administration of local anesthetic.
- Evaluate whether nitrous oxide is contraindicated for patients with a diagnosis of ADHD.
- Ensure the Restorative Dentistry checklist is completed prior to onset of patient care.

Exit Conference

The exit conference was held on May 18, 2012, at approximately 12:15 p.m. Present at the conference were the Monitor Team of [redacted], [redacted], CDA, RDH, [redacted], DDS, MS, and [redacted], DDS, MDS; [redacted] Chief Compliance Officer via telephone; Clinic staff member, [redacted], Office Manager and Compliance Liaison, and [redacted], Lead Dentist also attended. The preliminary findings discussed at the exit conference included the following:

- Records requested were timely copied and well organized. Specifically, the *Attestations* were in the compliance notebook attached to the applicable chart audit.
- All notices and posters were appropriately displayed and up to date.

- Staff members interviewed were knowledgeable of the translation service.
- Staff members interviewed were knowledgeable of the existence of the hotline and did not express reluctance in using it.
- The management in this Clinic has embraced compliance concepts as evidenced by supporting training and implementation of new policies, instituting their own chart audits and training on documentation, and creating fun and innovative ways to communicate policies.
- The Compliance Liaison demonstrated familiarity with the process for informing staff members of new and revised policies and procedures.
- The Policies and Procedure Manuals and Best Practices and White Papers Manual and Memos did not contain the required disclosures to check the intranet for the most recent version.
- Dentists and staff members were able to articulate the changes to the stabilization policy and generally supported the change.
- Dentists used appropriate techniques to administer local anesthesia for the procedures they were performing and demonstrated proper use of topical anesthetic.
- Dentists used good techniques to ameliorate the pain associated with the administration of local anesthesia and patients tolerated the procedure well.
- Restorative Dentistry checklists were not completed prior to beginning treatment.
- Proper sized mouth props were used and patients appeared comfortable.
- Maximum dose of local anesthesia was not consistently entered on the Op sheet prior to administering the agent.
- Dentists demonstrated knowledge of, and general acceptance of, the new patient stabilization policy.
- The number of dental assistants certified to monitor nitrous oxide analgesia may be impacting the use of the agent. Specifically, not all dental assistants are certified, and when the agent is used, it is sometimes necessary to reassign dental assistants to ensure a certified assistant is present in the room during the procedure. The Monitor observed this reassignment process and time delay it caused.
- The Monitor observed an EFDA placing sealants using proper technique.
- Dentists demonstrated knowledge of the indications, technique, and criteria for success over time for pulpotomies in primary teeth.

EXHIBIT 43

Procedure Code	Procedure Description	Pricing Indicator	Rate Type	Mod1	Mod2	Mod3	Mod4	Max Fee	Max Fee Eff. Date	Max Fee End Date	PA
00120	ANESTH EAR SURGERY	PRXOVR	DEF					NA	NA	NA	N
00120	ANESTH EAR SURGERY	ANESTH	DEF					NA	NA	NA	N
00124	ANESTH EAR EXAM	PRXOVR	DEF					NA	NA	NA	N
00124	ANESTH EAR EXAM	ANESTH	DEF					NA	NA	NA	N
00126	ANESTH TYMPANOTOMY	PRXOVR	DEF					NA	NA	NA	N
00126	ANESTH TYMPANOTOMY	ANESTH	DEF					NA	NA	NA	N
00140	ANESTH PROCEDURES ON EYE	PRXOVR	DEF					NA	NA	NA	N
00140	ANESTH PROCEDURES ON EYE	ANESTH	DEF					NA	NA	NA	N
00142	ANESTH LENS SURGERY	PRXOVR	DEF					NA	NA	NA	N
00142	ANESTH LENS SURGERY	ANESTH	DEF					NA	NA	NA	N
00144	ANESTH CORNEAL TRANSPLANT	PRXOVR	DEF					NA	NA	NA	N
00144	ANESTH CORNEAL TRANSPLANT	ANESTH	DEF					NA	NA	NA	N
00145	ANESTH VITREORETINAL SURG	PRXOVR	DEF					NA	NA	NA	N
00145	ANESTH VITREORETINAL SURG	ANESTH	DEF					NA	NA	NA	N
00147	ANESTH IRIDECTOMY	PRXOVR	DEF					NA	NA	NA	N
00147	ANESTH IRIDECTOMY	ANESTH	DEF					NA	NA	NA	N
00148	ANESTH EYE EXAM	PRXOVR	DEF					NA	NA	NA	N
00148	ANESTH EYE EXAM	ANESTH	DEF					NA	NA	NA	N
00160	ANESTH NOSE/SINUS SURGERY	PRXOVR	DEF					NA	NA	NA	N
00160	ANESTH NOSE/SINUS SURGERY	ANESTH	DEF					NA	NA	NA	N
00162	ANESTH NOSE/SINUS SURGERY	PRXOVR	DEF					NA	NA	NA	N
00162	ANESTH NOSE/SINUS SURGERY	ANESTH	DEF					NA	NA	NA	N

00164	ANESTH BIOPSY OF NOSE	PRXOVR	DEF					NA	NA	NA	N
00164	ANESTH BIOPSY OF NOSE	ANESTH	DEF					NA	NA	NA	N
00170	ANESTH PROCEDURE ON MOUTH	PRXOVR	DEF					NA	NA	NA	N
00170	ANESTH PROCEDURE ON MOUTH	ANESTH	DEF					NA	NA	NA	N
00172	ANESTH CLEFT PALATE REPAIR	PRXOVR	DEF					NA	NA	NA	N
00172	ANESTH CLEFT PALATE REPAIR	ANESTH	DEF					NA	NA	NA	N
00174	ANESTH PHARYNGEAL SURGERY	PRXOVR	DEF					NA	NA	NA	N
00174	ANESTH PHARYNGEAL SURGERY	ANESTH	DEF					NA	NA	NA	N
00176	ANESTH PHARYNGEAL SURGERY	PRXOVR	DEF					NA	NA	NA	N
00176	ANESTH PHARYNGEAL SURGERY	ANESTH	DEF					NA	NA	NA	N
00190	ANESTH FACE/SKULL BONE SURG	PRXOVR	DEF					NA	NA	NA	N
00190	ANESTH FACE/SKULL BONE SURG	ANESTH	DEF					NA	NA	NA	N
00192	ANESTH FACIAL BONE SURGERY	PRXOVR	DEF					NA	NA	NA	N
00192	ANESTH FACIAL BONE SURGERY	ANESTH	DEF					NA	NA	NA	N
00210	ANESTH CRANIAL SURG NOS	PRXOVR	DEF					NA	NA	NA	N
00210	ANESTH CRANIAL SURG NOS	ANESTH	DEF					NA	NA	NA	N
00211	ANESTH CRAN SURG HEMOTOMA	PRXOVR	DEF					NA	NA	NA	N
00211	ANESTH CRAN SURG HEMOTOMA	ANESTH	DEF					NA	NA	NA	N
00212	ANESTH SKULL DRAINAGE	PRXOVR	DEF					NA	NA	NA	N
00212	ANESTH SKULL DRAINAGE	ANESTH	DEF					NA	NA	NA	N

00214	ANESTH SKULL DRAINAGE	PRXOVR	DEF					NA	NA	NA	N
00214	ANESTH SKULL DRAINAGE	ANESTH	DEF					NA	NA	NA	N
00215	ANESTH SKULL REPAIR/FRACT	PRXOVR	DEF					NA	NA	NA	N
00215	ANESTH SKULL REPAIR/FRACT	ANESTH	DEF					NA	NA	NA	N
00216	ANESTH HEAD VESSEL SURGERY	PRXOVR	DEF					NA	NA	NA	N
00216	ANESTH HEAD VESSEL SURGERY	ANESTH	DEF					NA	NA	NA	N
00218	ANESTH SPECIAL HEAD SURGERY	PRXOVR	DEF					NA	NA	NA	N
00218	ANESTH SPECIAL HEAD SURGERY	ANESTH	DEF					NA	NA	NA	N
00220	ANESTH INTRCRN NERVE	PRXOVR	DEF					NA	NA	NA	N
00220	ANESTH INTRCRN NERVE	ANESTH	DEF					NA	NA	NA	N
00222	ANESTH HEAD NERVE SURGERY	PRXOVR	DEF					NA	NA	NA	N
00222	ANESTH HEAD NERVE SURGERY	ANESTH	DEF					NA	NA	NA	N
00300	ANESTH HEAD/NECK/PTRUNK	PRXOVR	DEF					NA	NA	NA	N
00300	ANESTH HEAD/NECK/PTRUNK	ANESTH	DEF					NA	NA	NA	N
00320	ANESTH NECK ORGAN 1YR/>	PRXOVR	DEF					NA	NA	NA	N
00320	ANESTH NECK ORGAN 1YR/>	ANESTH	DEF					NA	NA	NA	N
10021	FNA W/O IMAGE	PRXOVR	DEF					NA	NA	NA	N
10021	FNA W/O IMAGE	MAXFEE	DEF					73.55	7/1/2008	12/31/2299	N
10022	FNA W/IMAGE	PRXOVR	DEF					NA	NA	NA	N
10022	FNA W/IMAGE	MAXFEE	DEF					57.36	1/1/2010	12/31/2299	N
10040	ACNE SURGERY	PRXOVR	DEF					NA	NA	NA	N
10040	ACNE SURGERY	MAXFEE	DEF					62.13	1/1/2004	12/31/2299	N
10060	DRAINAGE OF SKIN ABSCESS	PRXOVR	DEF					NA	NA	NA	N
10060	DRAINAGE OF SKIN ABSCESS	MAXFEE	DEF					72.81	1/1/2004	12/31/2299	N

10061	DRAINAGE OF SKIN ABSCESS	PRXOVR	DEF					NA	NA	NA	N
10061	DRAINAGE OF SKIN ABSCESS	MAXFEE	DEF					87.31	7/1/2008	12/31/2299	N
10080	DRAINAGE OF PILONIDAL CYST	PRXOVR	DEF					NA	NA	NA	N
10080	DRAINAGE OF PILONIDAL CYST	MAXFEE	DEF					76.13	1/1/2010	12/31/2299	N
10081	DRAINAGE OF PILONIDAL CYST	PRXOVR	DEF					NA	NA	NA	N
10081	DRAINAGE OF PILONIDAL CYST	MAXFEE	DEF					103.02	1/1/2000	12/31/2299	N
10120	REMOVE FOREIGN BODY	PRXOVR	DEF					NA	NA	NA	N
10120	REMOVE FOREIGN BODY	MAXFEE	DEF					50.40	1/1/2000	12/31/2299	N
10121	REMOVE FOREIGN BODY	PRXOVR	DEF					NA	NA	NA	N
10121	REMOVE FOREIGN BODY	MAXFEE	DEF					106.80	1/1/2004	12/31/2299	N
10140	DRAINAGE OF HEMATOMA/FLUID	PRXOVR	DEF					NA	NA	NA	N
10140	DRAINAGE OF HEMATOMA/FLUID	MAXFEE	DEF					84.47	1/1/2004	12/31/2299	N
10160	PUNCTURE DRAINAGE OF LESION	PRXOVR	DEF					NA	NA	NA	N
10160	PUNCTURE DRAINAGE OF LESION	MAXFEE	DEF					55.67	1/1/2004	12/31/2299	N
10180	COMPLEX DRAINAGE WOUND	PRXOVR	DEF					NA	NA	NA	N
10180	COMPLEX DRAINAGE WOUND	MAXFEE	DEF					95.23	7/1/2008	12/31/2299	N
11000	DEBRIDE INFECTED SKIN	PRXOVR	DEF					NA	NA	NA	N
11000	DEBRIDE INFECTED SKIN	MAXFEE	DEF					34.34	1/1/2004	12/31/2299	N
11001	DEBRIDE INFECTED SKIN ADD-ON	PRXOVR	DEF					NA	NA	NA	N
11001	DEBRIDE INFECTED SKIN ADD-ON	MAXFEE	DEF					15.02	1/1/2000	12/31/2299	N
11004	DEBRIDE GENITALIA & PERINEUM	PRXOVR	DEF					NA	NA	NA	N

11004	DEBRIDE GENITALIA & PERINEUM	MAXFEE	DEF					415.55	1/1/2005	12/31/2299	N
11005	DEBRIDE ABDOM WALL	PRXOVR	DEF					NA	NA	NA	N
11005	DEBRIDE ABDOM WALL	MAXFEE	DEF					565.62	1/1/2005	12/31/2299	N
11006	DEBRIDE GENIT/PER/ABDOM WALL	PRXOVR	DEF					NA	NA	NA	N
11006	DEBRIDE GENIT/PER/ABDOM WALL	MAXFEE	DEF					523.27	1/1/2005	12/31/2299	N
11008	REMOVE MESH FROM ABD WALL	PRXOVR	DEF					NA	NA	NA	N
11008	REMOVE MESH FROM ABD WALL	MAXFEE	DEF					212.89	1/1/2005	12/31/2299	N
11010	DEBRIDE SKIN AT FX SITE	PRXOVR	DEF					NA	NA	NA	N
11010	DEBRIDE SKIN AT FX SITE	MAXFEE	DEF					214.12	1/1/2004	12/31/2299	N
11011	DEBRIDE SKIN MUSC AT FX SITE	PRXOVR	DEF					NA	NA	NA	N
11011	DEBRIDE SKIN MUSC AT FX SITE	MAXFEE	DEF					256.44	1/1/2010	12/31/2299	N
11012	DEB SKIN BONE AT FX SITE	PRXOVR	DEF					NA	NA	NA	N
11012	DEB SKIN BONE AT FX SITE	MAXFEE	DEF					360.03	1/1/2004	12/31/2299	N
11040	DEBRIDE SKIN; PARTIAL	PRXOVR	DEF					NA	NA	NA	N
11040	DEBRIDE SKIN; PARTIAL	MAXFEE	DEF					NA			N
11041	DEBRIDE SKIN; FULL	PRXOVR	DEF					NA	NA	NA	N
11041	DEBRIDE SKIN; FULL	MAXFEE	DEF					NA			N
11042	DEB SUBQ TISSUE 20 SQ CM/<	PRXOVR	DEF					NA	NA	NA	N
11042	DEB SUBQ TISSUE 20 SQ CM/<	MAXFEE	DEF					40.19	1/1/2010	12/31/2299	N
11043	DEB MUSC/FASCIA 20 SQ CM/<	PRXOVR	DEF					NA	NA	NA	N
11043	DEB MUSC/FASCIA 20 SQ CM/<	MAXFEE	DEF					124.70	7/1/2008	12/31/2299	N
11044	DEB BONE 20 SQ CM/<	PRXOVR	DEF					NA	NA	NA	N
11044	DEB BONE 20 SQ CM/<	MAXFEE	DEF					172.73	7/1/2008	12/31/2299	N
11045	DEB SUBQ TISSUE ADD-ON	PRXOVR	DEF					NA	NA	NA	N
11045	DEB SUBQ TISSUE ADD-ON	MAXFEE	DEF					15.55	1/1/2011	12/31/2299	N

11046	DEB MUSC/FASCIA ADD-ON	PRXOVR	DEF					NA	NA	NA	N
11046	DEB MUSC/FASCIA ADD-ON	MAXFEE	DEF					27.23	1/1/2011	12/31/2299	N
11047	DEB BONE ADD-ON	PRXOVR	DEF					NA	NA	NA	N
11047	DEB BONE ADD-ON	MAXFEE	DEF					44.83	1/1/2011	12/31/2299	N
11055	TRIM SKIN LESION	PRXOVR	DEF					NA	NA	NA	N
11055	TRIM SKIN LESION	MAXFEE	DEF					23.34	7/1/2008	12/31/2299	N
11056	TRIM SKIN LESIONS 2 TO 4	PRXOVR	DEF					NA	NA	NA	N
11056	TRIM SKIN LESIONS 2 TO 4	MAXFEE	DEF					28.90	7/1/2008	12/31/2299	N
11057	TRIM SKIN LESIONS OVER 4	PRXOVR	DEF					NA	NA	NA	N
11057	TRIM SKIN LESIONS OVER 4	MAXFEE	DEF					35.53	7/1/2008	12/31/2299	N
11100	BIOPSY SKIN LESION	PRXOVR	DEF					NA	NA	NA	N
11100	BIOPSY SKIN LESION	MAXFEE	DEF					47.20	7/1/2008	12/31/2299	N
11101	BIOPSY SKIN ADD-ON	PRXOVR	DEF					NA	NA	NA	N
11101	BIOPSY SKIN ADD-ON	MAXFEE	DEF					20.18	1/1/2000	12/31/2299	N
11200	REMOVAL OF SKIN TAGS <W/15	PRXOVR	DEF					NA	NA	NA	N
11200	REMOVAL OF SKIN TAGS <W/15	MAXFEE	DEF					54.08	1/1/2004	12/31/2299	N
11201	REMOVE SKIN TAGS ADD-ON	PRXOVR	DEF					NA	NA	NA	N
11201	REMOVE SKIN TAGS ADD-ON	MAXFEE	DEF					13.28	4/1/2008	12/31/2299	N
11300	SHAVE SKIN LESION 0.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
11300	SHAVE SKIN LESION 0.5 CM/<	MAXFEE	DEF					40.48	1/1/2004	12/31/2299	N
11301	SHAVE SKIN LESION 0.6-1.0 CM	PRXOVR	DEF					NA	NA	NA	N
11301	SHAVE SKIN LESION 0.6-1.0 CM	MAXFEE	DEF					43.85	7/1/2008	12/31/2299	N
11302	SHAVE SKIN LESION 1.1-2.0 CM	PRXOVR	DEF					NA	NA	NA	N
11302	SHAVE SKIN LESION 1.1-2.0 CM	MAXFEE	DEF					53.13	1/1/2000	12/31/2299	N
11303	SHAVE SKIN LESION >2.0 CM	PRXOVR	DEF					NA	NA	NA	N
11303	SHAVE SKIN LESION >2.0 CM	MAXFEE	DEF					69.80	1/1/2000	12/31/2299	N
11305	SHAVE SKIN LESION 0.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
11305	SHAVE SKIN LESION 0.5 CM/<	MAXFEE	DEF					41.20	1/1/2004	12/31/2299	N
11306	SHAVE SKIN LESION 0.6-1.0 CM	PRXOVR	DEF					NA	NA	NA	N

11306	SHAVE SKIN LESION 0.6-1.0 CM	MAXFEE	DEF					46.86	1/1/2000	12/31/2299	N
11307	SHAVE SKIN LESION 1.1-2.0 CM	PRXOVR	DEF					NA	NA	NA	N
11307	SHAVE SKIN LESION 1.1-2.0 CM	MAXFEE	DEF					56.65	1/1/2000	12/31/2299	N
11308	SHAVE SKIN LESION >2.0 CM	PRXOVR	DEF					NA	NA	NA	N
11308	SHAVE SKIN LESION >2.0 CM	MAXFEE	DEF					74.85	1/1/2000	12/31/2299	N
11310	SHAVE SKIN LESION 0.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
11310	SHAVE SKIN LESION 0.5 CM/<	MAXFEE	DEF					49.86	1/1/2004	12/31/2299	N
11311	SHAVE SKIN LESION 0.6-1.0 CM	PRXOVR	DEF					NA	NA	NA	N
11311	SHAVE SKIN LESION 0.6-1.0 CM	MAXFEE	DEF					51.99	1/1/2000	12/31/2299	N
11312	SHAVE SKIN LESION 1.1-2.0 CM	PRXOVR	DEF					NA	NA	NA	N
11312	SHAVE SKIN LESION 1.1-2.0 CM	MAXFEE	DEF					62.63	1/1/2000	12/31/2299	N
11313	SHAVE SKIN LESION >2.0 CM	PRXOVR	DEF					NA	NA	NA	N
11313	SHAVE SKIN LESION >2.0 CM	MAXFEE	DEF					83.17	1/1/2000	12/31/2299	N
11400	EXC TR-EXT B9+MARG 0.5 CM<	PRXOVR	DEF					NA	NA	NA	N
11400	EXC TR-EXT B9+MARG 0.5 CM<	MAXFEE	DEF					60.67	7/1/2008	12/31/2299	N
11401	EXC TR-EXT B9+MARG 0.6-1 CM	PRXOVR	DEF					NA	NA	NA	N
11401	EXC TR-EXT B9+MARG 0.6-1 CM	MAXFEE	DEF					71.83	7/1/2008	12/31/2299	N
11402	EXC TR-EXT B9+MARG 1.1-2 CM	PRXOVR	DEF					NA	NA	NA	N
11402	EXC TR-EXT B9+MARG 1.1-2 CM	MAXFEE	DEF					79.94	7/1/2008	12/31/2299	N
11403	EXC TR-EXT B9+MARG 2.1-3CM/<	PRXOVR	DEF					NA	NA	NA	N
11403	EXC TR-EXT B9+MARG 2.1-3CM/<	MAXFEE	DEF					87.35	4/1/2008	12/31/2299	N
11404	EXC TR-EXT B9+MARG 3.1-4 CM	PRXOVR	DEF					NA	NA	NA	N
11404	EXC TR-EXT B9+MARG 3.1-4 CM	MAXFEE	DEF					100.48	1/1/2000	12/31/2299	N

11406	EXC TR-EXT B9+MARG >4.0 CM	PRXOVR	DEF					NA	NA	NA	N
11406	EXC TR-EXT B9+MARG >4.0 CM	MAXFEE	DEF					132.81	1/1/2000	12/31/2299	N
11420	EXC H-F-NK-SP B9+MARG 0.5/<	PRXOVR	DEF					NA	NA	NA	N
11420	EXC H-F-NK-SP B9+MARG 0.5/<	MAXFEE	DEF					60.23	7/1/2008	12/31/2299	N
11421	EXC H-F-NK-SP B9+MARG 0.6-1	PRXOVR	DEF					NA	NA	NA	N
11421	EXC H-F-NK-SP B9+MARG 0.6-1	MAXFEE	DEF					77	7/1/2008	12/31/2299	N
11422	EXC H-F-NK-SP B9+MARG 1.1-2	PRXOVR	DEF					NA	NA	NA	N
11422	EXC H-F-NK-SP B9+MARG 1.1-2	MAXFEE	DEF					79.42	4/1/2008	12/31/2299	N
11423	EXC H-F-NK-SP B9+MARG 2.1-3	PRXOVR	DEF					NA	NA	NA	N
11423	EXC H-F-NK-SP B9+MARG 2.1-3	MAXFEE	DEF					97.96	4/1/2008	12/31/2299	N
11424	EXC H-F-NK-SP B9+MARG 3.1-4	PRXOVR	DEF					NA	NA	NA	N
11424	EXC H-F-NK-SP B9+MARG 3.1-4	MAXFEE	DEF					112.42	1/1/2000	12/31/2299	N
11426	EXC H-F-NK-SP B9+MARG >4 CM	PRXOVR	DEF					NA	NA	NA	N
11426	EXC H-F-NK-SP B9+MARG >4 CM	MAXFEE	DEF					160.11	1/1/2000	12/31/2299	N
11440	EXC FACE-MM B9+MARG 0.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
11440	EXC FACE-MM B9+MARG 0.5 CM/<	MAXFEE	DEF					68.33	7/1/2008	12/31/2299	N
11441	EXC FACE-MM B9+MARG 0.6-1 CM	PRXOVR	DEF					NA	NA	NA	N
11441	EXC FACE-MM B9+MARG 0.6-1 CM	MAXFEE	DEF					83.44	7/1/2008	12/31/2299	N
11442	EXC FACE-MM B9+MARG 1.1-2 CM	PRXOVR	DEF					NA	NA	NA	N
11442	EXC FACE-MM B9+MARG 1.1-2 CM	MAXFEE	DEF					87.37	4/1/2008	12/31/2299	N
11443	EXC FACE-MM B9+MARG 2.1-3 CM	PRXOVR	DEF					NA	NA	NA	N

11443	EXC FACE-MM B9+MARG 2.1-3 CM	MAXFEE	DEF					113.37	4/1/2008	12/31/2299	N
11444	EXC FACE-MM B9+MARG 3.1-4 CM	PRXOVR	DEF					NA	NA	NA	N
11444	EXC FACE-MM B9+MARG 3.1-4 CM	MAXFEE	DEF					137.81	1/1/2000	12/31/2299	N
11446	EXC FACE-MM B9+MARG >4 CM	PRXOVR	DEF					NA	NA	NA	N
11446	EXC FACE-MM B9+MARG >4 CM	MAXFEE	DEF					177.67	1/1/2000	12/31/2299	N
11450	REMOVAL SWEAT GLAND LESION	PRXOVR	DEF					NA	NA	NA	N
11450	REMOVAL SWEAT GLAND LESION	MAXFEE	DEF					154.33	1/1/2000	12/31/2299	N
11451	REMOVAL SWEAT GLAND LESION	PRXOVR	DEF					NA	NA	NA	N
11451	REMOVAL SWEAT GLAND LESION	MAXFEE	DEF					194.12	1/1/2000	12/31/2299	N
11462	REMOVAL SWEAT GLAND LESION	PRXOVR	DEF					NA	NA	NA	N
11462	REMOVAL SWEAT GLAND LESION	MAXFEE	DEF					140.31	1/1/2000	12/31/2299	N
11463	REMOVAL SWEAT GLAND LESION	PRXOVR	DEF					NA	NA	NA	N
11463	REMOVAL SWEAT GLAND LESION	MAXFEE	DEF					177.54	1/1/2000	12/31/2299	N
11470	REMOVAL SWEAT GLAND LESION	PRXOVR	DEF					NA	NA	NA	N
11470	REMOVAL SWEAT GLAND LESION	MAXFEE	DEF					174.01	1/1/2000	12/31/2299	N
11471	REMOVAL SWEAT GLAND LESION	PRXOVR	DEF					NA	NA	NA	N
11471	REMOVAL SWEAT GLAND LESION	MAXFEE	DEF					202.63	1/1/2000	12/31/2299	N

11600	EXC TR-EXT MAL+MARG 0.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
11600	EXC TR-EXT MAL+MARG 0.5 CM/<	MAXFEE	DEF					88.69	1/1/2010	12/31/2299	N
11601	EXC TR-EXT MAL+MARG 0.6-1 CM	PRXOVR	DEF					NA	NA	NA	N
11601	EXC TR-EXT MAL+MARG 0.6-1 CM	MAXFEE	DEF					105.38	7/1/2008	12/31/2299	N
11602	EXC TR-EXT MAL+MARG 1.1-2 CM	PRXOVR	DEF					NA	NA	NA	N
11602	EXC TR-EXT MAL+MARG 1.1-2 CM	MAXFEE	DEF					113.51	7/1/2008	12/31/2299	N
11603	EXC TR-EXT MAL+MARG 2.1-3 CM	PRXOVR	DEF					NA	NA	NA	N
11603	EXC TR-EXT MAL+MARG 2.1-3 CM	MAXFEE	DEF					130.62	7/1/2008	12/31/2299	N
11604	EXC TR-EXT MAL+MARG 3.1-4 CM	PRXOVR	DEF					NA	NA	NA	N
11604	EXC TR-EXT MAL+MARG 3.1-4 CM	MAXFEE	DEF					137.37	1/1/2000	12/31/2299	N
11606	EXC TR-EXT MAL+MARG >4 CM	PRXOVR	DEF					NA	NA	NA	N
11606	EXC TR-EXT MAL+MARG >4 CM	MAXFEE	DEF					179.86	1/1/2000	12/31/2299	N
11620	EXC H-F-NK-SP MAL+MARG 0.5/<	PRXOVR	DEF					NA	NA	NA	N
11620	EXC H-F-NK-SP MAL+MARG 0.5/<	MAXFEE	DEF					89.81	1/1/2010	12/31/2299	N
11621	EXC S/N/H/F/G MAL+MRG 0.6-1	PRXOVR	DEF					NA	NA	NA	N
11621	EXC S/N/H/F/G MAL+MRG 0.6-1	MAXFEE	DEF					105.82	7/1/2008	12/31/2299	N
11622	EXC S/N/H/F/G MAL+MRG 1.1-2	PRXOVR	DEF					NA	NA	NA	N
11622	EXC S/N/H/F/G MAL+MRG 1.1-2	MAXFEE	DEF					123.12	4/1/2008	12/31/2299	N
11623	EXC S/N/H/F/G MAL+MRG 2.1-3	PRXOVR	DEF					NA	NA	NA	N
11623	EXC S/N/H/F/G MAL+MRG 2.1-3	MAXFEE	DEF					147.13	4/1/2008	12/31/2299	N

11624	EXC S/N/H/F/G MAL+MRG 3.1-4	PRXOVR	DEF					NA	NA	NA	N
11624	EXC S/N/H/F/G MAL+MRG 3.1-4	MAXFEE	DEF					175.74	1/1/2000	12/31/2299	N
11626	EXC S/N/H/F/G MAL+MRG >4 CM	PRXOVR	DEF					NA	NA	NA	N
11626	EXC S/N/H/F/G MAL+MRG >4 CM	MAXFEE	DEF					211.54	1/1/2000	12/31/2299	N
11640	EXC F/E/E/N/L MAL+MRG 0.5CM<	PRXOVR	DEF					NA	NA	NA	N
11640	EXC F/E/E/N/L MAL+MRG 0.5CM<	MAXFEE	DEF					94	7/1/2008	12/31/2299	N
11641	EXC F/E/E/N/L MAL+MRG 0.6-1	PRXOVR	DEF					NA	NA	NA	N
11641	EXC F/E/E/N/L MAL+MRG 0.6-1	MAXFEE	DEF					123.83	4/1/2008	12/31/2299	N
11642	EXC F/E/E/N/L MAL+MRG 1.1-2	PRXOVR	DEF					NA	NA	NA	N
11642	EXC F/E/E/N/L MAL+MRG 1.1-2	MAXFEE	DEF					146.94	4/1/2008	12/31/2299	N
11643	EXC F/E/E/N/L MAL+MRG 2.1-3	PRXOVR	DEF					NA	NA	NA	N
11643	EXC F/E/E/N/L MAL+MRG 2.1-3	MAXFEE	DEF					173.46	4/1/2008	12/31/2299	N
11644	EXC F/E/E/N/L MAL+MRG 3.1-4	PRXOVR	DEF					NA	NA	NA	N
11644	EXC F/E/E/N/L MAL+MRG 3.1-4	MAXFEE	DEF					215.29	1/1/2000	12/31/2299	N
11646	EXC F/E/E/N/L MAL+MRG >4 CM	PRXOVR	DEF					NA	NA	NA	N
11646	EXC F/E/E/N/L MAL+MRG >4 CM	MAXFEE	DEF					280.33	1/1/2000	12/31/2299	N
11720	DEBRIDE NAIL 1-5	PRXOVR	DEF					NA	NA	NA	N
11720	DEBRIDE NAIL 1-5	MAXFEE	DEF					14.69	1/1/2010	12/31/2299	N
11721	DEBRIDE NAIL 6 OR MORE	PRXOVR	DEF					NA	NA	NA	N
11721	DEBRIDE NAIL 6 OR MORE	MAXFEE	DEF					28.86	1/1/2000	12/31/2299	N
11730	REMOVAL OF NAIL PLATE	PRXOVR	DEF					NA	NA	NA	N
11730	REMOVAL OF NAIL PLATE	MAXFEE	DEF					49.14	7/1/2008	12/31/2299	N
11732	REMOVE NAIL PLATE ADD-ON	PRXOVR	DEF					NA	NA	NA	N
11732	REMOVE NAIL PLATE ADD-ON	MAXFEE	DEF					23.11	7/1/2008	12/31/2299	N
11740	DRAIN BLOOD FROM UNDER NAIL	PRXOVR	DEF					NA	NA	NA	N

11740	DRAIN BLOOD FROM UNDER NAIL	MAXFEE	DEF					21.69	1/1/2000	12/31/2299	N
11750	REMOVAL OF NAIL BED	PRXOVR	DEF					NA	NA	NA	N
11750	REMOVAL OF NAIL BED	MAXFEE	DEF					104.25	7/1/2008	12/31/2299	N
11752	REMOVE NAIL BED/FINGER TIP	PRXOVR	DEF					NA	NA	NA	N
11752	REMOVE NAIL BED/FINGER TIP	MAXFEE	DEF					148.47	7/1/2008	12/31/2299	N
11755	BIOPSY NAIL UNIT	PRXOVR	DEF					NA	NA	NA	N
11755	BIOPSY NAIL UNIT	MAXFEE	DEF					65.78	7/1/2008	12/31/2299	N
11760	REPAIR OF NAIL BED	PRXOVR	DEF					NA	NA	NA	N
11760	REPAIR OF NAIL BED	MAXFEE	DEF					73.43	7/1/2008	12/31/2299	N
11762	RECONSTRUCTION OF NAIL BED	PRXOVR	DEF					NA	NA	NA	N
11762	RECONSTRUCTION OF NAIL BED	MAXFEE	DEF					142.15	1/1/2000	12/31/2299	N
11765	EXCISION OF NAIL FOLD TOE	PRXOVR	DEF					NA	NA	NA	N
11765	EXCISION OF NAIL FOLD TOE	MAXFEE	DEF					34.26	1/1/2000	12/31/2299	N
11770	REMOVE PILONIDAL CYST SIMPLE	PRXOVR	DEF					NA	NA	NA	N
11770	REMOVE PILONIDAL CYST SIMPLE	MAXFEE	DEF					144.57	1/1/2000	12/31/2299	N
11771	REMOVE PILONIDAL CYST EXTEN	PRXOVR	DEF					NA	NA	NA	N
11771	REMOVE PILONIDAL CYST EXTEN	MAXFEE	DEF					286.73	1/1/2000	12/31/2299	N
11772	REMOVE PILONIDAL CYST COMPL	PRXOVR	DEF					NA	NA	NA	N
11772	REMOVE PILONIDAL CYST COMPL	MAXFEE	DEF					331.49	1/1/2000	12/31/2299	N
11900	INJECT SKIN LESIONS </W 7	PRXOVR	DEF					NA	NA	NA	N
11900	INJECT SKIN LESIONS </W 7	MAXFEE	DEF					34.24	1/1/2004	12/31/2299	N
11901	INJECT SKIN LESIONS >7	PRXOVR	DEF					NA	NA	NA	N

11901	INJECT SKIN LESIONS >7	MAXFEE	DEF					41.35	1/1/2004	12/31/2299	N
11950	TX CONTOUR DEFECTS 1 CC/<	PRXOVR	DEF					NA	NA	NA	N
11950	TX CONTOUR DEFECTS 1 CC/<	MAXFEE	DEF					44.44	7/1/2008	12/31/2299	N
11951	TX CONTOUR DEFECTS 1.1-5.0CC	PRXOVR	DEF					NA	NA	NA	N
11951	TX CONTOUR DEFECTS 1.1-5.0CC	MAXFEE	DEF					62.96	7/1/2008	12/31/2299	N
11952	TX CONTOUR DEFECTS 5.1-10CC	PRXOVR	DEF					NA	NA	NA	N
11952	TX CONTOUR DEFECTS 5.1-10CC	MAXFEE	DEF					88.91	7/1/2008	12/31/2299	N
11954	TX CONTOUR DEFECTS >10.0 CC	PRXOVR	DEF					NA	NA	NA	N
11954	TX CONTOUR DEFECTS >10.0 CC	MAXFEE	DEF					115.45	7/1/2003	12/31/2299	N
11960	INSERT TISSUE EXPANDER(S)	PRXOVR	DEF					NA	NA	NA	N
11960	INSERT TISSUE EXPANDER(S)	MAXFEE	DEF					522.51	7/1/2003	12/31/2299	N
11971	REMOVE TISSUE EXPANDER(S)	PRXOVR	DEF					NA	NA	NA	N
11971	REMOVE TISSUE EXPANDER(S)	MAXFEE	DEF					154.89	7/1/2008	12/31/2299	N
11975	INSERT CONTRACEPTIVE CAP	PRXOVR	DEF					NA	NA	NA	N
11975	INSERT CONTRACEPTIVE CAP	MAXFEE	DEF					NA			N
11976	REMOVE CONTRACEPTIVE CAPSULE	PRXOVR	DEF					NA	NA	NA	N
11976	REMOVE CONTRACEPTIVE CAPSULE	MAXFEE	DEF					86.83	1/1/2000	12/31/2299	N
11977	REMOVAL/REINSERT CONTRA CAP	PRXOVR	DEF					NA	NA	NA	N
11977	REMOVAL/REINSERT CONTRA CAP	MAXFEE	DEF					NA			N
11980	IMPLANT HORMONE PELLET(S)	PRXOVR	DEF					NA	NA	NA	N

11980	IMPLANT HORMONE PELLET(S)	MAXFEE	DEF					81.56	1/1/2000	12/31/2299	N
11981	INSERT DRUG IMPLANT DEVICE	PRXOVR	DEF					NA	NA	NA	N
11981	INSERT DRUG IMPLANT DEVICE	MAXFEE	DEF					71.80	1/1/2010	12/31/2299	N
11982	REMOVE DRUG IMPLANT DEVICE	PRXOVR	DEF					NA	NA	NA	N
11982	REMOVE DRUG IMPLANT DEVICE	MAXFEE	DEF					88.05	1/1/2010	12/31/2299	N
11983	REMOVE/INSERT DRUG IMPLANT	PRXOVR	DEF					NA	NA	NA	N
11983	REMOVE/INSERT DRUG IMPLANT	MAXFEE	DEF					155.84	1/1/2002	12/31/2299	N
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<	PRXOVR	DEF					NA	NA	NA	N
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<	MAXFEE	DEF					67.35	1/1/2000	12/31/2299	N
12002	RPR S/N/AX/GEN/TRNK2.6-7.5CM	PRXOVR	DEF					NA	NA	NA	N
12002	RPR S/N/AX/GEN/TRNK2.6-7.5CM	MAXFEE	DEF					77.98	1/1/2000	12/31/2299	N
12004	RPR S/N/AX/GEN/TRK7.6-12.5CM	PRXOVR	DEF					NA	NA	NA	N
12004	RPR S/N/AX/GEN/TRK7.6-12.5CM	MAXFEE	DEF					96.45	1/1/2000	12/31/2299	N
12005	RPR S/N/A/GEN/TRK12.6-20.0CM	PRXOVR	DEF					NA	NA	NA	N
12005	RPR S/N/A/GEN/TRK12.6-20.0CM	MAXFEE	DEF					122.20	1/1/2000	12/31/2299	N
12006	RPR S/N/A/GEN/TRK20.1-30.0CM	PRXOVR	DEF					NA	NA	NA	N
12006	RPR S/N/A/GEN/TRK20.1-30.0CM	MAXFEE	DEF					156.01	1/1/2000	12/31/2299	N

12007	RPR S/N/AX/GEN/TRNK >30.0 CM	PRXOVR	DEF					NA	NA	NA	N
12007	RPR S/N/AX/GEN/TRNK >30.0 CM	MAXFEE	DEF					170.61	1/1/2000	12/31/2299	N
12011	RPR F/E/E/N/L/M 2.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
12011	RPR F/E/E/N/L/M 2.5 CM/<	MAXFEE	DEF					74.24	1/1/2000	12/31/2299	N
12013	RPR F/E/E/N/L/M 2.6-5.0 CM	PRXOVR	DEF					NA	NA	NA	N
12013	RPR F/E/E/N/L/M 2.6-5.0 CM	MAXFEE	DEF					87.06	1/1/2000	12/31/2299	N
12014	RPR F/E/E/N/L/M 5.1-7.5 CM	PRXOVR	DEF					NA	NA	NA	N
12014	RPR F/E/E/N/L/M 5.1-7.5 CM	MAXFEE	DEF					104.63	1/1/2000	12/31/2299	N
12015	RPR F/E/E/N/L/M 7.6-12.5 CM	PRXOVR	DEF					NA	NA	NA	N
12015	RPR F/E/E/N/L/M 7.6-12.5 CM	MAXFEE	DEF					135.24	1/1/2000	12/31/2299	N
12016	RPR FE/E/EN/L/M 12.6-20.0 CM	PRXOVR	DEF					NA	NA	NA	N
12016	RPR FE/E/EN/L/M 12.6-20.0 CM	MAXFEE	DEF					169.44	1/1/2000	12/31/2299	N
12017	RPR FE/E/EN/L/M 20.1-30.0 CM	PRXOVR	DEF					NA	NA	NA	N
12017	RPR FE/E/EN/L/M 20.1-30.0 CM	MAXFEE	DEF					175.17	1/1/2012	12/31/2299	N
12018	RPR F/E/E/N/L/M >30.0 CM	PRXOVR	DEF					NA	NA	NA	N
12018	RPR F/E/E/N/L/M >30.0 CM	MAXFEE	DEF					207.15	1/1/2012	12/31/2299	N
12020	CLOSURE OF SPLIT WOUND	PRXOVR	DEF					NA	NA	NA	N
12020	CLOSURE OF SPLIT WOUND	MAXFEE	DEF					109.03	1/1/2000	12/31/2299	N
12021	CLOSURE OF SPLIT WOUND	PRXOVR	DEF					NA	NA	NA	N
12021	CLOSURE OF SPLIT WOUND	MAXFEE	DEF					82.08	7/1/2008	12/31/2299	N
12031	INTMD RPR S/A/T/EXT 2.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
12031	INTMD RPR S/A/T/EXT 2.5 CM/<	MAXFEE	DEF					85.58	1/1/2000	12/31/2299	N
12032	INTMD RPR S/A/T/EXT 2.6-7.5	PRXOVR	DEF					NA	NA	NA	N
12032	INTMD RPR S/A/T/EXT 2.6-7.5	MAXFEE	DEF					101.46	1/1/2000	12/31/2299	N
12034	INTMD RPR S/TR/EXT 7.6-12.5	PRXOVR	DEF					NA	NA	NA	N
12034	INTMD RPR S/TR/EXT 7.6-12.5	MAXFEE	DEF					123.85	1/1/2000	12/31/2299	N
12035	INTMD RPR S/A/T/EXT 12.6-20	PRXOVR	DEF					NA	NA	NA	N
12035	INTMD RPR S/A/T/EXT 12.6-20	MAXFEE	DEF					147.97	1/1/2000	12/31/2299	N
12036	INTMD RPR S/A/T/EXT 20.1-30	PRXOVR	DEF					NA	NA	NA	N

12036	INTMD RPR S/A/T/EXT 20.1-30	MAXFEE	DEF					185.44	1/1/2000	12/31/2299	N
12037	INTMD RPR S/TR/EXT >30.0 CM	PRXOVR	DEF					NA	NA	NA	N
12037	INTMD RPR S/TR/EXT >30.0 CM	MAXFEE	DEF					221.75	1/1/2000	12/31/2299	N
12041	INTMD RPR N-HF/GENIT 2.5CM/<	PRXOVR	DEF					NA	NA	NA	N
12041	INTMD RPR N-HF/GENIT 2.5CM/<	MAXFEE	DEF					95.57	1/1/2000	12/31/2299	N
12042	INTMD RPR N-HF/GENIT2.6-7.5	PRXOVR	DEF					NA	NA	NA	N
12042	INTMD RPR N-HF/GENIT2.6-7.5	MAXFEE	DEF					112.31	1/1/2000	12/31/2299	N
12044	INTMD RPR N-HF/GENIT7.6-12.5	PRXOVR	DEF					NA	NA	NA	N
12044	INTMD RPR N-HF/GENIT7.6-12.5	MAXFEE	DEF					133.41	1/1/2000	12/31/2299	N
12045	INTMD RPR N-HF/GENIT12.6-20	PRXOVR	DEF					NA	NA	NA	N
12045	INTMD RPR N-HF/GENIT12.6-20	MAXFEE	DEF					160.11	1/1/2000	12/31/2299	N
12046	INTMD RPR N-HF/GENIT20.1-30	PRXOVR	DEF					NA	NA	NA	N
12046	INTMD RPR N-HF/GENIT20.1-30	MAXFEE	DEF					202.40	1/1/2000	12/31/2299	N
12047	INTMD RPR N-HF/GENIT >30.0CM	PRXOVR	DEF					NA	NA	NA	N
12047	INTMD RPR N-HF/GENIT >30.0CM	MAXFEE	DEF					243.52	1/1/2000	12/31/2299	N
12051	INTMD RPR FACE/MM 2.5 CM/<	PRXOVR	DEF					NA	NA	NA	N
12051	INTMD RPR FACE/MM 2.5 CM/<	MAXFEE	DEF					101.83	1/1/2000	12/31/2299	N
12052	INTMD RPR FACE/MM 2.6-5.0 CM	PRXOVR	DEF					NA	NA	NA	N
12052	INTMD RPR FACE/MM 2.6-5.0 CM	MAXFEE	DEF					119.27	1/1/2000	12/31/2299	N
12053	INTMD RPR FACE/MM 5.1-7.5 CM	PRXOVR	DEF					NA	NA	NA	N
12053	INTMD RPR FACE/MM 5.1-7.5 CM	MAXFEE	DEF					135.28	1/1/2000	12/31/2299	N
12054	INTMD RPR FACE/MM 7.6-12.5CM	PRXOVR	DEF					NA	NA	NA	N
12054	INTMD RPR FACE/MM 7.6-12.5CM	MAXFEE	DEF					164.53	1/1/2000	12/31/2299	N

12055	INTMD RPR FACE/MM 12.6-20 CM	PRXOVR	DEF					NA	NA	NA	N
12055	INTMD RPR FACE/MM 12.6-20 CM	MAXFEE	DEF					209.37	1/1/2000	12/31/2299	N
12056	INTMD RPR FACE/MM 20.1-30.0	PRXOVR	DEF					NA	NA	NA	N
12056	INTMD RPR FACE/MM 20.1-30.0	MAXFEE	DEF					272.32	1/1/2000	12/31/2299	N
12057	INTMD RPR FACE/MM >30.0 CM	PRXOVR	DEF					NA	NA	NA	N
12057	INTMD RPR FACE/MM >30.0 CM	MAXFEE	DEF					303.87	1/1/2000	12/31/2299	N
13100	CMPLX RPR TRUNK 1.1-2.5 CM	PRXOVR	DEF					NA	NA	NA	N
13100	CMPLX RPR TRUNK 1.1-2.5 CM	MAXFEE	DEF					123.92	1/1/2000	12/31/2299	N
13101	CMPLX RPR TRUNK 2.6-7.5 CM	PRXOVR	DEF					NA	NA	NA	N
13101	CMPLX RPR TRUNK 2.6-7.5 CM	MAXFEE	DEF					166.23	10/1/2004	12/31/2299	N
13102	CMPLX RPR TRUNK ADDL 5CM/<	PRXOVR	DEF					NA	NA	NA	N
13102	CMPLX RPR TRUNK ADDL 5CM/<	MAXFEE	DEF					56.24	1/1/2007	12/31/2299	N
13120	CMPLX RPR S/A/L 1.1-2.5 CM	PRXOVR	DEF					NA	NA	NA	N
13120	CMPLX RPR S/A/L 1.1-2.5 CM	MAXFEE	DEF					134.11	1/1/2000	12/31/2299	N
13121	CMPLX RPR S/A/L 2.6-7.5 CM	PRXOVR	DEF					NA	NA	NA	N
13121	CMPLX RPR S/A/L 2.6-7.5 CM	MAXFEE	DEF					192.19	1/1/2000	12/31/2299	N
13122	CMPLX RPR S/A/L ADDL 5 CM/>	PRXOVR	DEF					NA	NA	NA	N
13122	CMPLX RPR S/A/L ADDL 5 CM/>	MAXFEE	DEF					65.60	1/1/2007	12/31/2299	N
13131	CMPLX RPR F/C/C/M/N/AX/G/H/F	PRXOVR	DEF					NA	NA	NA	N
13131	CMPLX RPR F/C/C/M/N/AX/G/H/F	MAXFEE	DEF					162.27	1/1/2000	12/31/2299	N
13132	CMPLX RPR F/C/C/M/N/AX/G/H/F	PRXOVR	DEF					NA	NA	NA	N

13132	CMPLX RPR F/C/C/M/N/AX/G/H/F	MAXFEE	DEF					270.46	1/1/2000	12/31/2299	N
13133	CMPLX RPR F/C/C/M/N/AX/G/H/F	PRXOVR	DEF					NA	NA	NA	N
13133	CMPLX RPR F/C/C/M/N/AX/G/H/F	MAXFEE	DEF					95.96	1/1/2007	12/31/2299	N
13150	CMPLX RPR E/N/E/L 1.0 CM/<	PRXOVR	DEF					NA	NA	NA	N
13150	CMPLX RPR E/N/E/L 1.0 CM/<	MAXFEE	DEF					165.11	1/1/2000	12/31/2299	N
13151	CMPLX RPR E/N/E/L 1.1-2.5 CM	PRXOVR	DEF					NA	NA	NA	N
13151	CMPLX RPR E/N/E/L 1.1-2.5 CM	MAXFEE	DEF					197.77	1/1/2000	12/31/2299	N
13152	CMPLX RPR E/N/E/L 2.6-7.5 CM	PRXOVR	DEF					NA	NA	NA	N
13152	CMPLX RPR E/N/E/L 2.6-7.5 CM	MAXFEE	DEF					311.49	1/1/2000	12/31/2299	N
13153	CMPLX RPR E/N/E/L ADDL 5CM/<	PRXOVR	DEF					NA	NA	NA	N
13153	CMPLX RPR E/N/E/L ADDL 5CM/<	MAXFEE	DEF					105.31	1/1/2007	12/31/2299	N
13160	LATE CLOSURE OF WOUND	PRXOVR	DEF					NA	NA	NA	N
13160	LATE CLOSURE OF WOUND	MAXFEE	DEF					427.63	7/1/2008	12/31/2299	N
15002	WOUND PREP TRK/ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
15002	WOUND PREP TRK/ARM/LEG	MAXFEE	DEF					180	1/1/2007	12/31/2299	N
15003	WOUND PREP ADDL 100 CM	PRXOVR	DEF					NA	NA	NA	N
15003	WOUND PREP ADDL 100 CM	MAXFEE	DEF					38.79	1/1/2010	12/31/2299	N
15004	WOUND PREP F/N/HF/G	PRXOVR	DEF					NA	NA	NA	N
15004	WOUND PREP F/N/HF/G	MAXFEE	DEF					217.41	1/1/2007	12/31/2299	N
15005	WND PREP F/N/HF/G ADDL CM	PRXOVR	DEF					NA	NA	NA	N
15005	WND PREP F/N/HF/G ADDL CM	MAXFEE	DEF					67.78	1/1/2007	12/31/2299	N
15040	HARVEST CULTURED SKIN GRAFT	PRXOVR	DEF					NA	NA	NA	N
15040	HARVEST CULTURED SKIN GRAFT	MAXFEE	DEF					106.11	1/1/2010	12/31/2299	N
15050	SKIN PINCH GRAFT	PRXOVR	DEF					NA	NA	NA	N
15050	SKIN PINCH GRAFT	MAXFEE	DEF					230.80	7/1/2008	12/31/2299	N

15100	SKIN SPLT GRFT TRNK/ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
15100	SKIN SPLT GRFT TRNK/ARM/LEG	MAXFEE	DEF					387.90	7/1/2008	12/31/2299	N
15101	SKIN SPLT GRFT T/A/L ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15101	SKIN SPLT GRFT T/A/L ADD-ON	MAXFEE	DEF					90.21	1/1/2000	12/31/2299	N
15110	EPIDRM AUTOGRFT TRNK/ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
15110	EPIDRM AUTOGRFT TRNK/ARM/LEG	MAXFEE	DEF					563.28	4/1/2006	12/31/2299	N
15111	EPIDRM AUTOGRFT T/A/L ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15111	EPIDRM AUTOGRFT T/A/L ADD-ON	MAXFEE	DEF					89.81	4/1/2006	12/31/2299	N
15115	EPIDRM A-GRFT FACE/NCK/HF/G	PRXOVR	DEF					NA	NA	NA	N
15115	EPIDRM A-GRFT FACE/NCK/HF/G	MAXFEE	DEF					530.72	4/1/2006	12/31/2299	N
15116	EPIDRM A-GRFT F/N/HF/G ADDL	PRXOVR	DEF					NA	NA	NA	N
15116	EPIDRM A-GRFT F/N/HF/G ADDL	MAXFEE	DEF					116.67	4/1/2006	12/31/2299	N
15120	SKN SPLT A-GRFT FAC/NCK/HF/G	PRXOVR	DEF					NA	NA	NA	N
15120	SKN SPLT A-GRFT FAC/NCK/HF/G	MAXFEE	DEF					438.51	1/1/2002	12/31/2299	N
15121	SKN SPLT A-GRFT F/N/HF/G ADD	PRXOVR	DEF					NA	NA	NA	N
15121	SKN SPLT A-GRFT F/N/HF/G ADD	MAXFEE	DEF					143.79	1/1/2010	12/31/2299	N
15130	DERM AUTOGRAFT TRNK/ARM/LEG	PRXOVR	DEF					NA	NA	NA	N

15130	DERM AUTOGRAFT TRNK/ARM/LEG	MAXFEE	DEF					452.64	1/1/2010	12/31/2299	N
15131	DERM AUTOGRAFT T/A/L ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15131	DERM AUTOGRAFT T/A/L ADD-ON	MAXFEE	DEF					73.28	4/22/2006	12/31/2299	N
15135	DERM AUTOGRAFT FACE/NCK/HF/G	PRXOVR	DEF					NA	NA	NA	N
15135	DERM AUTOGRAFT FACE/NCK/HF/G	MAXFEE	DEF					568.16	4/1/2006	12/31/2299	N
15136	DERM AUTOGRAFT F/N/HF/G ADD	PRXOVR	DEF					NA	NA	NA	N
15136	DERM AUTOGRAFT F/N/HF/G ADD	MAXFEE	DEF					68.65	4/1/2006	12/31/2299	N
15150	CULT SKIN GRFT T/ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
15150	CULT SKIN GRFT T/ARM/LEG	MAXFEE	DEF					468.58	4/1/2006	12/31/2299	N
15151	CULT SKIN GRFT T/A/L ADDL	PRXOVR	DEF					NA	NA	NA	N
15151	CULT SKIN GRFT T/A/L ADDL	MAXFEE	DEF					94.96	4/1/2006	12/31/2299	N
15152	CULT SKIN GRAFT T/A/L +%	PRXOVR	DEF					NA	NA	NA	N
15152	CULT SKIN GRAFT T/A/L +%	MAXFEE	DEF					116.67	4/1/2006	12/31/2299	N
15155	CULT SKIN GRAFT F/N/HF/G	PRXOVR	DEF					NA	NA	NA	N
15155	CULT SKIN GRAFT F/N/HF/G	MAXFEE	DEF					470.48	4/1/2006	12/31/2299	N
15156	CULT SKIN GRFT F/N/HFG ADD	PRXOVR	DEF					NA	NA	NA	N
15156	CULT SKIN GRFT F/N/HFG ADD	MAXFEE	DEF					123.73	4/1/2006	12/31/2299	N
15157	CULT EPIDERM GRFT F/N/HFG +%	PRXOVR	DEF					NA	NA	NA	N
15157	CULT EPIDERM GRFT F/N/HFG +%	MAXFEE	DEF					136.75	4/1/2006	12/31/2299	N
15170	ACELL GRAFT TRUNK/ARMS/LEGS	PRXOVR	DEF					NA	NA	NA	N
15170	ACELL GRAFT TRUNK/ARMS/LEGS	MAXFEE	DEF					NA			N

15171	ACELL GRAFT T/ARM/LEG ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15171	ACELL GRAFT T/ARM/LEG ADD-ON	MAXFEE	DEF					NA			N
15175	ACELLULAR GRAFT F/N/HF/G	PRXOVR	DEF					NA	NA	NA	N
15175	ACELLULAR GRAFT F/N/HF/G	MAXFEE	DEF					NA			N
15176	ACELL GRAFT F/N/HF/G ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15176	ACELL GRAFT F/N/HF/G ADD-ON	MAXFEE	DEF					NA			N
15200	SKIN FULL GRAFT TRUNK	PRXOVR	DEF					NA	NA	NA	N
15200	SKIN FULL GRAFT TRUNK	MAXFEE	DEF					351.64	1/1/2000	12/31/2299	N
15201	SKIN FULL GRAFT TRUNK ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15201	SKIN FULL GRAFT TRUNK ADD-ON	MAXFEE	DEF					67.60	1/1/2010	12/31/2299	N
15220	SKIN FULL GRAFT SCLP/ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
15220	SKIN FULL GRAFT SCLP/ARM/LEG	MAXFEE	DEF					365.48	1/1/2000	12/31/2299	N
15221	SKIN FULL GRAFT ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15221	SKIN FULL GRAFT ADD-ON	MAXFEE	DEF					61.58	1/1/2010	12/31/2299	N
15240	SKIN FULL GRFT FACE/GENIT/HF	PRXOVR	DEF					NA	NA	NA	N
15240	SKIN FULL GRFT FACE/GENIT/HF	MAXFEE	DEF					423.82	1/1/2002	12/31/2299	N
15241	SKIN FULL GRAFT ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15241	SKIN FULL GRAFT ADD-ON	MAXFEE	DEF					95.75	1/1/2010	12/31/2299	N
15260	SKIN FULL GRAFT EEN & LIPS	PRXOVR	DEF					NA	NA	NA	N
15260	SKIN FULL GRAFT EEN & LIPS	MAXFEE	DEF					477.26	1/1/2000	12/31/2299	N
15261	SKIN FULL GRAFT ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15261	SKIN FULL GRAFT ADD-ON	MAXFEE	DEF					131.25	7/1/2008	12/31/2299	N

15275	SKIN SUB GRAFT FACE/NK/HF/G	PRXOVR	DEF					NA	NA	NA	N
15275	SKIN SUB GRAFT FACE/NK/HF/G	MAXFEE	DEF					59.22	1/1/2012	12/31/2299	N
15276	SKIN SUB GRAFT F/N/HF/G ADDL	PRXOVR	DEF					NA	NA	NA	N
15276	SKIN SUB GRAFT F/N/HF/G ADDL	MAXFEE	DEF					12.95	1/1/2012	12/31/2299	N
15277	SKN SUB GRFT F/N/HF/G CHILD	PRXOVR	DEF					NA	NA	NA	N
15277	SKN SUB GRFT F/N/HF/G CHILD	MAXFEE	DEF					114.43	1/1/2012	12/31/2299	N
15278	SKN SUB GRFT F/N/HF/G CH ADD	PRXOVR	DEF					NA	NA	NA	N
15278	SKN SUB GRFT F/N/HF/G CH ADD	MAXFEE	DEF					31.37	1/1/2012	12/31/2299	N
15300	APPLY SKINALLOGRFT T/ARM/LG	PRXOVR	DEF					NA	NA	NA	N
15300	APPLY SKINALLOGRFT T/ARM/LG	MAXFEE	DEF					NA			N
15301	APPLY SKNALLOGRFT T/A/L ADDL	PRXOVR	DEF					NA	NA	NA	N
15301	APPLY SKNALLOGRFT T/A/L ADDL	MAXFEE	DEF					NA			N
15320	APPLY SKIN ALLOGRFT F/N/HF/G	PRXOVR	DEF					NA	NA	NA	N
15320	APPLY SKIN ALLOGRFT F/N/HF/G	MAXFEE	DEF					NA			N
15321	APLY SKNALLOGRFT F/N/HFG ADD	PRXOVR	DEF					NA	NA	NA	N
15321	APLY SKNALLOGRFT F/N/HFG ADD	MAXFEE	DEF					NA			N
15330	APLY ACELL ALOGRFT T/ARM/LEG	PRXOVR	DEF					NA	NA	NA	N

15330	APLY ACELL ALOGRFT T/ARM/LEG	MAXFEE	DEF					NA			N
15331	APLY ACELL GRFT T/A/L ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15331	APLY ACELL GRFT T/A/L ADD-ON	MAXFEE	DEF					NA			N
15335	APPLY ACELL GRAFT F/N/HF/G	PRXOVR	DEF					NA	NA	NA	N
15335	APPLY ACELL GRAFT F/N/HF/G	MAXFEE	DEF					NA			N
15336	APLY ACELL GRFT F/N/HF/G ADD	PRXOVR	DEF					NA	NA	NA	N
15336	APLY ACELL GRFT F/N/HF/G ADD	MAXFEE	DEF					NA			N
15340	APPLY CULT SKIN SUBSTITUTE	PRXOVR	DEF					NA	NA	NA	N
15340	APPLY CULT SKIN SUBSTITUTE	MAXFEE	DEF					NA			N
15341	APPLY CULT SKIN SUB ADD-ON	PRXOVR	DEF					NA	NA	NA	N
15341	APPLY CULT SKIN SUB ADD-ON	MAXFEE	DEF					NA			N
15342	CULTURED SKIN GRAFT; 25 CM	PRXOVR	DEF					NA	NA	NA	N
15342	CULTURED SKIN GRAFT; 25 CM	MAXFEE	DEF					NA			N
15343	CULTURE SKN GRAFT ADDL 25 CM	PRXOVR	DEF					NA	NA	NA	N
15343	CULTURE SKN GRAFT ADDL 25 CM	MAXFEE	DEF					NA			N
15360	APPLY CULT DERM SUB T/A/L	PRXOVR	DEF					NA	NA	NA	N
15360	APPLY CULT DERM SUB T/A/L	MAXFEE	DEF					NA			N
15361	APLY CULT DERM SUB T/A/L ADD	PRXOVR	DEF					NA	NA	NA	N
15361	APLY CULT DERM SUB T/A/L ADD	MAXFEE	DEF					NA			N

15365	APPLY CULT DERM SUB F/N/HF/G	PRXOVR	DEF					NA	NA	NA	N
15365	APPLY CULT DERM SUB F/N/HF/G	MAXFEE	DEF					NA			N
15366	APPLY CULT DERM F/HF/G ADD	PRXOVR	DEF					NA	NA	NA	N
15366	APPLY CULT DERM F/HF/G ADD	MAXFEE	DEF					NA			N
15400	APPLY SKIN XENOGRAFT T/A/L	PRXOVR	DEF					NA	NA	NA	N
15400	APPLY SKIN XENOGRAFT T/A/L	MAXFEE	DEF					NA			N
15401	APPLY SKN XENOGRFT T/A/L ADD	PRXOVR	DEF					NA	NA	NA	N
15401	APPLY SKN XENOGRFT T/A/L ADD	MAXFEE	DEF					NA			N
17000	DESTRUCT PREMALG LESION	PRXOVR	DEF					NA	NA	NA	N
17000	DESTRUCT PREMALG LESION	MAXFEE	DEF					44.24	1/1/2004	12/31/2299	N
17003	DESTRUCT PREMALG LES 2-14	PRXOVR	DEF					NA	NA	NA	N
17003	DESTRUCT PREMALG LES 2-14	MAXFEE	DEF					5.98	1/1/2010	12/31/2299	N
17004	DESTROY PREMAL LESIONS 15/>	PRXOVR	DEF					NA	NA	NA	N
17004	DESTROY PREMAL LESIONS 15/>	MAXFEE	DEF					132.38	1/1/2000	12/31/2299	N
20000	INCISION OF ABSCESS	PRXOVR	DEF					NA	NA	NA	N
20000	INCISION OF ABSCESS	MAXFEE	DEF					NA			N
20005	I&D ABSCESS SUBFASCIAL	PRXOVR	DEF					NA	NA	NA	N
20005	I&D ABSCESS SUBFASCIAL	MAXFEE	DEF					146.39	1/1/2000	12/31/2299	N
20100	EXPLORE WOUND NECK	PRXOVR	DEF					NA	NA	NA	N
20100	EXPLORE WOUND NECK	MAXFEE	DEF					415.65	1/1/2000	12/31/2299	N
20101	EXPLORE WOUND CHEST	PRXOVR	DEF					NA	NA	NA	N
20101	EXPLORE WOUND CHEST	MAXFEE	DEF					135.30	1/1/2000	12/31/2299	N
20102	EXPLORE WOUND ABDOMEN	PRXOVR	DEF					NA	NA	NA	N

20102	EXPLORE WOUND ABDOMEN	MAXFEE	DEF					166.43	1/1/2000	12/31/2299	N
20103	EXPLORE WOUND EXTREMITY	PRXOVR	DEF					NA	NA	NA	N
20103	EXPLORE WOUND EXTREMITY	MAXFEE	DEF					223.69	4/1/2008	12/31/2299	N
20150	EXCISE EPIPHYSEAL BAR	PRXOVR	DEF					NA	NA	NA	N
20150	EXCISE EPIPHYSEAL BAR	MAXFEE	DEF					689.26	4/1/2008	12/31/2299	N
20200	MUSCLE BIOPSY	PRXOVR	DEF					NA	NA	NA	N
20200	MUSCLE BIOPSY	MAXFEE	DEF					73.06	1/1/2000	12/31/2299	N
20205	DEEP MUSCLE BIOPSY	PRXOVR	DEF					NA	NA	NA	N
20205	DEEP MUSCLE BIOPSY	MAXFEE	DEF					124.38	1/1/2010	12/31/2299	N
20206	NEEDLE BIOPSY MUSCLE	PRXOVR	DEF					NA	NA	NA	N
20206	NEEDLE BIOPSY MUSCLE	MAXFEE	DEF					53.29	1/1/2010	12/31/2299	N
20220	BONE BIOPSY TROCAR/NEEDLE	PRXOVR	DEF					NA	NA	NA	N
20220	BONE BIOPSY TROCAR/NEEDLE	MAXFEE	DEF					66.39	1/1/2010	12/31/2299	N
20225	BONE BIOPSY TROCAR/NEEDLE	PRXOVR	DEF					NA	NA	NA	N
20225	BONE BIOPSY TROCAR/NEEDLE	MAXFEE	DEF					102.60	1/1/2010	12/31/2299	N
20240	BONE BIOPSY EXCISIONAL	PRXOVR	DEF					NA	NA	NA	N
20240	BONE BIOPSY EXCISIONAL	MAXFEE	DEF					143.71	1/1/2000	12/31/2299	N
20245	BONE BIOPSY EXCISIONAL	PRXOVR	DEF					NA	NA	NA	N
20245	BONE BIOPSY EXCISIONAL	MAXFEE	DEF					343.50	7/1/2008	12/31/2299	N
20250	OPEN BONE BIOPSY	PRXOVR	DEF					NA	NA	NA	N
20250	OPEN BONE BIOPSY	MAXFEE	DEF					270.54	1/1/2000	12/31/2299	N
20251	OPEN BONE BIOPSY	PRXOVR	DEF					NA	NA	NA	N
20251	OPEN BONE BIOPSY	MAXFEE	DEF					307.90	1/1/2000	12/31/2299	N
20500	INJECTION OF SINUS TRACT	PRXOVR	DEF					NA	NA	NA	N
20500	INJECTION OF SINUS TRACT	MAXFEE	DEF					92.92	1/1/2010	12/31/2299	N
20501	INJECT SINUS TRACT FOR X-RAY	PRXOVR	DEF					NA	NA	NA	N

20501	INJECT SINUS TRACT FOR X-RAY	MAXFEE	DEF					35	1/1/2010	12/31/2299	N
20520	REMOVAL OF FOREIGN BODY	PRXOVR	DEF					NA	NA	NA	N
20520	REMOVAL OF FOREIGN BODY	MAXFEE	DEF					115.14	1/1/2010	12/31/2299	N
20525	REMOVAL OF FOREIGN BODY	PRXOVR	DEF					NA	NA	NA	N
20525	REMOVAL OF FOREIGN BODY	MAXFEE	DEF					169.81	1/1/2000	12/31/2299	N
20526	THER INJECTION CARP TUNNEL	PRXOVR	DEF					NA	NA	NA	N
20526	THER INJECTION CARP TUNNEL	MAXFEE	DEF					44.53	1/1/2002	12/31/2299	N
20550	INJ TENDON SHEATH/LIGAMENT	PRXOVR	DEF					NA	NA	NA	N
20550	INJ TENDON SHEATH/LIGAMENT	MAXFEE	DEF					41.82	1/1/2004	12/31/2299	N
20551	INJ TENDON ORIGIN/INSERTION	PRXOVR	DEF					NA	NA	NA	N
20551	INJ TENDON ORIGIN/INSERTION	MAXFEE	DEF					44.53	1/1/2002	12/31/2299	N
20552	INJ TRIGGER POINT 1/2 MUSCL	PRXOVR	DEF					NA	NA	NA	N
20552	INJ TRIGGER POINT 1/2 MUSCL	MAXFEE	DEF					42.08	1/1/2010	12/31/2299	N
20553	INJECT TRIGGER POINTS 3/>	PRXOVR	DEF					NA	NA	NA	N
20553	INJECT TRIGGER POINTS 3/>	MAXFEE	DEF					44.53	1/1/2002	12/31/2299	N
20555	PLACE NDL MUSC/TIS FOR RT	PRXOVR	DEF					NA	NA	NA	N
20555	PLACE NDL MUSC/TIS FOR RT	MAXFEE	DEF					197.78	1/1/2008	12/31/2299	N
20600	DRAIN/INJECT JOINT/BURSA	PRXOVR	DEF					NA	NA	NA	N
20600	DRAIN/INJECT JOINT/BURSA	MAXFEE	DEF					36.77	1/1/2004	12/31/2299	N
20605	DRAIN/INJECT JOINT/BURSA	PRXOVR	DEF					NA	NA	NA	N
20605	DRAIN/INJECT JOINT/BURSA	MAXFEE	DEF					40.43	1/1/2004	12/31/2299	N
20610	DRAIN/INJECT JOINT/BURSA	PRXOVR	DEF					NA	NA	NA	N
20610	DRAIN/INJECT JOINT/BURSA	MAXFEE	DEF					48.91	1/1/2004	12/31/2299	N
20612	ASPIRATE/INJ GANGLION CYST	PRXOVR	DEF					NA	NA	NA	N

20612	ASPIRATE/INJ GANGLION CYST	MAXFEE	DEF					38.40	7/1/2003	12/31/2299	N
20615	TREATMENT OF BONE CYST	PRXOVR	DEF					NA	NA	NA	N
20615	TREATMENT OF BONE CYST	MAXFEE	DEF					88.18	7/1/2008	12/31/2299	N
20650	INSERT AND REMOVE BONE PIN	PRXOVR	DEF					NA	NA	NA	N
20650	INSERT AND REMOVE BONE PIN	MAXFEE	DEF					97.34	1/1/2000	12/31/2299	N
20660	APPLY REM FIXATION DEVICE	PRXOVR	DEF					NA	NA	NA	N
20660	APPLY REM FIXATION DEVICE	MAXFEE	DEF					108.71	1/1/2004	12/31/2299	N
20661	APPLICATION OF HEAD BRACE	PRXOVR	DEF					NA	NA	NA	N
20661	APPLICATION OF HEAD BRACE	MAXFEE	DEF					249.65	1/1/2004	12/31/2299	N
20662	APPLICATION OF PELVIS BRACE	PRXOVR	DEF					NA	NA	NA	N
20662	APPLICATION OF PELVIS BRACE	MAXFEE	DEF					338.43	1/1/2004	12/31/2299	N
20663	APPLICATION OF THIGH BRACE	PRXOVR	DEF					NA	NA	NA	N
20663	APPLICATION OF THIGH BRACE	MAXFEE	DEF					272.05	1/1/2004	12/31/2299	N
20664	APPLICATION OF HALO	PRXOVR	DEF					NA	NA	NA	N
20664	APPLICATION OF HALO	MAXFEE	DEF					395.56	7/1/2008	12/31/2299	N
20665	REMOVAL OF FIXATION DEVICE	PRXOVR	DEF					NA	NA	NA	N
20665	REMOVAL OF FIXATION DEVICE	MAXFEE	DEF					95.93	1/1/2004	12/31/2299	N
20670	REMOVAL OF SUPPORT IMPLANT	PRXOVR	DEF					NA	NA	NA	N
20670	REMOVAL OF SUPPORT IMPLANT	MAXFEE	DEF					121.89	1/1/2010	12/31/2299	N
20680	REMOVAL OF SUPPORT IMPLANT	PRXOVR	DEF					NA	NA	NA	N

20680	REMOVAL OF SUPPORT IMPLANT	MAXFEE	DEF					214.09	7/1/2008	12/31/2299	N
20690	APPLY BONE FIXATION DEVICE	PRXOVR	DEF					NA	NA	NA	N
20690	APPLY BONE FIXATION DEVICE	MAXFEE	DEF					188.18	1/1/2000	12/31/2299	N
20692	APPLY BONE FIXATION DEVICE	PRXOVR	DEF					NA	NA	NA	N
20692	APPLY BONE FIXATION DEVICE	MAXFEE	DEF					316.91	1/1/2004	12/31/2299	N
20693	ADJUST BONE FIXATION DEVICE	PRXOVR	DEF					NA	NA	NA	N
20693	ADJUST BONE FIXATION DEVICE	MAXFEE	DEF					254.36	7/1/2008	12/31/2299	N
20694	REMOVE BONE FIXATION DEVICE	PRXOVR	DEF					NA	NA	NA	N
20694	REMOVE BONE FIXATION DEVICE	MAXFEE	DEF					201.41	1/1/2000	12/31/2299	N
20696	COMP MULTIPLANE EXT FIXATION	PRXOVR	DEF					NA	NA	NA	N
20696	COMP MULTIPLANE EXT FIXATION	MAXFEE	DEF					793.95	1/1/2009	12/31/2299	N
20697	COMP EXT FIXATE STRUT CHANGE	PRXOVR	DEF					NA	NA	NA	N
20697	COMP EXT FIXATE STRUT CHANGE	MAXFEE	DEF					863.02	1/1/2009	12/31/2299	N
20802	REPLANTATION ARM COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20802	REPLANTATION ARM COMPLETE	MAXFEE	DEF					2094.16	1/1/2000	12/31/2299	N
20805	REPLANT FOREARM COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20805	REPLANT FOREARM COMPLETE	MAXFEE	DEF					2616.58	1/1/2000	12/31/2299	N

20808	REPLANTATION HAND COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20808	REPLANTATION HAND COMPLETE	MAXFEE	DEF					3169.36	1/1/2000	12/31/2299	N
20816	REPLANTATION DIGIT COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20816	REPLANTATION DIGIT COMPLETE	MAXFEE	DEF					1704.98	1/1/2000	12/31/2299	N
20822	REPLANTATION DIGIT COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20822	REPLANTATION DIGIT COMPLETE	MAXFEE	DEF					1433.36	1/1/2000	12/31/2299	N
20824	REPLANTATION THUMB COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20824	REPLANTATION THUMB COMPLETE	MAXFEE	DEF					1677.77	1/1/2000	12/31/2299	N
20827	REPLANTATION THUMB COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20827	REPLANTATION THUMB COMPLETE	MAXFEE	DEF					1470.02	1/1/2000	12/31/2299	N
20838	REPLANTATION FOOT COMPLETE	PRXOVR	DEF					NA	NA	NA	N
20838	REPLANTATION FOOT COMPLETE	MAXFEE	DEF					2142.08	1/1/2000	12/31/2299	N
20900	REMOVAL OF BONE FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
20900	REMOVAL OF BONE FOR GRAFT	MAXFEE	DEF					226.45	1/1/2010	12/31/2299	N
20902	REMOVAL OF BONE FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
20902	REMOVAL OF BONE FOR GRAFT	MAXFEE	DEF					313.49	1/1/2010	12/31/2299	N
20910	REMOVE CARTILAGE FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N

20910	REMOVE CARTILAGE FOR GRAFT	MAXFEE	DEF					233.70	7/1/2008	12/31/2299	N
20912	REMOVE CARTILAGE FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
20912	REMOVE CARTILAGE FOR GRAFT	MAXFEE	DEF					306.28	1/1/2000	12/31/2299	N
20920	REMOVAL OF FASCIA FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
20920	REMOVAL OF FASCIA FOR GRAFT	MAXFEE	DEF					254	1/1/2000	12/31/2299	N
20922	REMOVAL OF FASCIA FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
20922	REMOVAL OF FASCIA FOR GRAFT	MAXFEE	DEF					315.03	1/1/2000	12/31/2299	N
20924	REMOVAL OF TENDON FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
20924	REMOVAL OF TENDON FOR GRAFT	MAXFEE	DEF					329.88	1/1/2000	12/31/2299	N
20926	REMOVAL OF TISSUE FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
20926	REMOVAL OF TISSUE FOR GRAFT	MAXFEE	DEF					234.82	7/1/2008	12/31/2299	N
20931	SP BONE ALGRFT STRUCT ADD-ON	PRXOVR	DEF					NA	NA	NA	N
20931	SP BONE ALGRFT STRUCT ADD-ON	MAXFEE	DEF					95.02	1/1/2000	12/31/2299	N
20937	SP BONE AGRFT MORSEL ADD-ON	PRXOVR	DEF					NA	NA	NA	N
20937	SP BONE AGRFT MORSEL ADD-ON	MAXFEE	DEF					145.48	1/1/2000	12/31/2299	N
20938	SP BONE AGRFT STRUCT ADD-ON	PRXOVR	DEF					NA	NA	NA	N
20938	SP BONE AGRFT STRUCT ADD-ON	MAXFEE	DEF					157.27	1/1/2000	12/31/2299	N
20950	FLUID PRESSURE MUSCLE	PRXOVR	DEF					NA	NA	NA	N

20950	FLUID PRESSURE MUSCLE	MAXFEE	DEF					67.93	1/1/2000	12/31/2299	N
20955	FIBULA BONE GRAFT MICROVASC	PRXOVR	DEF					NA	NA	NA	N
20955	FIBULA BONE GRAFT MICROVASC	MAXFEE	DEF					2021.90	1/1/2000	12/31/2299	N
20956	ILIAC BONE GRAFT MICROVASC	PRXOVR	DEF					NA	NA	NA	N
20956	ILIAC BONE GRAFT MICROVASC	MAXFEE	DEF					1822.62	4/1/2008	12/31/2299	N
20957	MT BONE GRAFT MICROVASC	PRXOVR	DEF					NA	NA	NA	N
20957	MT BONE GRAFT MICROVASC	MAXFEE	DEF					1844.51	4/1/2008	12/31/2299	N
20962	OTHER BONE GRAFT MICROVASC	PRXOVR	DEF					NA	NA	NA	N
20962	OTHER BONE GRAFT MICROVASC	MAXFEE	DEF					1900.53	1/1/2004	12/31/2299	N
20969	BONE/SKIN GRAFT MICROVASC	PRXOVR	DEF					NA	NA	NA	N
20969	BONE/SKIN GRAFT MICROVASC	MAXFEE	DEF					2249.66	1/1/2004	12/31/2299	N
20970	BONE/SKIN GRAFT ILIAC CREST	PRXOVR	DEF					NA	NA	NA	N
20970	BONE/SKIN GRAFT ILIAC CREST	MAXFEE	DEF					2196.74	1/1/2004	12/31/2299	N
20972	BONE/SKIN GRAFT METATARSAL	PRXOVR	DEF					NA	NA	NA	N
20972	BONE/SKIN GRAFT METATARSAL	MAXFEE	DEF					2160.77	4/1/2008	12/31/2299	N
20973	BONE/SKIN GRAFT GREAT TOE	PRXOVR	DEF					NA	NA	NA	N
20973	BONE/SKIN GRAFT GREAT TOE	MAXFEE	DEF					2333.22	1/1/2004	12/31/2299	N
20974	ELECTRICAL BONE STIMULATION	PRXOVR	DEF					NA	NA	NA	N

20974	ELECTRICAL BONE STIMULATION	MAXFEE	DEF					38.79	12/1/2005	12/31/2299	N
20975	ELECTRICAL BONE STIMULATION	PRXOVR	DEF					NA	NA	NA	N
20975	ELECTRICAL BONE STIMULATION	MAXFEE	DEF					144.52	12/15/2005	12/31/2299	N
20979	US BONE STIMULATION	PRXOVR	DEF					NA	NA	NA	N
20979	US BONE STIMULATION	MAXFEE	DEF					36.97	1/1/2004	12/31/2299	N
20982	ABLATE BONE TUMOR(S) PERQ	PRXOVR	DEF					NA	NA	NA	N
20982	ABLATE BONE TUMOR(S) PERQ	MAXFEE	DEF					2850.06	4/1/2008	12/31/2299	N
20985	CPTR-ASST DIR MS PX	PRXOVR	DEF					NA	NA	NA	N
20985	CPTR-ASST DIR MS PX	MAXFEE	DEF					92.78	1/1/2008	12/31/2299	N
20986	CPTR-ASST DIR MS PX IO IMG	PRXOVR	DEF					NA	NA	NA	N
20986	CPTR-ASST DIR MS PX IO IMG	MANUAL	DEF					NA	NA	NA	N
20987	CPTR-ASST DIR MS PX PRE IMG	PRXOVR	DEF					NA	NA	NA	N
20987	CPTR-ASST DIR MS PX PRE IMG	MANUAL	DEF					NA	NA	NA	N
20999	MUSCULOSKELETAL SURGERY	PRXOVR	DEF					NA	NA	NA	N
20999	MUSCULOSKELETAL SURGERY	MANUAL	DEF					NA	NA	NA	N
21010	INCISION OF JAW JOINT	PRXOVR	DEF					NA	NA	NA	N
21010	INCISION OF JAW JOINT	MAXFEE	DEF					532.99	1/1/2000	12/31/2299	N
21011	EXC FACE LES SC <2 CM	PRXOVR	DEF					NA	NA	NA	N
21011	EXC FACE LES SC <2 CM	MAXFEE	DEF					133.17	1/1/2010	12/31/2299	N
21012	EXC FACE LES SBQ 2 CM/<	PRXOVR	DEF					NA	NA	NA	N
21012	EXC FACE LES SBQ 2 CM/<	MAXFEE	DEF					183.31	1/1/2010	12/31/2299	N
21013	EXC FACE TUM DEEP < 2 CM	PRXOVR	DEF					NA	NA	NA	N
21013	EXC FACE TUM DEEP < 2 CM	MAXFEE	DEF					215.88	1/1/2010	12/31/2299	N

21014	EXC FACE TUM DEEP 2 CM/>	PRXOVR	DEF					NA	NA	NA	N
21014	EXC FACE TUM DEEP 2 CM/>	MAXFEE	DEF					283.58	1/1/2010	12/31/2299	N
21015	RESECT FACE TUM < 2 CM	PRXOVR	DEF					NA	NA	NA	N
21015	RESECT FACE TUM < 2 CM	MAXFEE	DEF					319.48	1/1/2004	12/31/2299	N
21016	RESECT FACE TUM 2 CM/>	PRXOVR	DEF					NA	NA	NA	N
21016	RESECT FACE TUM 2 CM/>	MAXFEE	DEF					574.10	1/1/2010	12/31/2299	N
21025	EXCISION OF BONE LOWER JAW	PRXOVR	DEF					NA	NA	NA	N
21025	EXCISION OF BONE LOWER JAW	MAXFEE	DEF					516.94	7/1/2008	12/31/2299	N
21026	EXCISION OF FACIAL BONE(S)	PRXOVR	DEF					NA	NA	NA	N
21026	EXCISION OF FACIAL BONE(S)	MAXFEE	DEF					258.22	7/1/2008	12/31/2299	N
21029	CONTOUR OF FACE BONE LESION	PRXOVR	DEF					NA	NA	NA	N
21029	CONTOUR OF FACE BONE LESION	MAXFEE	DEF					427.22	1/1/2004	12/31/2299	N
21030	EXCISE MAX/ZYGOMA B9 TUMOR	PRXOVR	DEF					NA	NA	NA	N
21030	EXCISE MAX/ZYGOMA B9 TUMOR	MAXFEE	DEF					272.33	1/1/2000	12/31/2299	N
21031	REMOVE EXOSTOSIS MANDIBLE	PRXOVR	DEF					NA	NA	NA	N
21031	REMOVE EXOSTOSIS MANDIBLE	MAXFEE	DEF					191.15	7/1/2008	12/31/2299	N
21032	REMOVE EXOSTOSIS MAXILLA	PRXOVR	DEF					NA	NA	NA	N
21032	REMOVE EXOSTOSIS MAXILLA	MAXFEE	DEF					194.57	7/1/2008	12/31/2299	N
21034	EXCISE MAX/ZYGOMA MAL TUMOR	PRXOVR	DEF					NA	NA	NA	N
21034	EXCISE MAX/ZYGOMA MAL TUMOR	MAXFEE	DEF					641.57	7/1/2008	12/31/2299	N
21040	EXCISE MANDIBLE LESION	PRXOVR	DEF					NA	NA	NA	N

21040	EXCISE MANDIBLE LESION	MAXFEE	DEF					210.26	7/1/2008	12/31/2299	N
21044	REMOVAL OF JAW BONE LESION	PRXOVR	DEF					NA	NA	NA	N
21044	REMOVAL OF JAW BONE LESION	MAXFEE	DEF					569.59	1/1/2000	12/31/2299	N
21045	EXTENSIVE JAW SURGERY	PRXOVR	DEF					NA	NA	NA	N
21045	EXTENSIVE JAW SURGERY	MAXFEE	DEF					791.67	1/1/2000	12/31/2299	N
21046	REMOVE MANDIBLE CYST COMPLEX	PRXOVR	DEF					NA	NA	NA	N
21046	REMOVE MANDIBLE CYST COMPLEX	MAXFEE	DEF					613.58	1/1/2004	12/31/2299	N
21047	EXCISE LWR JAW CYST W/REPAIR	PRXOVR	DEF					NA	NA	NA	N
21047	EXCISE LWR JAW CYST W/REPAIR	MAXFEE	DEF					760.42	1/1/2004	12/31/2299	N
21048	REMOVE MAXILLA CYST COMPLEX	PRXOVR	DEF					NA	NA	NA	N
21048	REMOVE MAXILLA CYST COMPLEX	MAXFEE	DEF					631.48	7/1/2003	12/31/2299	N
21049	EXCIS UPPR JAW CYST W/REPAIR	PRXOVR	DEF					NA	NA	NA	N
21049	EXCIS UPPR JAW CYST W/REPAIR	MAXFEE	DEF					720.46	7/1/2003	12/31/2299	N
21050	REMOVAL OF JAW JOINT	PRXOVR	DEF					NA	NA	NA	N
21050	REMOVAL OF JAW JOINT	MAXFEE	DEF					608.02	1/1/2000	12/31/2299	N
21060	REMOVE JAW JOINT CARTILAGE	PRXOVR	DEF					NA	NA	NA	N
21060	REMOVE JAW JOINT CARTILAGE	MAXFEE	DEF					568.62	1/1/2000	12/31/2299	N
21070	REMOVE CORONOID PROCESS	PRXOVR	DEF					NA	NA	NA	N
21070	REMOVE CORONOID PROCESS	MAXFEE	DEF					403.09	1/1/2000	12/31/2299	N
21073	MNPJ OF TMJ W/ANESTH	PRXOVR	DEF					NA	NA	NA	N
21073	MNPJ OF TMJ W/ANESTH	MAXFEE	DEF					217.07	1/1/2008	12/31/2299	N

21076	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21076	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					726.79	1/1/2000	12/31/2299	N
21077	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21077	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					1827.48	1/1/2000	12/31/2299	N
21079	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21079	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					1025.57	7/1/2003	12/31/2299	N
21080	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21080	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					1171.37	7/1/2003	12/31/2299	N
21081	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21081	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					1056.18	7/1/2003	12/31/2299	N
21082	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21082	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					932.95	7/1/2003	12/31/2299	N
21083	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21083	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					900.52	7/1/2003	12/31/2299	N
21084	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21084	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					1032.57	7/1/2003	12/31/2299	N
21085	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N

21085	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					402.91	7/1/2003	12/31/2299	N
21086	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21086	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					1146.21	7/1/2003	12/31/2299	N
21087	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21087	PREPARE FACE/ORAL PROSTHESIS	MAXFEE	DEF					1125.71	7/1/2003	12/31/2299	N
21088	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21088	PREPARE FACE/ORAL PROSTHESIS	MANUAL	DEF					NA	NA	NA	N
21089	PREPARE FACE/ORAL PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
21089	PREPARE FACE/ORAL PROSTHESIS	MANUAL	DEF					NA	NA	NA	N
21100	MAXILLOFACIAL FIXATION	PRXOVR	DEF					NA	NA	NA	N
21100	MAXILLOFACIAL FIXATION	MAXFEE	DEF					203.23	7/1/2008	12/31/2299	N
21116	INJECTION JAW JOINT X-RAY	PRXOVR	DEF					NA	NA	NA	N
21116	INJECTION JAW JOINT X-RAY	MAXFEE	DEF					36.52	1/1/2010	12/31/2299	N
21120	RECONSTRUCTION OF CHIN	PRXOVR	DEF					NA	NA	NA	N
21120	RECONSTRUCTION OF CHIN	MAXFEE	DEF					271.51	7/1/2008	12/31/2299	N
21121	RECONSTRUCTION OF CHIN	PRXOVR	DEF					NA	NA	NA	N
21121	RECONSTRUCTION OF CHIN	MAXFEE	DEF					367.13	1/1/2004	12/31/2299	N
21122	RECONSTRUCTION OF CHIN	PRXOVR	DEF					NA	NA	NA	N
21122	RECONSTRUCTION OF CHIN	MAXFEE	DEF					410.55	1/1/2004	12/31/2299	N
21123	RECONSTRUCTION OF CHIN	PRXOVR	DEF					NA	NA	NA	N
21123	RECONSTRUCTION OF CHIN	MAXFEE	DEF					520.14	1/1/2004	12/31/2299	N
21125	AUGMENTATION LOWER JAW BONE	PRXOVR	DEF					NA	NA	NA	N

21125	AUGMENTATION LOWER JAW BONE	MAXFEE	DEF					406.30	7/1/2008	12/31/2299	N
21127	AUGMENTATION LOWER JAW BONE	PRXOVR	DEF					NA	NA	NA	N
21127	AUGMENTATION LOWER JAW BONE	MAXFEE	DEF					517.63	1/1/2004	12/31/2299	N
21137	REDUCTION OF FOREHEAD	PRXOVR	DEF					NA	NA	NA	N
21137	REDUCTION OF FOREHEAD	MAXFEE	DEF					458.48	4/1/2008	12/31/2299	N
21138	REDUCTION OF FOREHEAD	PRXOVR	DEF					NA	NA	NA	N
21138	REDUCTION OF FOREHEAD	MAXFEE	DEF					566.39	4/1/2008	12/31/2299	N
21139	REDUCTION OF FOREHEAD	PRXOVR	DEF					NA	NA	NA	N
21139	REDUCTION OF FOREHEAD	MAXFEE	DEF					665.17	4/1/2008	12/31/2299	N
21141	LEFORT I-1 PIECE W/O GRAFT	PRXOVR	DEF					NA	NA	NA	N
21141	LEFORT I-1 PIECE W/O GRAFT	MAXFEE	DEF					855.57	1/1/2000	12/31/2299	N
21142	LEFORT I-2 PIECE W/O GRAFT	PRXOVR	DEF					NA	NA	NA	N
21142	LEFORT I-2 PIECE W/O GRAFT	MAXFEE	DEF					889.53	1/1/2000	12/31/2299	N
21143	LEFORT I-3/> PIECE W/O GRAFT	PRXOVR	DEF					NA	NA	NA	N
21143	LEFORT I-3/> PIECE W/O GRAFT	MAXFEE	DEF					924.15	1/1/2000	12/31/2299	N
21145	LEFORT I-1 PIECE W/ GRAFT	PRXOVR	DEF					NA	NA	NA	N
21145	LEFORT I-1 PIECE W/ GRAFT	MAXFEE	DEF					912.07	1/1/2000	12/31/2299	N
21146	LEFORT I-2 PIECE W/ GRAFT	PRXOVR	DEF					NA	NA	NA	N
21146	LEFORT I-2 PIECE W/ GRAFT	MAXFEE	DEF					946.35	1/1/2000	12/31/2299	N
21147	LEFORT I-3/> PIECE W/ GRAFT	PRXOVR	DEF					NA	NA	NA	N
21147	LEFORT I-3/> PIECE W/ GRAFT	MAXFEE	DEF					990.35	1/1/2000	12/31/2299	N
21150	LEFORT II ANTERIOR INTRUSION	PRXOVR	DEF					NA	NA	NA	N
21150	LEFORT II ANTERIOR INTRUSION	MAXFEE	DEF					1177.19	4/1/2008	12/31/2299	N
21151	LEFORT II W/BONE GRAFTS	PRXOVR	DEF					NA	NA	NA	N
21151	LEFORT II W/BONE GRAFTS	MAXFEE	DEF					1300.61	1/1/2000	12/31/2299	N

21154	LEFORT III W/O LEFORT I	PRXOVR	DEF					NA	NA	NA	N
21154	LEFORT III W/O LEFORT I	MAXFEE	DEF					1415.22	1/1/2000	12/31/2299	N
21155	LEFORT III W/ LEFORT I	PRXOVR	DEF					NA	NA	NA	N
21155	LEFORT III W/ LEFORT I	MAXFEE	DEF					1578.36	1/1/2000	12/31/2299	N
21159	LEFORT III W/FHDW/O LEFORT I	PRXOVR	DEF					NA	NA	NA	N
21159	LEFORT III W/FHDW/O LEFORT I	MAXFEE	DEF					1956.16	1/1/2000	12/31/2299	N
21160	LEFORT III W/FHD W/ LEFORT I	PRXOVR	DEF					NA	NA	NA	N
21160	LEFORT III W/FHD W/ LEFORT I	MAXFEE	DEF					2109.20	1/1/2000	12/31/2299	N
21172	RECONSTRUCT ORBIT/FOREHEAD	PRXOVR	DEF					NA	NA	NA	N
21172	RECONSTRUCT ORBIT/FOREHEAD	MAXFEE	DEF					1282.50	1/1/2000	12/31/2299	N
21175	RECONSTRUCT ORBIT/FOREHEAD	PRXOVR	DEF					NA	NA	NA	N
21175	RECONSTRUCT ORBIT/FOREHEAD	MAXFEE	DEF					1548.84	1/1/2000	12/31/2299	N
21179	RECONSTRUCT ENTIRE FOREHEAD	PRXOVR	DEF					NA	NA	NA	N
21179	RECONSTRUCT ENTIRE FOREHEAD	MAXFEE	DEF					1051.34	1/1/2000	12/31/2299	N
21180	RECONSTRUCT ENTIRE FOREHEAD	PRXOVR	DEF					NA	NA	NA	N
21180	RECONSTRUCT ENTIRE FOREHEAD	MAXFEE	DEF					1176.45	1/1/2000	12/31/2299	N
21181	CONTOUR CRANIAL BONE LESION	PRXOVR	DEF					NA	NA	NA	N
21181	CONTOUR CRANIAL BONE LESION	MAXFEE	DEF					462.32	1/1/2004	12/31/2299	N
21182	RECONSTRUCT CRANIAL BONE	PRXOVR	DEF					NA	NA	NA	N
21182	RECONSTRUCT CRANIAL BONE	MAXFEE	DEF					1523.60	1/1/2000	12/31/2299	N

21183	RECONSTRUCT CRANIAL BONE	PRXOVR	DEF					NA	NA	NA	N
21183	RECONSTRUCT CRANIAL BONE	MAXFEE	DEF					1653.31	1/1/2000	12/31/2299	N
21184	RECONSTRUCT CRANIAL BONE	PRXOVR	DEF					NA	NA	NA	N
21184	RECONSTRUCT CRANIAL BONE	MAXFEE	DEF					1781.43	1/1/2000	12/31/2299	N
21188	RECONSTRUCTION OF MIDFACE	PRXOVR	DEF					NA	NA	NA	N
21188	RECONSTRUCTION OF MIDFACE	MAXFEE	DEF					1049.24	1/1/2000	12/31/2299	N
21193	RECONST LWR JAW W/O GRAFT	PRXOVR	DEF					NA	NA	NA	N
21193	RECONST LWR JAW W/O GRAFT	MAXFEE	DEF					788	1/1/2000	12/31/2299	N
21194	RECONST LWR JAW W/GRAFT	PRXOVR	DEF					NA	NA	NA	N
21194	RECONST LWR JAW W/GRAFT	MAXFEE	DEF					921.91	1/1/2000	12/31/2299	N
21195	RECONST LWR JAW W/O FIXATION	PRXOVR	DEF					NA	NA	NA	N
21195	RECONST LWR JAW W/O FIXATION	MAXFEE	DEF					800.29	1/1/2000	12/31/2299	N
21196	RECONST LWR JAW W/FIXATION	PRXOVR	DEF					NA	NA	NA	N
21196	RECONST LWR JAW W/FIXATION	MAXFEE	DEF					878.78	1/1/2000	12/31/2299	N
21198	RECONSTR LWR JAW SEGMENT	PRXOVR	DEF					NA	NA	NA	N
21198	RECONSTR LWR JAW SEGMENT	MAXFEE	DEF					768.88	4/1/2008	12/31/2299	N
21199	RECONSTR LWR JAW W/ADVANCE	PRXOVR	DEF					NA	NA	NA	N
21199	RECONSTR LWR JAW W/ADVANCE	MAXFEE	DEF					767.55	4/1/2008	12/31/2299	N

21206	RECONSTRUCT UPPER JAW BONE	PRXOVR	DEF					NA	NA	NA	N
21206	RECONSTRUCT UPPER JAW BONE	MAXFEE	DEF					657.52	1/1/2000	12/31/2299	N
21208	AUGMENTATION OF FACIAL BONES	PRXOVR	DEF					NA	NA	NA	N
21208	AUGMENTATION OF FACIAL BONES	MAXFEE	DEF					561.14	1/1/2000	12/31/2299	N
21209	REDUCTION OF FACIAL BONES	PRXOVR	DEF					NA	NA	NA	N
21209	REDUCTION OF FACIAL BONES	MAXFEE	DEF					343.14	7/1/2008	12/31/2299	N
21210	FACE BONE GRAFT	PRXOVR	DEF					NA	NA	NA	N
21210	FACE BONE GRAFT	MAXFEE	DEF					565.83	1/1/2000	12/31/2299	N
21215	LOWER JAW BONE GRAFT	PRXOVR	DEF					NA	NA	NA	N
21215	LOWER JAW BONE GRAFT	MAXFEE	DEF					594.54	1/1/2000	12/31/2299	N
21230	RIB CARTILAGE GRAFT	PRXOVR	DEF					NA	NA	NA	N
21230	RIB CARTILAGE GRAFT	MAXFEE	DEF					583.54	1/1/2000	12/31/2299	N
21235	EAR CARTILAGE GRAFT	PRXOVR	DEF					NA	NA	NA	N
21235	EAR CARTILAGE GRAFT	MAXFEE	DEF					407.18	1/1/2000	12/31/2299	N
21240	RECONSTRUCTION OF JAW JOINT	PRXOVR	DEF					NA	NA	NA	N
21240	RECONSTRUCTION OF JAW JOINT	MAXFEE	DEF					782.74	1/1/2000	12/31/2299	N
21242	RECONSTRUCTION OF JAW JOINT	PRXOVR	DEF					NA	NA	NA	N
21242	RECONSTRUCTION OF JAW JOINT	MAXFEE	DEF					730.34	1/1/2000	12/31/2299	N
21243	RECONSTRUCTION OF JAW JOINT	PRXOVR	DEF					NA	NA	NA	N
21243	RECONSTRUCTION OF JAW JOINT	MAXFEE	DEF					940.96	1/1/2000	12/31/2299	N

21244	RECONSTRUCTION OF LOWER JAW	PRXOVR	DEF					NA	NA	NA	N
21244	RECONSTRUCTION OF LOWER JAW	MAXFEE	DEF					670.65	1/1/2000	12/31/2299	N
21245	RECONSTRUCTION OF JAW	PRXOVR	DEF					NA	NA	NA	N
21245	RECONSTRUCTION OF JAW	MAXFEE	DEF					628.88	1/1/2000	12/31/2299	N
21246	RECONSTRUCTION OF JAW	PRXOVR	DEF					NA	NA	NA	N
21246	RECONSTRUCTION OF JAW	MAXFEE	DEF					576.06	1/1/2000	12/31/2299	N
21247	RECONSTRUCT LOWER JAW BONE	PRXOVR	DEF					NA	NA	NA	N
21247	RECONSTRUCT LOWER JAW BONE	MAXFEE	DEF					1219.56	1/1/2000	12/31/2299	N
21248	RECONSTRUCTION OF JAW	PRXOVR	DEF					NA	NA	NA	N
21248	RECONSTRUCTION OF JAW	MAXFEE	DEF					637	1/1/2000	12/31/2299	N
21249	RECONSTRUCTION OF JAW	PRXOVR	DEF					NA	NA	NA	N
21249	RECONSTRUCTION OF JAW	MAXFEE	DEF					973.15	1/1/2000	12/31/2299	N
21255	RECONSTRUCT LOWER JAW BONE	PRXOVR	DEF					NA	NA	NA	N
21255	RECONSTRUCT LOWER JAW BONE	MAXFEE	DEF					919.29	1/1/2000	12/31/2299	N
21256	RECONSTRUCTION OF ORBIT	PRXOVR	DEF					NA	NA	NA	N
21256	RECONSTRUCTION OF ORBIT	MAXFEE	DEF					911.51	1/1/2000	12/31/2299	N
21260	REVISE EYE SOCKETS	PRXOVR	DEF					NA	NA	NA	N
21260	REVISE EYE SOCKETS	MAXFEE	DEF					911.10	4/1/2008	12/31/2299	N
21261	REVISE EYE SOCKETS	PRXOVR	DEF					NA	NA	NA	N
21261	REVISE EYE SOCKETS	MAXFEE	DEF					1318.39	1/1/2000	12/31/2299	N
21263	REVISE EYE SOCKETS	PRXOVR	DEF					NA	NA	NA	N
21263	REVISE EYE SOCKETS	MAXFEE	DEF					1517.61	1/1/2000	12/31/2299	N
21267	REVISE EYE SOCKETS	PRXOVR	DEF					NA	NA	NA	N
21267	REVISE EYE SOCKETS	MAXFEE	DEF					959.04	1/1/2000	12/31/2299	N
21268	REVISE EYE SOCKETS	PRXOVR	DEF					NA	NA	NA	N
21268	REVISE EYE SOCKETS	MAXFEE	DEF					1131.98	1/1/2000	12/31/2299	N

21270	AUGMENTATION CHEEK BONE	PRXOVR	DEF					NA	NA	NA	N
21270	AUGMENTATION CHEEK BONE	MAXFEE	DEF					539.79	1/1/2000	12/31/2299	N
21275	REVISION ORBITOFACIAL BONES	PRXOVR	DEF					NA	NA	NA	N
21275	REVISION ORBITOFACIAL BONES	MAXFEE	DEF					582.09	1/1/2000	12/31/2299	N
21280	REVISION OF EYELID	PRXOVR	DEF					NA	NA	NA	N
21280	REVISION OF EYELID	MAXFEE	DEF					354.46	1/1/2000	12/31/2299	N
21282	REVISION OF EYELID	PRXOVR	DEF					NA	NA	NA	N
21282	REVISION OF EYELID	MAXFEE	DEF					228.05	1/1/2000	12/31/2299	N
21295	REVISION OF JAW MUSCLE/BONE	PRXOVR	DEF					NA	NA	NA	N
21295	REVISION OF JAW MUSCLE/BONE	MAXFEE	DEF					94.94	7/1/2008	12/31/2299	N
21296	REVISION OF JAW MUSCLE/BONE	PRXOVR	DEF					NA	NA	NA	N
21296	REVISION OF JAW MUSCLE/BONE	MAXFEE	DEF					217.39	1/1/2004	12/31/2299	N
21299	CRANIO/MAXILLOFACIAL SURGERY	PRXOVR	DEF					NA	NA	NA	N
21299	CRANIO/MAXILLOFACIAL SURGERY	MANUAL	DEF					NA	NA	NA	N
21300	TREATMENT OF SKULL FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21300	TREATMENT OF SKULL FRACTURE	MAXFEE	DEF					NA			N
21310	CLOSED TX NOSE FX W/O MANJ	PRXOVR	DEF					NA	NA	NA	N
21310	CLOSED TX NOSE FX W/O MANJ	MAXFEE	DEF					24.44	1/1/2010	12/31/2299	N
21315	CLOSED TX NOSE FX W/O STABLJ	PRXOVR	DEF					NA	NA	NA	N

21315	CLOSED TX NOSE FX W/O STABLJ	MAXFEE	DEF					100.53	1/1/2000	12/31/2299	N
21320	CLOSED TX NOSE FX W/ STABLJ	PRXOVR	DEF					NA	NA	NA	N
21320	CLOSED TX NOSE FX W/ STABLJ	MAXFEE	DEF					110.90	1/1/2010	12/31/2299	N
21325	OPEN TX NOSE FX UNCOMPLICATD	PRXOVR	DEF					NA	NA	NA	N
21325	OPEN TX NOSE FX UNCOMPLICATD	MAXFEE	DEF					263.29	7/1/2008	12/31/2299	N
21330	OPEN TX NOSE FX W/SKELE FIXJ	PRXOVR	DEF					NA	NA	NA	N
21330	OPEN TX NOSE FX W/SKELE FIXJ	MAXFEE	DEF					322.96	7/1/2008	12/31/2299	N
21335	OPEN TX NOSE & SEPTAL FX	PRXOVR	DEF					NA	NA	NA	N
21335	OPEN TX NOSE & SEPTAL FX	MAXFEE	DEF					500.89	1/1/2000	12/31/2299	N
21336	OPEN TX SEPTAL FX W/WO STABJ	PRXOVR	DEF					NA	NA	NA	N
21336	OPEN TX SEPTAL FX W/WO STABJ	MAXFEE	DEF					343.04	7/1/2008	12/31/2299	N
21337	CLOSED TX SEPTAL&NOSE FX	PRXOVR	DEF					NA	NA	NA	N
21337	CLOSED TX SEPTAL&NOSE FX	MAXFEE	DEF					165.46	1/1/2000	12/31/2299	N
21338	OPEN NASOETHMOID FX W/O FIXJ	PRXOVR	DEF					NA	NA	NA	N
21338	OPEN NASOETHMOID FX W/O FIXJ	MAXFEE	DEF					431.18	7/1/2008	12/31/2299	N
21339	OPEN NASOETHMOID FX W/ FIXJ	PRXOVR	DEF					NA	NA	NA	N
21339	OPEN NASOETHMOID FX W/ FIXJ	MAXFEE	DEF					471.49	7/1/2008	12/31/2299	N
21340	PERQ TX NASOETHMOID FX	PRXOVR	DEF					NA	NA	NA	N
21340	PERQ TX NASOETHMOID FX	MAXFEE	DEF					541.69	1/1/2000	12/31/2299	N
21343	OPEN TX DPRSD FRONT SINUS FX	PRXOVR	DEF					NA	NA	NA	N

21343	OPEN TX DPRSD FRONT SINUS FX	MAXFEE	DEF					634.32	7/1/2008	12/31/2299	N
21344	OPEN TX COMPL FRONT SINUS FX	PRXOVR	DEF					NA	NA	NA	N
21344	OPEN TX COMPL FRONT SINUS FX	MAXFEE	DEF					823.93	7/1/2008	12/31/2299	N
21345	CLOSED TX NOSE/JAW FX	PRXOVR	DEF					NA	NA	NA	N
21345	CLOSED TX NOSE/JAW FX	MAXFEE	DEF					447.76	1/1/2004	12/31/2299	N
21346	OPN TX NASOMAX FX W/FIXJ	PRXOVR	DEF					NA	NA	NA	N
21346	OPN TX NASOMAX FX W/FIXJ	MAXFEE	DEF					547.78	1/1/2000	12/31/2299	N
21347	OPN TX NASOMAX FX MULTPLE	PRXOVR	DEF					NA	NA	NA	N
21347	OPN TX NASOMAX FX MULTPLE	MAXFEE	DEF					629.02	1/1/2000	12/31/2299	N
21348	OPN TX NASOMAX FX W/GRAFT	PRXOVR	DEF					NA	NA	NA	N
21348	OPN TX NASOMAX FX W/GRAFT	MAXFEE	DEF					780.24	1/1/2000	12/31/2299	N
21355	PERQ TX MALAR FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21355	PERQ TX MALAR FRACTURE	MAXFEE	DEF					167.45	7/1/2008	12/31/2299	N
21356	OPN TX DPRSD ZYGOMATIC ARCH	PRXOVR	DEF					NA	NA	NA	N
21356	OPN TX DPRSD ZYGOMATIC ARCH	MAXFEE	DEF					253.06	1/1/2007	12/31/2299	N
21360	OPN TX DPRSD MALAR FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21360	OPN TX DPRSD MALAR FRACTURE	MAXFEE	DEF					375.55	4/1/2008	12/31/2299	N
21365	OPN TX COMPLX MALAR FX	PRXOVR	DEF					NA	NA	NA	N
21365	OPN TX COMPLX MALAR FX	MAXFEE	DEF					743.60	1/1/2004	12/31/2299	N
21366	OPN TX COMPLX MALAR W/GRFT	PRXOVR	DEF					NA	NA	NA	N

21366	OPN TX COMPLX MALAR W/GRFT	MAXFEE	DEF					819.55	1/1/2000	12/31/2299	N
21385	OPN TX ORBIT FX TRANSANTRAL	PRXOVR	DEF					NA	NA	NA	N
21385	OPN TX ORBIT FX TRANSANTRAL	MAXFEE	DEF					502.99	1/1/2004	12/31/2299	N
21386	OPN TX ORBIT FX PERIORBITAL	PRXOVR	DEF					NA	NA	NA	N
21386	OPN TX ORBIT FX PERIORBITAL	MAXFEE	DEF					503.10	1/1/2004	12/31/2299	N
21387	OPN TX ORBIT FX COMBINED	PRXOVR	DEF					NA	NA	NA	N
21387	OPN TX ORBIT FX COMBINED	MAXFEE	DEF					481.11	1/1/2004	12/31/2299	N
21390	OPN TX ORBIT PERIORBTL IMPLT	PRXOVR	DEF					NA	NA	NA	N
21390	OPN TX ORBIT PERIORBTL IMPLT	MAXFEE	DEF					582.12	4/1/2008	12/31/2299	N
21395	OPN TX ORBIT PERIORBT W/GRFT	PRXOVR	DEF					NA	NA	NA	N
21395	OPN TX ORBIT PERIORBT W/GRFT	MAXFEE	DEF					622.68	1/1/2004	12/31/2299	N
21400	CLOSED TX ORBIT W/O MANIPULJ	PRXOVR	DEF					NA	NA	NA	N
21400	CLOSED TX ORBIT W/O MANIPULJ	MAXFEE	DEF					92.28	1/1/2000	12/31/2299	N
21401	CLOSED TX ORBIT W/ MANIPULJ	PRXOVR	DEF					NA	NA	NA	N
21401	CLOSED TX ORBIT W/ MANIPULJ	MAXFEE	DEF					168.17	1/1/2000	12/31/2299	N
21406	OPN TX ORBIT FX W/O IMPLANT	PRXOVR	DEF					NA	NA	NA	N
21406	OPN TX ORBIT FX W/O IMPLANT	MAXFEE	DEF					348.90	4/1/2008	12/31/2299	N
21407	OPN TX ORBIT FX W/IMPLANT	PRXOVR	DEF					NA	NA	NA	N
21407	OPN TX ORBIT FX W/IMPLANT	MAXFEE	DEF					437.29	4/1/2008	12/31/2299	N

21408	OPN TX ORBIT FX W/BONE GRFT	PRXOVR	DEF					NA	NA	NA	N
21408	OPN TX ORBIT FX W/BONE GRFT	MAXFEE	DEF					575.12	1/1/2000	12/31/2299	N
21421	TREAT MOUTH ROOF FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21421	TREAT MOUTH ROOF FRACTURE	MAXFEE	DEF					314.94	7/1/2008	12/31/2299	N
21422	TREAT MOUTH ROOF FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21422	TREAT MOUTH ROOF FRACTURE	MAXFEE	DEF					472.94	1/1/2004	12/31/2299	N
21423	TREAT MOUTH ROOF FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21423	TREAT MOUTH ROOF FRACTURE	MAXFEE	DEF					542.72	1/1/2000	12/31/2299	N
21431	TREAT CRANIOFACIAL FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21431	TREAT CRANIOFACIAL FRACTURE	MAXFEE	DEF					375.08	7/1/2008	12/31/2299	N
21432	TREAT CRANIOFACIAL FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21432	TREAT CRANIOFACIAL FRACTURE	MAXFEE	DEF					414.65	1/1/2000	12/31/2299	N
21433	TREAT CRANIOFACIAL FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21433	TREAT CRANIOFACIAL FRACTURE	MAXFEE	DEF					1174.07	1/1/2000	12/31/2299	N
21435	TREAT CRANIOFACIAL FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21435	TREAT CRANIOFACIAL FRACTURE	MAXFEE	DEF					833.30	1/1/2000	12/31/2299	N
21436	TREAT CRANIOFACIAL FRACTURE	PRXOVR	DEF					NA	NA	NA	N

21436	TREAT CRANIOFACIAL FRACTURE	MAXFEE	DEF					1169.23	1/1/2000	12/31/2299	N
21440	TREAT DENTAL RIDGE FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21440	TREAT DENTAL RIDGE FRACTURE	MAXFEE	DEF					243.15	7/1/2008	12/31/2299	N
21445	TREAT DENTAL RIDGE FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21445	TREAT DENTAL RIDGE FRACTURE	MAXFEE	DEF					319.75	7/1/2008	12/31/2299	N
21450	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21450	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					229.89	7/1/2008	12/31/2299	N
21451	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21451	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					310.38	7/1/2008	12/31/2299	N
21452	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21452	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					157.44	7/1/2008	12/31/2299	N
21453	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21453	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					379.90	7/1/2008	12/31/2299	N
21454	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21454	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					378.10	1/1/2000	12/31/2299	N
21461	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21461	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					475.81	7/1/2008	12/31/2299	N

21462	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21462	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					551.94	1/1/2000	12/31/2299	N
21465	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21465	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					549.24	1/1/2000	12/31/2299	N
21470	TREAT LOWER JAW FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21470	TREAT LOWER JAW FRACTURE	MAXFEE	DEF					835.20	1/1/2004	12/31/2299	N
21480	RESET DISLOCATED JAW	PRXOVR	DEF					NA	NA	NA	N
21480	RESET DISLOCATED JAW	MAXFEE	DEF					27.62	1/1/2010	12/31/2299	N
21485	RESET DISLOCATED JAW	PRXOVR	DEF					NA	NA	NA	N
21485	RESET DISLOCATED JAW	MAXFEE	DEF					275.57	7/1/2008	12/31/2299	N
21490	REPAIR DISLOCATED JAW	PRXOVR	DEF					NA	NA	NA	N
21490	REPAIR DISLOCATED JAW	MAXFEE	DEF					499.57	7/1/2008	12/31/2299	N
21493	TREAT HYOID BONE FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21493	TREAT HYOID BONE FRACTURE	MAXFEE	DEF					NA			N
21494	TREAT HYOID BONE FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21494	TREAT HYOID BONE FRACTURE	MAXFEE	DEF					NA			N
21495	TREAT HYOID BONE FRACTURE	PRXOVR	DEF					NA	NA	NA	N
21495	TREAT HYOID BONE FRACTURE	MAXFEE	DEF					329.38	7/1/2008	12/31/2299	N
21499	HEAD SURGERY PROCEDURE	PRXOVR	DEF					NA	NA	NA	N
21499	HEAD SURGERY PROCEDURE	MANUAL	DEF					NA	NA	NA	N
30400	RECONSTRUCTION OF NOSE	PRXOVR	DEF					NA	NA	NA	N

30400	RECONSTRUCTION OF NOSE	MAXFEE	DEF					559.22	7/1/2008	12/31/2299	N
30410	RECONSTRUCTION OF NOSE	PRXOVR	DEF					NA	NA	NA	N
30410	RECONSTRUCTION OF NOSE	MAXFEE	DEF					680.92	7/1/2008	12/31/2299	N
30420	RECONSTRUCTION OF NOSE	PRXOVR	DEF					NA	NA	NA	N
30420	RECONSTRUCTION OF NOSE	MAXFEE	DEF					736.55	7/1/2003	12/31/2299	N
30430	REVISION OF NOSE	PRXOVR	DEF					NA	NA	NA	N
30430	REVISION OF NOSE	MAXFEE	DEF					503.07	7/1/2008	12/31/2299	N
30435	REVISION OF NOSE	PRXOVR	DEF					NA	NA	NA	N
30435	REVISION OF NOSE	MAXFEE	DEF					668.47	7/1/2008	12/31/2299	N
30450	REVISION OF NOSE	PRXOVR	DEF					NA	NA	NA	N
30450	REVISION OF NOSE	MAXFEE	DEF					874.92	7/1/2008	12/31/2299	N
30460	REVISION OF NOSE	PRXOVR	DEF					NA	NA	NA	N
30460	REVISION OF NOSE	MAXFEE	DEF					499.98	1/1/2004	12/31/2299	N
30462	REVISION OF NOSE	PRXOVR	DEF					NA	NA	NA	N
30462	REVISION OF NOSE	MAXFEE	DEF					969.04	1/1/2004	12/31/2299	N
30465	REPAIR NASAL STENOSIS	PRXOVR	DEF					NA	NA	NA	N
30465	REPAIR NASAL STENOSIS	MAXFEE	DEF					600.56	1/1/2004	12/31/2299	N
30520	REPAIR OF NASAL SEPTUM	PRXOVR	DEF					NA	NA	NA	N
30520	REPAIR OF NASAL SEPTUM	MAXFEE	DEF					328.19	1/1/2000	12/31/2299	N
30540	REPAIR NASAL DEFECT	PRXOVR	DEF					NA	NA	NA	N
30540	REPAIR NASAL DEFECT	MAXFEE	DEF					386.89	1/1/2000	12/31/2299	N
30545	REPAIR NASAL DEFECT	PRXOVR	DEF					NA	NA	NA	N
30545	REPAIR NASAL DEFECT	MAXFEE	DEF					584.66	1/1/2004	12/31/2299	N
30560	RELEASE OF NASAL ADHESIONS	PRXOVR	DEF					NA	NA	NA	N
30560	RELEASE OF NASAL ADHESIONS	MAXFEE	DEF					97.40	1/1/2004	12/31/2299	N
30580	REPAIR UPPER JAW FISTULA	PRXOVR	DEF					NA	NA	NA	N
30580	REPAIR UPPER JAW FISTULA	MAXFEE	DEF					335.05	1/1/2000	12/31/2299	N
30600	REPAIR MOUTH/NOSE FISTULA	PRXOVR	DEF					NA	NA	NA	N

30600	REPAIR MOUTH/NOSE FISTULA	MAXFEE	DEF					262.93	1/1/2000	12/31/2299	N
30620	INTRANASAL RECONSTRUCTION	PRXOVR	DEF					NA	NA	NA	N
30620	INTRANASAL RECONSTRUCTION	MAXFEE	DEF					346.60	1/1/2000	12/31/2299	N
30630	REPAIR NASAL SEPTUM DEFECT	PRXOVR	DEF					NA	NA	NA	N
30630	REPAIR NASAL SEPTUM DEFECT	MAXFEE	DEF					365.30	1/1/2000	12/31/2299	N
40490	BIOPSY OF LIP	PRXOVR	DEF					NA	NA	NA	N
40490	BIOPSY OF LIP	MAXFEE	DEF					63.27	7/1/2008	12/31/2299	N
40500	PARTIAL EXCISION OF LIP	PRXOVR	DEF					NA	NA	NA	N
40500	PARTIAL EXCISION OF LIP	MAXFEE	DEF					251.36	1/1/2000	12/31/2299	N
40510	PARTIAL EXCISION OF LIP	PRXOVR	DEF					NA	NA	NA	N
40510	PARTIAL EXCISION OF LIP	MAXFEE	DEF					273.73	1/1/2000	12/31/2299	N
40520	PARTIAL EXCISION OF LIP	PRXOVR	DEF					NA	NA	NA	N
40520	PARTIAL EXCISION OF LIP	MAXFEE	DEF					259.27	1/1/2000	12/31/2299	N
40525	RECONSTRUCT LIP WITH FLAP	PRXOVR	DEF					NA	NA	NA	N
40525	RECONSTRUCT LIP WITH FLAP	MAXFEE	DEF					438.59	1/1/2000	12/31/2299	N
40527	RECONSTRUCT LIP WITH FLAP	PRXOVR	DEF					NA	NA	NA	N
40527	RECONSTRUCT LIP WITH FLAP	MAXFEE	DEF					524.88	1/1/2000	12/31/2299	N
40530	PARTIAL REMOVAL OF LIP	PRXOVR	DEF					NA	NA	NA	N
40530	PARTIAL REMOVAL OF LIP	MAXFEE	DEF					286.10	1/1/2000	12/31/2299	N
40650	REPAIR LIP	PRXOVR	DEF					NA	NA	NA	N
40650	REPAIR LIP	MAXFEE	DEF					211.48	1/1/2000	12/31/2299	N
40652	REPAIR LIP	PRXOVR	DEF					NA	NA	NA	N
40652	REPAIR LIP	MAXFEE	DEF					251.40	1/1/2000	12/31/2299	N
40654	REPAIR LIP	PRXOVR	DEF					NA	NA	NA	N
40654	REPAIR LIP	MAXFEE	DEF					309.61	1/1/2000	12/31/2299	N
40700	REPAIR CLEFT LIP/NASAL	PRXOVR	DEF					NA	NA	NA	N

40700	REPAIR CLEFT LIP/NASAL	MAXFEE	DEF					585.65	1/1/2004	12/31/2299	N
40701	REPAIR CLEFT LIP/NASAL	PRXOVR	DEF					NA	NA	NA	N
40701	REPAIR CLEFT LIP/NASAL	MAXFEE	DEF					892.37	1/1/2004	12/31/2299	N
40702	REPAIR CLEFT LIP/NASAL	PRXOVR	DEF					NA	NA	NA	N
40702	REPAIR CLEFT LIP/NASAL	MAXFEE	DEF					603.04	1/1/2000	12/31/2299	N
40720	REPAIR CLEFT LIP/NASAL	PRXOVR	DEF					NA	NA	NA	N
40720	REPAIR CLEFT LIP/NASAL	MAXFEE	DEF					644.75	1/1/2004	12/31/2299	N
40761	REPAIR CLEFT LIP/NASAL	PRXOVR	DEF					NA	NA	NA	N
40761	REPAIR CLEFT LIP/NASAL	MAXFEE	DEF					709.15	1/1/2004	12/31/2299	N
40799	LIP SURGERY PROCEDURE	PRXOVR	DEF					NA	NA	NA	N
40799	LIP SURGERY PROCEDURE	MANUAL	DEF					NA	NA	NA	N
40800	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
40800	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					81.67	1/1/2004	12/31/2299	N
40801	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
40801	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					149.13	7/1/2008	12/31/2299	N
40804	REMOVAL FOREIGN BODY MOUTH	PRXOVR	DEF					NA	NA	NA	N
40804	REMOVAL FOREIGN BODY MOUTH	MAXFEE	DEF					96.34	1/1/2004	12/31/2299	N
40805	REMOVAL FOREIGN BODY MOUTH	PRXOVR	DEF					NA	NA	NA	N
40805	REMOVAL FOREIGN BODY MOUTH	MAXFEE	DEF					141.30	1/1/2004	12/31/2299	N
40806	INCISION OF LIP FOLD	PRXOVR	DEF					NA	NA	NA	N
40806	INCISION OF LIP FOLD	MAXFEE	DEF					20.11	1/1/2004	12/31/2299	N
40808	BIOPSY OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
40808	BIOPSY OF MOUTH LESION	MAXFEE	DEF					83.15	7/1/2008	12/31/2299	N
40810	EXCISION OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
40810	EXCISION OF MOUTH LESION	MAXFEE	DEF					72.81	1/1/2000	12/31/2299	N
40812	EXCISE/REPAIR MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N

40812	EXCISE/REPAIR MOUTH LESION	MAXFEE	DEF					107.10	1/1/2000	12/31/2299	N
40814	EXCISE/REPAIR MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
40814	EXCISE/REPAIR MOUTH LESION	MAXFEE	DEF					179.88	1/1/2000	12/31/2299	N
40816	EXCISION OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
40816	EXCISION OF MOUTH LESION	MAXFEE	DEF					197.65	7/1/2008	12/31/2299	N
40818	EXCISE ORAL MUCOSA FOR GRAFT	PRXOVR	DEF					NA	NA	NA	N
40818	EXCISE ORAL MUCOSA FOR GRAFT	MAXFEE	DEF					143.33	7/1/2008	12/31/2299	N
40819	EXCISE LIP OR CHEEK FOLD	PRXOVR	DEF					NA	NA	NA	N
40819	EXCISE LIP OR CHEEK FOLD	MAXFEE	DEF					121.98	7/1/2008	12/31/2299	N
40820	TREATMENT OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
40820	TREATMENT OF MOUTH LESION	MAXFEE	DEF					82.95	7/1/2008	12/31/2299	N
40830	REPAIR MOUTH LACERATION	PRXOVR	DEF					NA	NA	NA	N
40830	REPAIR MOUTH LACERATION	MAXFEE	DEF					84.49	7/1/2008	12/31/2299	N
40831	REPAIR MOUTH LACERATION	PRXOVR	DEF					NA	NA	NA	N
40831	REPAIR MOUTH LACERATION	MAXFEE	DEF					121	7/1/2008	12/31/2299	N
40840	RECONSTRUCTION OF MOUTH	PRXOVR	DEF					NA	NA	NA	N
40840	RECONSTRUCTION OF MOUTH	MAXFEE	DEF					399.82	1/1/2000	12/31/2299	N
40842	RECONSTRUCTION OF MOUTH	PRXOVR	DEF					NA	NA	NA	N
40842	RECONSTRUCTION OF MOUTH	MAXFEE	DEF					399.76	1/1/2000	12/31/2299	N
40843	RECONSTRUCTION OF MOUTH	PRXOVR	DEF					NA	NA	NA	N
40843	RECONSTRUCTION OF MOUTH	MAXFEE	DEF					550	1/1/2000	12/31/2299	N
40844	RECONSTRUCTION OF MOUTH	PRXOVR	DEF					NA	NA	NA	N
40844	RECONSTRUCTION OF MOUTH	MAXFEE	DEF					723.50	1/1/2000	12/31/2299	N
40845	RECONSTRUCTION OF MOUTH	PRXOVR	DEF					NA	NA	NA	N
40845	RECONSTRUCTION OF MOUTH	MAXFEE	DEF					988.38	1/1/2000	12/31/2299	N

40899	MOUTH SURGERY PROCEDURE	PRXOVR	DEF					NA	NA	NA	N
40899	MOUTH SURGERY PROCEDURE	MANUAL	DEF					NA	NA	NA	N
41000	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41000	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					98.66	7/1/2008	12/31/2299	N
41005	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41005	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					95.58	1/1/2004	12/31/2299	N
41006	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41006	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					139.92	7/1/2008	12/31/2299	N
41007	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41007	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					162.02	1/1/2000	12/31/2299	N
41008	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41008	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					182.18	7/1/2008	12/31/2299	N
41009	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41009	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					184.27	1/1/2000	12/31/2299	N
41010	INCISION OF TONGUE FOLD	PRXOVR	DEF					NA	NA	NA	N
41010	INCISION OF TONGUE FOLD	MAXFEE	DEF					56.29	7/1/2008	12/31/2299	N
41015	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41015	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					178.76	7/1/2008	12/31/2299	N
41016	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41016	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					217.82	7/1/2008	12/31/2299	N
41017	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41017	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					185.96	7/1/2008	12/31/2299	N
41018	DRAINAGE OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41018	DRAINAGE OF MOUTH LESION	MAXFEE	DEF					241.24	1/1/2000	12/31/2299	N
41019	PLACE NEEDLES H&N FOR RT	PRXOVR	DEF					NA	NA	NA	N
41019	PLACE NEEDLES H&N FOR RT	MAXFEE	DEF					291.79	1/1/2008	12/31/2299	N
41100	BIOPSY OF TONGUE	PRXOVR	DEF					NA	NA	NA	N
41100	BIOPSY OF TONGUE	MAXFEE	DEF					72.58	10/1/2004	12/31/2299	N
41105	BIOPSY OF TONGUE	PRXOVR	DEF					NA	NA	NA	N

41105	BIOPSY OF TONGUE	MAXFEE	DEF					71.67	1/1/2004	12/31/2299	N
41108	BIOPSY OF FLOOR OF MOUTH	PRXOVR	DEF					NA	NA	NA	N
41108	BIOPSY OF FLOOR OF MOUTH	MAXFEE	DEF					56.98	1/1/2000	12/31/2299	N
41110	EXCISION OF TONGUE LESION	PRXOVR	DEF					NA	NA	NA	N
41110	EXCISION OF TONGUE LESION	MAXFEE	DEF					100.06	7/1/2008	12/31/2299	N
41112	EXCISION OF TONGUE LESION	PRXOVR	DEF					NA	NA	NA	N
41112	EXCISION OF TONGUE LESION	MAXFEE	DEF					140.50	1/1/2000	12/31/2299	N
41113	EXCISION OF TONGUE LESION	PRXOVR	DEF					NA	NA	NA	N
41113	EXCISION OF TONGUE LESION	MAXFEE	DEF					175.92	1/1/2000	12/31/2299	N
41114	EXCISION OF TONGUE LESION	PRXOVR	DEF					NA	NA	NA	N
41114	EXCISION OF TONGUE LESION	MAXFEE	DEF					399.84	1/1/2000	12/31/2299	N
41115	EXCISION OF TONGUE FOLD	PRXOVR	DEF					NA	NA	NA	N
41115	EXCISION OF TONGUE FOLD	MAXFEE	DEF					97.37	1/1/2004	12/31/2299	N
41116	EXCISION OF MOUTH LESION	PRXOVR	DEF					NA	NA	NA	N
41116	EXCISION OF MOUTH LESION	MAXFEE	DEF					134.90	1/1/2000	12/31/2299	N
41120	PARTIAL REMOVAL OF TONGUE	PRXOVR	DEF					NA	NA	NA	N
41120	PARTIAL REMOVAL OF TONGUE	MAXFEE	DEF					554.84	7/1/2008	12/31/2299	N
41130	PARTIAL REMOVAL OF TONGUE	PRXOVR	DEF					NA	NA	NA	N
41130	PARTIAL REMOVAL OF TONGUE	MAXFEE	DEF					673.27	7/1/2008	12/31/2299	N
41135	TONGUE AND NECK SURGERY	PRXOVR	DEF					NA	NA	NA	N
41135	TONGUE AND NECK SURGERY	MAXFEE	DEF					1128.12	7/1/2008	12/31/2299	N
41140	REMOVAL OF TONGUE	PRXOVR	DEF					NA	NA	NA	N
41140	REMOVAL OF TONGUE	MAXFEE	DEF					1198.92	1/1/2000	12/31/2299	N
41145	TONGUE REMOVAL NECK SURGERY	PRXOVR	DEF					NA	NA	NA	N
41145	TONGUE REMOVAL NECK SURGERY	MAXFEE	DEF					1452.24	7/1/2008	12/31/2299	N

41150	TONGUE MOUTH JAW SURGERY	PRXOVR	DEF					NA	NA	NA	N
41150	TONGUE MOUTH JAW SURGERY	MAXFEE	DEF					1153.22	7/1/2008	12/31/2299	N
41153	TONGUE MOUTH NECK SURGERY	PRXOVR	DEF					NA	NA	NA	N
41153	TONGUE MOUTH NECK SURGERY	MAXFEE	DEF					1286.74	1/1/2000	12/31/2299	N
41155	TONGUE JAW & NECK SURGERY	PRXOVR	DEF					NA	NA	NA	N
41155	TONGUE JAW & NECK SURGERY	MAXFEE	DEF					1518.62	1/1/2000	12/31/2299	N
41250	REPAIR TONGUE LACERATION	PRXOVR	DEF					NA	NA	NA	N
41250	REPAIR TONGUE LACERATION	MAXFEE	DEF					86.14	1/1/2000	12/31/2299	N
41251	REPAIR TONGUE LACERATION	PRXOVR	DEF					NA	NA	NA	N
41251	REPAIR TONGUE LACERATION	MAXFEE	DEF					120.46	7/1/2008	12/31/2299	N
41252	REPAIR TONGUE LACERATION	PRXOVR	DEF					NA	NA	NA	N
41252	REPAIR TONGUE LACERATION	MAXFEE	DEF					146.51	1/1/2000	12/31/2299	N
41500	FIXATION OF TONGUE	PRXOVR	DEF					NA	NA	NA	N
41500	FIXATION OF TONGUE	MAXFEE	DEF					236.29	7/1/2008	12/31/2299	N
41510	TONGUE TO LIP SURGERY	PRXOVR	DEF					NA	NA	NA	N
41510	TONGUE TO LIP SURGERY	MAXFEE	DEF					238.60	7/1/2008	12/31/2299	N
41512	TONGUE SUSPENSION	PRXOVR	DEF					NA	NA	NA	N
41512	TONGUE SUSPENSION	MAXFEE	DEF					426.11	1/1/2009	12/31/2299	N
41520	RECONSTRUCTION TONGUE FOLD	PRXOVR	DEF					NA	NA	NA	N
41520	RECONSTRUCTION TONGUE FOLD	MAXFEE	DEF					148.53	1/1/2000	12/31/2299	N
41530	TONGUE BASE VOL REDUCTION	PRXOVR	DEF					NA	NA	NA	N
41530	TONGUE BASE VOL REDUCTION	MAXFEE	DEF					2040.81	1/1/2009	12/31/2299	N

41599	TONGUE AND MOUTH SURGERY	PRXOVR	DEF					NA	NA	NA	N
41599	TONGUE AND MOUTH SURGERY	MANUAL	DEF					NA	NA	NA	N
41800	DRAINAGE OF GUM LESION	PRXOVR	DEF					NA	NA	NA	N
41800	DRAINAGE OF GUM LESION	MAXFEE	DEF					59.05	7/1/2008	12/31/2299	N
41805	REMOVAL FOREIGN BODY GUM	PRXOVR	DEF					NA	NA	NA	N
41805	REMOVAL FOREIGN BODY GUM	MAXFEE	DEF					96.52	7/1/2008	12/31/2299	N
41806	REMOVAL FOREIGN BODY JAWBONE	PRXOVR	DEF					NA	NA	NA	N
41806	REMOVAL FOREIGN BODY JAWBONE	MAXFEE	DEF					130.49	7/1/2008	12/31/2299	N
41821	EXCISION OF GUM FLAP	PRXOVR	DEF					NA	NA	NA	N
41821	EXCISION OF GUM FLAP	MANUAL	DEF					NA	NA	NA	N
41822	EXCISION OF GUM LESION	PRXOVR	DEF					NA	NA	NA	N
41822	EXCISION OF GUM LESION	MAXFEE	DEF					141.40	7/1/2008	12/31/2299	N
41823	EXCISION OF GUM LESION	PRXOVR	DEF					NA	NA	NA	N
41823	EXCISION OF GUM LESION	MAXFEE	DEF					207.56	7/1/2008	12/31/2299	N
41825	EXCISION OF GUM LESION	PRXOVR	DEF					NA	NA	NA	N
41825	EXCISION OF GUM LESION	MAXFEE	DEF					78.14	1/1/2000	12/31/2299	N
41826	EXCISION OF GUM LESION	PRXOVR	DEF					NA	NA	NA	N
41826	EXCISION OF GUM LESION	MAXFEE	DEF					118.22	10/1/2004	12/31/2299	N
41827	EXCISION OF GUM LESION	PRXOVR	DEF					NA	NA	NA	N
41827	EXCISION OF GUM LESION	MAXFEE	DEF					189.47	1/1/2000	12/31/2299	N
41850	TREATMENT OF GUM LESION	PRXOVR	DEF					NA	NA	NA	N
41850	TREATMENT OF GUM LESION	MANUAL	DEF					NA	NA	NA	N
41899	DENTAL SURGERY PROCEDURE	PRXOVR	DEF					NA	NA	NA	N
41899	DENTAL SURGERY PROCEDURE	MANUAL	DEF					NA	NA	NA	N

42000	DRAINAGE MOUTH ROOF LESION	PRXOVR	DEF					NA	NA	NA	N
42000	DRAINAGE MOUTH ROOF LESION	MAXFEE	DEF					54.98	1/1/2000	12/31/2299	N
42100	BIOPSY ROOF OF MOUTH	PRXOVR	DEF					NA	NA	NA	N
42100	BIOPSY ROOF OF MOUTH	MAXFEE	DEF					62.85	1/1/2000	12/31/2299	N
42104	EXCISION LESION MOUTH ROOF	PRXOVR	DEF					NA	NA	NA	N
42104	EXCISION LESION MOUTH ROOF	MAXFEE	DEF					90.45	1/1/2004	12/31/2299	N
42106	EXCISION LESION MOUTH ROOF	PRXOVR	DEF					NA	NA	NA	N
42106	EXCISION LESION MOUTH ROOF	MAXFEE	DEF					116.05	1/1/2004	12/31/2299	N
42107	EXCISION LESION MOUTH ROOF	PRXOVR	DEF					NA	NA	NA	N
42107	EXCISION LESION MOUTH ROOF	MAXFEE	DEF					243.73	1/1/2000	12/31/2299	N
42120	REMOVE PALATE/LESION	PRXOVR	DEF					NA	NA	NA	N
42120	REMOVE PALATE/LESION	MAXFEE	DEF					499.25	7/1/2008	12/31/2299	N
42140	EXCISION OF UVULA	PRXOVR	DEF					NA	NA	NA	N
42140	EXCISION OF UVULA	MAXFEE	DEF					89.43	1/1/2000	12/31/2299	N
42145	REPAIR PALATE PHARYNX/UVULA	PRXOVR	DEF					NA	NA	NA	N
42145	REPAIR PALATE PHARYNX/UVULA	MAXFEE	DEF					460.75	1/1/2000	12/31/2299	N
42160	TREATMENT MOUTH ROOF LESION	PRXOVR	DEF					NA	NA	NA	N
42160	TREATMENT MOUTH ROOF LESION	MAXFEE	DEF					94.33	1/1/2004	12/31/2299	N
42180	REPAIR PALATE	PRXOVR	DEF					NA	NA	NA	N
42180	REPAIR PALATE	MAXFEE	DEF					129.87	1/1/2000	12/31/2299	N
42182	REPAIR PALATE	PRXOVR	DEF					NA	NA	NA	N

42182	REPAIR PALATE	MAXFEE	DEF					192.46	1/1/2000	12/31/2299	N
42200	RECONSTRUCT CLEFT PALATE	PRXOVR	DEF					NA	NA	NA	N
42200	RECONSTRUCT CLEFT PALATE	MAXFEE	DEF					516.28	1/1/2000	12/31/2299	N
42205	RECONSTRUCT CLEFT PALATE	PRXOVR	DEF					NA	NA	NA	N
42205	RECONSTRUCT CLEFT PALATE	MAXFEE	DEF					514.08	1/1/2000	12/31/2299	N
42210	RECONSTRUCT CLEFT PALATE	PRXOVR	DEF					NA	NA	NA	N
42210	RECONSTRUCT CLEFT PALATE	MAXFEE	DEF					687.13	1/1/2000	12/31/2299	N
42215	RECONSTRUCT CLEFT PALATE	PRXOVR	DEF					NA	NA	NA	N
42215	RECONSTRUCT CLEFT PALATE	MAXFEE	DEF					448.66	1/1/2000	12/31/2299	N
42220	RECONSTRUCT CLEFT PALATE	PRXOVR	DEF					NA	NA	NA	N
42220	RECONSTRUCT CLEFT PALATE	MAXFEE	DEF					342.66	1/1/2000	12/31/2299	N
42225	RECONSTRUCT CLEFT PALATE	PRXOVR	DEF					NA	NA	NA	N
42225	RECONSTRUCT CLEFT PALATE	MAXFEE	DEF					552.56	7/1/2008	12/31/2299	N
42226	LENGTHENING OF PALATE	PRXOVR	DEF					NA	NA	NA	N
42226	LENGTHENING OF PALATE	MAXFEE	DEF					526.46	7/1/2008	12/31/2299	N
42227	LENGTHENING OF PALATE	PRXOVR	DEF					NA	NA	NA	N
42227	LENGTHENING OF PALATE	MAXFEE	DEF					521.40	7/1/2008	12/31/2299	N
42235	REPAIR PALATE	PRXOVR	DEF					NA	NA	NA	N
42235	REPAIR PALATE	MAXFEE	DEF					421.42	7/1/2008	12/31/2299	N
42260	REPAIR NOSE TO LIP FISTULA	PRXOVR	DEF					NA	NA	NA	N
42260	REPAIR NOSE TO LIP FISTULA	MAXFEE	DEF					377.96	7/1/2008	12/31/2299	N
42280	PREPARATION PALATE MOLD	PRXOVR	DEF					NA	NA	NA	N
42280	PREPARATION PALATE MOLD	MAXFEE	DEF					90.25	1/1/2000	12/31/2299	N
42281	INSERTION PALATE PROSTHESIS	PRXOVR	DEF					NA	NA	NA	N
42281	INSERTION PALATE PROSTHESIS	MAXFEE	DEF					100.42	7/1/2008	12/31/2299	N
42299	PALATE/UVULA SURGERY	PRXOVR	DEF					NA	NA	NA	N
42299	PALATE/UVULA SURGERY	MANUAL	DEF					NA	NA	NA	N
42300	DRAINAGE OF SALIVARY GLAND	PRXOVR	DEF					NA	NA	NA	N

42300	DRAINAGE OF SALIVARY GLAND	MAXFEE	DEF					122.65	1/1/2010	12/31/2299	N
42305	DRAINAGE OF SALIVARY GLAND	PRXOVR	DEF					NA	NA	NA	N
42305	DRAINAGE OF SALIVARY GLAND	MAXFEE	DEF					238.44	1/1/2000	12/31/2299	N
42310	DRAINAGE OF SALIVARY GLAND	PRXOVR	DEF					NA	NA	NA	N
42310	DRAINAGE OF SALIVARY GLAND	MAXFEE	DEF					105.85	1/1/2004	12/31/2299	N
42320	DRAINAGE OF SALIVARY GLAND	PRXOVR	DEF					NA	NA	NA	N
42320	DRAINAGE OF SALIVARY GLAND	MAXFEE	DEF					140.89	12/15/2005	12/31/2299	N
42325	CREATE SALIVARY CYST DRAIN	PRXOVR	DEF					NA	NA	NA	N
42325	CREATE SALIVARY CYST DRAIN	MAXFEE	DEF					NA			N
42326	CREATE SALIVARY CYST DRAIN	PRXOVR	DEF					NA	NA	NA	N
42326	CREATE SALIVARY CYST DRAIN	MAXFEE	DEF					NA			N
42330	REMOVAL OF SALIVARY STONE	PRXOVR	DEF					NA	NA	NA	N
42330	REMOVAL OF SALIVARY STONE	MAXFEE	DEF					95.40	1/1/2000	12/31/2299	N
42335	REMOVAL OF SALIVARY STONE	PRXOVR	DEF					NA	NA	NA	N
42335	REMOVAL OF SALIVARY STONE	MAXFEE	DEF					159.11	1/1/2004	12/31/2299	N
42340	REMOVAL OF SALIVARY STONE	PRXOVR	DEF					NA	NA	NA	N
42340	REMOVAL OF SALIVARY STONE	MAXFEE	DEF					236.96	1/1/2000	12/31/2299	N
42400	BIOPSY OF SALIVARY GLAND	PRXOVR	DEF					NA	NA	NA	N

42400	BIOPSY OF SALIVARY GLAND	MAXFEE	DEF					47.88	1/1/2010	12/31/2299	N
42405	BIOPSY OF SALIVARY GLAND	PRXOVR	DEF					NA	NA	NA	N
42405	BIOPSY OF SALIVARY GLAND	MAXFEE	DEF					137.35	1/1/2000	12/31/2299	N
42408	EXCISION OF SALIVARY CYST	PRXOVR	DEF					NA	NA	NA	N
42408	EXCISION OF SALIVARY CYST	MAXFEE	DEF					213.22	1/1/2000	12/31/2299	N
42409	DRAINAGE OF SALIVARY CYST	PRXOVR	DEF					NA	NA	NA	N
42409	DRAINAGE OF SALIVARY CYST	MAXFEE	DEF					151.61	1/1/2000	12/31/2299	N
42410	EXCISE PAROTID GLAND/LESION	PRXOVR	DEF					NA	NA	NA	N
42410	EXCISE PAROTID GLAND/LESION	MAXFEE	DEF					429.10	1/1/2000	12/31/2299	N
42415	EXCISE PAROTID GLAND/LESION	PRXOVR	DEF					NA	NA	NA	N
42415	EXCISE PAROTID GLAND/LESION	MAXFEE	DEF					804.62	1/1/2004	12/31/2299	N
42420	EXCISE PAROTID GLAND/LESION	PRXOVR	DEF					NA	NA	NA	N
42420	EXCISE PAROTID GLAND/LESION	MAXFEE	DEF					931.76	1/1/2000	12/31/2299	N
42425	EXCISE PAROTID GLAND/LESION	PRXOVR	DEF					NA	NA	NA	N
42425	EXCISE PAROTID GLAND/LESION	MAXFEE	DEF					654.68	1/1/2000	12/31/2299	N
42426	EXCISE PAROTID GLAND/LESION	PRXOVR	DEF					NA	NA	NA	N
42426	EXCISE PAROTID GLAND/LESION	MAXFEE	DEF					1181.05	1/1/2000	12/31/2299	N
42440	EXCISE SUBMAXILLARY GLAND	PRXOVR	DEF					NA	NA	NA	N
42440	EXCISE SUBMAXILLARY GLAND	MAXFEE	DEF					385.44	1/1/2010	12/31/2299	N
42450	EXCISE SUBLINGUAL GLAND	PRXOVR	DEF					NA	NA	NA	N

42450	EXCISE SUBLINGUAL GLAND	MAXFEE	DEF					219.15	1/1/2000	12/31/2299	N
42500	REPAIR SALIVARY DUCT	PRXOVR	DEF					NA	NA	NA	N
42500	REPAIR SALIVARY DUCT	MAXFEE	DEF					238.11	1/1/2000	12/31/2299	N
42505	REPAIR SALIVARY DUCT	PRXOVR	DEF					NA	NA	NA	N
42505	REPAIR SALIVARY DUCT	MAXFEE	DEF					342.73	1/1/2000	12/31/2299	N
42507	PAROTID DUCT DIVERSION	PRXOVR	DEF					NA	NA	NA	N
42507	PAROTID DUCT DIVERSION	MAXFEE	DEF					303.22	1/1/2000	12/31/2299	N
42508	PAROTID DUCT DIVERSION	PRXOVR	DEF					NA	NA	NA	N
42508	PAROTID DUCT DIVERSION	MAXFEE	DEF					455.52	1/1/2000	12/31/2299	N
42509	PAROTID DUCT DIVERSION	PRXOVR	DEF					NA	NA	NA	N
42509	PAROTID DUCT DIVERSION	MAXFEE	DEF					527.59	1/1/2000	12/31/2299	N
42510	PAROTID DUCT DIVERSION	PRXOVR	DEF					NA	NA	NA	N
42510	PAROTID DUCT DIVERSION	MAXFEE	DEF					413.92	1/1/2000	12/31/2299	N
42550	INJECTION FOR SALIVARY X-RAY	PRXOVR	DEF					NA	NA	NA	N
42550	INJECTION FOR SALIVARY X-RAY	MAXFEE	DEF					51.33	10/1/2004	12/31/2299	N
42600	CLOSURE OF SALIVARY FISTULA	PRXOVR	DEF					NA	NA	NA	N
42600	CLOSURE OF SALIVARY FISTULA	MAXFEE	DEF					242.18	1/1/2000	12/31/2299	N
42650	DILATION OF SALIVARY DUCT	PRXOVR	DEF					NA	NA	NA	N
42650	DILATION OF SALIVARY DUCT	MAXFEE	DEF					50.96	1/1/2004	12/31/2299	N
42660	DILATION OF SALIVARY DUCT	PRXOVR	DEF					NA	NA	NA	N
42660	DILATION OF SALIVARY DUCT	MAXFEE	DEF					63.38	1/1/2004	12/31/2299	N
42665	LIGATION OF SALIVARY DUCT	PRXOVR	DEF					NA	NA	NA	N
42665	LIGATION OF SALIVARY DUCT	MAXFEE	DEF					129.85	4/1/2006	12/31/2299	N
42699	SALIVARY SURGERY PROCEDURE	PRXOVR	DEF					NA	NA	NA	N
42699	SALIVARY SURGERY PROCEDURE	MANUAL	DEF					NA	NA	NA	N

70140	X-RAY EXAM OF FACIAL BONES	PRXOVR	DEF					NA	NA	NA	N
70140	X-RAY EXAM OF FACIAL BONES	MAXFEE	DEF					25.40	1/1/2000	12/31/2299	N
70140	X-RAY EXAM OF FACIAL BONES	MAXFEE	DEF	TC				16.51	1/1/2000	12/31/2299	N
70140	X-RAY EXAM OF FACIAL BONES	MAXFEE	DEF	26				8.89	1/1/2000	12/31/2299	N
70150	X-RAY EXAM OF FACIAL BONES	PRXOVR	DEF					NA	NA	NA	N
70150	X-RAY EXAM OF FACIAL BONES	MAXFEE	DEF					33.14	1/1/2000	12/31/2299	N
70150	X-RAY EXAM OF FACIAL BONES	MAXFEE	DEF	TC				21.54	1/1/2000	12/31/2299	N
70150	X-RAY EXAM OF FACIAL BONES	MAXFEE	DEF	26				11.60	1/1/2000	12/31/2299	N
70160	X-RAY EXAM OF NASAL BONES	PRXOVR	DEF					NA	NA	NA	N
70160	X-RAY EXAM OF NASAL BONES	MAXFEE	DEF					21.75	1/1/2000	12/31/2299	N
70160	X-RAY EXAM OF NASAL BONES	MAXFEE	DEF	TC				14.14	1/1/2000	12/31/2299	N
70160	X-RAY EXAM OF NASAL BONES	MAXFEE	DEF	26				7.61	1/1/2000	12/31/2299	N
70170	X-RAY EXAM OF TEAR DUCT	PRXOVR	DEF					NA	NA	NA	N
70170	X-RAY EXAM OF TEAR DUCT	MAXFEE	DEF					39.37	1/1/2000	12/31/2299	N
70170	X-RAY EXAM OF TEAR DUCT	MAXFEE	DEF	TC				25.59	1/1/2000	12/31/2299	N
70170	X-RAY EXAM OF TEAR DUCT	MAXFEE	DEF	26				13.78	1/1/2000	12/31/2299	N
70190	X-RAY EXAM OF EYE SOCKETS	PRXOVR	DEF					NA	NA	NA	N
70190	X-RAY EXAM OF EYE SOCKETS	MAXFEE	DEF					26.15	1/1/2000	12/31/2299	N
70190	X-RAY EXAM OF EYE SOCKETS	MAXFEE	DEF	TC				17	1/1/2000	12/31/2299	N

70190	X-RAY EXAM OF EYE SOCKETS	MAXFEE	DEF	26				9.15	1/1/2000	12/31/2299	N
70200	X-RAY EXAM OF EYE SOCKETS	PRXOVR	DEF					NA	NA	NA	N
70200	X-RAY EXAM OF EYE SOCKETS	MAXFEE	DEF					32.87	1/1/2010	12/31/2299	N
70200	X-RAY EXAM OF EYE SOCKETS	MAXFEE	DEF	TC				21.37	1/1/2010	12/31/2299	N
70200	X-RAY EXAM OF EYE SOCKETS	MAXFEE	DEF	26				11.50	1/1/2010	12/31/2299	N
70210	X-RAY EXAM OF SINUSES	PRXOVR	DEF					NA	NA	NA	N
70210	X-RAY EXAM OF SINUSES	MAXFEE	DEF					24.59	1/1/2000	12/31/2299	N
70210	X-RAY EXAM OF SINUSES	MAXFEE	DEF	TC				17.21	1/1/2000	12/31/2299	N
70210	X-RAY EXAM OF SINUSES	MAXFEE	DEF	26				7.38	1/1/2000	12/31/2299	N
70220	X-RAY EXAM OF SINUSES	PRXOVR	DEF					NA	NA	NA	N
70220	X-RAY EXAM OF SINUSES	MAXFEE	DEF					31.82	1/1/2010	12/31/2299	N
70220	X-RAY EXAM OF SINUSES	MAXFEE	DEF	TC				20.68	1/1/2010	12/31/2299	N
70220	X-RAY EXAM OF SINUSES	MAXFEE	DEF	26				11.14	1/1/2010	12/31/2299	N
70240	X-RAY EXAM PITUITARY SADDLE	PRXOVR	DEF					NA	NA	NA	N
70240	X-RAY EXAM PITUITARY SADDLE	MAXFEE	DEF					19.69	1/1/2000	12/31/2299	N
70240	X-RAY EXAM PITUITARY SADDLE	MAXFEE	DEF	TC				11.81	1/1/2000	12/31/2299	N
70240	X-RAY EXAM PITUITARY SADDLE	MAXFEE	DEF	26				7.88	1/1/2000	12/31/2299	N
70250	X-RAY EXAM OF SKULL	PRXOVR	DEF					NA	NA	NA	N
70250	X-RAY EXAM OF SKULL	MAXFEE	DEF					27.53	7/26/2007	12/31/2299	N
70250	X-RAY EXAM OF SKULL	MAXFEE	DEF	TC				19.27	7/26/2007	12/31/2299	N
70250	X-RAY EXAM OF SKULL	MAXFEE	DEF	26				8.26	7/26/2007	12/31/2299	N
70260	X-RAY EXAM OF SKULL	PRXOVR	DEF					NA	NA	NA	N
70260	X-RAY EXAM OF SKULL	MAXFEE	DEF					39.42	7/26/2007	12/31/2299	N

70260	X-RAY EXAM OF SKULL	MAXFEE	DEF	TC				27.59	7/26/2007	12/31/2299	N
70260	X-RAY EXAM OF SKULL	MAXFEE	DEF	26				11.83	7/26/2007	12/31/2299	N
70300	X-RAY EXAM OF TEETH	PRXOVR	DEF					NA	NA	NA	N
70300	X-RAY EXAM OF TEETH	MAXFEE	DEF					11.86	1/1/2000	12/31/2299	N
70300	X-RAY EXAM OF TEETH	MAXFEE	DEF	TC				7.12	1/1/2000	12/31/2299	N
70300	X-RAY EXAM OF TEETH	MAXFEE	DEF	26				4.74	1/1/2000	12/31/2299	N
70310	X-RAY EXAM OF TEETH	PRXOVR	DEF					NA	NA	NA	N
70310	X-RAY EXAM OF TEETH	MAXFEE	DEF					18.47	7/26/2007	12/31/2299	N
70310	X-RAY EXAM OF TEETH	MAXFEE	DEF	TC				12.93	7/26/2007	12/31/2299	N
70310	X-RAY EXAM OF TEETH	MAXFEE	DEF	26				5.54	7/26/2007	12/31/2299	N
70320	FULL MOUTH X-RAY OF TEETH	PRXOVR	DEF					NA	NA	NA	N
70320	FULL MOUTH X-RAY OF TEETH	MAXFEE	DEF					31.58	1/1/2000	12/31/2299	N
70320	FULL MOUTH X-RAY OF TEETH	MAXFEE	DEF	TC				22.11	1/1/2000	12/31/2299	N
70320	FULL MOUTH X-RAY OF TEETH	MAXFEE	DEF	26				9.47	1/1/2000	12/31/2299	N
70328	X-RAY EXAM OF JAW JOINT	PRXOVR	DEF					NA	NA	NA	N
70328	X-RAY EXAM OF JAW JOINT	MAXFEE	DEF					21.44	7/26/2007	12/31/2299	N
70328	X-RAY EXAM OF JAW JOINT	MAXFEE	DEF	TC				15.01	7/26/2007	12/31/2299	N
70328	X-RAY EXAM OF JAW JOINT	MAXFEE	DEF	26				6.43	7/26/2007	12/31/2299	N
70330	X-RAY EXAM OF JAW JOINTS	PRXOVR	DEF					NA	NA	NA	N
70330	X-RAY EXAM OF JAW JOINTS	MAXFEE	DEF					33.83	1/1/2000	12/31/2299	N
70330	X-RAY EXAM OF JAW JOINTS	MAXFEE	DEF	TC				23.68	1/1/2000	12/31/2299	N
70330	X-RAY EXAM OF JAW JOINTS	MAXFEE	DEF	26				10.15	1/1/2000	12/31/2299	N
70332	X-RAY EXAM OF JAW JOINT	PRXOVR	DEF					NA	NA	NA	N
70332	X-RAY EXAM OF JAW JOINT	MAXFEE	DEF					72.78	1/1/2010	12/31/2299	N
70332	X-RAY EXAM OF JAW JOINT	MAXFEE	DEF	TC				50.95	1/1/2010	12/31/2299	N
70332	X-RAY EXAM OF JAW JOINT	MAXFEE	DEF	26				21.83	1/1/2010	12/31/2299	N
70336	MAGNETIC IMAGE JAW JOINT	PRXOVR	DEF					NA	NA	NA	N

70336	MAGNETIC IMAGE JAW JOINT	MAXFEE	DEF					345	7/1/2008	12/31/2299	N
70336	MAGNETIC IMAGE JAW JOINT	MAXFEE	DEF	TC				276	7/1/2008	12/31/2299	N
70336	MAGNETIC IMAGE JAW JOINT	MAXFEE	DEF	26				69	7/1/2008	12/31/2299	N
70350	X-RAY HEAD FOR ORTHODONTIA	PRXOVR	DEF					NA	NA	NA	N
70350	X-RAY HEAD FOR ORTHODONTIA	MAXFEE	DEF					17.55	1/1/2010	12/31/2299	N
70350	X-RAY HEAD FOR ORTHODONTIA	MAXFEE	DEF	TC				10.53	1/1/2010	12/31/2299	N
70350	X-RAY HEAD FOR ORTHODONTIA	MAXFEE	DEF	26				7.02	1/1/2010	12/31/2299	N
70355	PANORAMIC X-RAY OF JAWS	PRXOVR	DEF					NA	NA	NA	N
70355	PANORAMIC X-RAY OF JAWS	MAXFEE	DEF					19.93	1/1/2010	12/31/2299	N
70355	PANORAMIC X-RAY OF JAWS	MAXFEE	DEF	TC				12.95	1/1/2010	12/31/2299	N
70355	PANORAMIC X-RAY OF JAWS	MAXFEE	DEF	26				6.98	1/1/2010	12/31/2299	N
70360	X-RAY EXAM OF NECK	PRXOVR	DEF					NA	NA	NA	N
70360	X-RAY EXAM OF NECK	MAXFEE	DEF					18.88	7/26/2007	12/31/2299	N
70360	X-RAY EXAM OF NECK	MAXFEE	DEF	TC				13.22	7/26/2007	12/31/2299	N
70360	X-RAY EXAM OF NECK	MAXFEE	DEF	26				5.66	7/26/2007	12/31/2299	N
70370	THROAT X-RAY & FLUOROSCOPY	PRXOVR	DEF					NA	NA	NA	N
70370	THROAT X-RAY & FLUOROSCOPY	MAXFEE	DEF					50	1/1/2000	12/31/2299	N
70370	THROAT X-RAY & FLUOROSCOPY	MAXFEE	DEF	TC				35	1/1/2000	12/31/2299	N
70370	THROAT X-RAY & FLUOROSCOPY	MAXFEE	DEF	26				15	1/1/2000	12/31/2299	N
70371	SPEECH EVALUATION COMPLEX	PRXOVR	DEF					NA	NA	NA	N
70371	SPEECH EVALUATION COMPLEX	MAXFEE	DEF					84.52	1/1/2010	12/31/2299	N
70371	SPEECH EVALUATION COMPLEX	MAXFEE	DEF	TC				50.71	1/1/2010	12/31/2299	N

70371	SPEECH EVALUATION COMPLEX	MAXFEE	DEF	26				33.81	1/1/2010	12/31/2299	N
70373	CONTRAST X-RAY OF LARYNX	PRXOVR	DEF					NA	NA	NA	N
70373	CONTRAST X-RAY OF LARYNX	MAXFEE	DEF					68.48	1/1/2000	12/31/2299	N
70373	CONTRAST X-RAY OF LARYNX	MAXFEE	DEF	TC				47.94	1/1/2000	12/31/2299	N
70373	CONTRAST X-RAY OF LARYNX	MAXFEE	DEF	26				20.54	1/1/2000	12/31/2299	N
70380	X-RAY EXAM OF SALIVARY GLAND	PRXOVR	DEF					NA	NA	NA	N
70380	X-RAY EXAM OF SALIVARY GLAND	MAXFEE	DEF					25.96	1/1/2000	12/31/2299	N
70380	X-RAY EXAM OF SALIVARY GLAND	MAXFEE	DEF	TC				18.17	1/1/2000	12/31/2299	N
70380	X-RAY EXAM OF SALIVARY GLAND	MAXFEE	DEF	26				7.79	1/1/2000	12/31/2299	N
70390	X-RAY EXAM OF SALIVARY DUCT	PRXOVR	DEF					NA	NA	NA	N
70390	X-RAY EXAM OF SALIVARY DUCT	MAXFEE	DEF					65.98	1/1/2000	12/31/2299	N
70390	X-RAY EXAM OF SALIVARY DUCT	MAXFEE	DEF	TC				49.49	1/1/2000	12/31/2299	N
70390	X-RAY EXAM OF SALIVARY DUCT	MAXFEE	DEF	26				16.50	1/1/2000	12/31/2299	N
70450	CT HEAD/BRAIN W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70450	CT HEAD/BRAIN W/O DYE	MAXFEE	DEF					168.71	1/1/2000	12/31/2299	N
70450	CT HEAD/BRAIN W/O DYE	MAXFEE	DEF	TC				134.97	1/1/2000	12/31/2299	N
70450	CT HEAD/BRAIN W/O DYE	MAXFEE	DEF	26				33.74	1/1/2000	12/31/2299	N
70460	CT HEAD/BRAIN W/DYE	PRXOVR	DEF					NA	NA	NA	N
70460	CT HEAD/BRAIN W/DYE	MAXFEE	DEF					206.28	1/1/2000	12/31/2299	N
70460	CT HEAD/BRAIN W/DYE	MAXFEE	DEF	TC				154.71	1/1/2000	12/31/2299	N

70460	CT HEAD/BRAIN W/DYE	MAXFEE	DEF	26				51.57	1/1/2000	12/31/2299	N
70470	CT HEAD/BRAIN W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
70470	CT HEAD/BRAIN W/O & W/DYE	MAXFEE	DEF					252.17	1/1/2000	12/31/2299	N
70470	CT HEAD/BRAIN W/O & W/DYE	MAXFEE	DEF	TC				201.74	1/1/2000	12/31/2299	N
70470	CT HEAD/BRAIN W/O & W/DYE	MAXFEE	DEF	26				50.43	1/1/2000	12/31/2299	N
70480	CT ORBIT/EAR/FOSSA W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70480	CT ORBIT/EAR/FOSSA W/O DYE	MAXFEE	DEF					185.96	1/1/2000	12/31/2299	N
70480	CT ORBIT/EAR/FOSSA W/O DYE	MAXFEE	DEF	TC				130.17	1/1/2000	12/31/2299	N
70480	CT ORBIT/EAR/FOSSA W/O DYE	MAXFEE	DEF	26				55.79	1/1/2000	12/31/2299	N
70481	CT ORBIT/EAR/FOSSA W/DYE	PRXOVR	DEF					NA	NA	NA	N
70481	CT ORBIT/EAR/FOSSA W/DYE	MAXFEE	DEF					216.19	7/26/2007	12/31/2299	N
70481	CT ORBIT/EAR/FOSSA W/DYE	MAXFEE	DEF	TC				172.95	7/26/2007	12/31/2299	N
70481	CT ORBIT/EAR/FOSSA W/DYE	MAXFEE	DEF	26				43.24	7/26/2007	12/31/2299	N
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	MAXFEE	DEF					259.32	1/1/2000	12/31/2299	N
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	MAXFEE	DEF	TC				194.49	1/1/2000	12/31/2299	N
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	MAXFEE	DEF	26				64.83	1/1/2000	12/31/2299	N
70486	CT MAXILLOFACIAL W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70486	CT MAXILLOFACIAL W/O DYE	MAXFEE	DEF					179.99	7/26/2007	12/31/2299	N
70486	CT MAXILLOFACIAL W/O DYE	MAXFEE	DEF	TC				143.99	7/26/2007	12/31/2299	N
70486	CT MAXILLOFACIAL W/O DYE	MAXFEE	DEF	26				36	7/26/2007	12/31/2299	N
70487	CT MAXILLOFACIAL W/DYE	PRXOVR	DEF					NA	NA	NA	N
70487	CT MAXILLOFACIAL W/DYE	MAXFEE	DEF					213.08	7/26/2007	12/31/2299	N
70487	CT MAXILLOFACIAL W/DYE	MAXFEE	DEF	TC				170.46	7/26/2007	12/31/2299	N

70487	CT MAXILLOFACIAL W/DYE	MAXFEE	DEF	26				42.62	7/26/2007	12/31/2299	N
70488	CT MAXILLOFACIAL W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
70488	CT MAXILLOFACIAL W/O & W/DYE	MAXFEE	DEF					258.23	1/1/2000	12/31/2299	N
70488	CT MAXILLOFACIAL W/O & W/DYE	MAXFEE	DEF	TC				193.67	1/1/2000	12/31/2299	N
70488	CT MAXILLOFACIAL W/O & W/DYE	MAXFEE	DEF	26				64.56	1/1/2000	12/31/2299	N
70490	CT SOFT TISSUE NECK W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70490	CT SOFT TISSUE NECK W/O DYE	MAXFEE	DEF					185.96	1/1/2000	12/31/2299	N
70490	CT SOFT TISSUE NECK W/O DYE	MAXFEE	DEF	TC				130.17	1/1/2000	12/31/2299	N
70490	CT SOFT TISSUE NECK W/O DYE	MAXFEE	DEF	26				55.79	1/1/2000	12/31/2299	N
70491	CT SOFT TISSUE NECK W/DYE	PRXOVR	DEF					NA	NA	NA	N
70491	CT SOFT TISSUE NECK W/DYE	MAXFEE	DEF					216.19	7/26/2007	12/31/2299	N
70491	CT SOFT TISSUE NECK W/DYE	MAXFEE	DEF	TC				172.95	7/26/2007	12/31/2299	N
70491	CT SOFT TISSUE NECK W/DYE	MAXFEE	DEF	26				43.24	7/26/2007	12/31/2299	N
70492	CT SFT TSUE NCK W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
70492	CT SFT TSUE NCK W/O & W/DYE	MAXFEE	DEF					259.25	1/1/2000	12/31/2299	N
70492	CT SFT TSUE NCK W/O & W/DYE	MAXFEE	DEF	TC				194.44	1/1/2000	12/31/2299	N
70492	CT SFT TSUE NCK W/O & W/DYE	MAXFEE	DEF	26				64.81	1/1/2000	12/31/2299	N
70496	CT ANGIOGRAPHY HEAD	PRXOVR	DEF					NA	NA	NA	N
70496	CT ANGIOGRAPHY HEAD	MAXFEE	DEF					291.68	1/1/2001	12/31/2299	N
70496	CT ANGIOGRAPHY HEAD	MAXFEE	DEF	TC				218.76	1/1/2001	12/31/2299	N
70496	CT ANGIOGRAPHY HEAD	MAXFEE	DEF	26				72.92	1/1/2001	12/31/2299	N

70498	CT ANGIOGRAPHY NECK	PRXOVR	DEF					NA	NA	NA	N
70498	CT ANGIOGRAPHY NECK	MAXFEE	DEF					291.68	1/1/2001	12/31/2299	N
70498	CT ANGIOGRAPHY NECK	MAXFEE	DEF	TC				218.76	1/1/2001	12/31/2299	N
70498	CT ANGIOGRAPHY NECK	MAXFEE	DEF	26				72.92	1/1/2001	12/31/2299	N
70540	MRI ORBIT/FACE/NECK W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70540	MRI ORBIT/FACE/NECK W/O DYE	MAXFEE	DEF					377.90	1/1/2000	12/31/2299	N
70540	MRI ORBIT/FACE/NECK W/O DYE	MAXFEE	DEF	TC				302.32	1/1/2000	12/31/2299	N
70540	MRI ORBIT/FACE/NECK W/O DYE	MAXFEE	DEF	26				75.58	1/1/2000	12/31/2299	N
70541	MAGNETIC IMAGE; HEAD (MRA)	PRXOVR	DEF					NA	NA	NA	N
70541	MAGNETIC IMAGE; HEAD (MRA)	MAXFEE	DEF					NA			N
70542	MRI ORBIT/FACE/NECK W/DYE	PRXOVR	DEF					NA	NA	NA	N
70542	MRI ORBIT/FACE/NECK W/DYE	MAXFEE	DEF					445.02	7/26/2007	12/31/2299	N
70542	MRI ORBIT/FACE/NECK W/DYE	MAXFEE	DEF	TC				356.02	7/26/2007	12/31/2299	N
70542	MRI ORBIT/FACE/NECK W/DYE	MAXFEE	DEF	26				89	7/26/2007	12/31/2299	N
70543	MRI ORBT/FAC/NCK W/O &W/DYE	PRXOVR	DEF					NA	NA	NA	N
70543	MRI ORBT/FAC/NCK W/O &W/DYE	MAXFEE	DEF					592.28	7/1/2008	12/31/2299	N
70543	MRI ORBT/FAC/NCK W/O &W/DYE	MAXFEE	DEF	TC				473.82	7/1/2008	12/31/2299	N
70543	MRI ORBT/FAC/NCK W/O &W/DYE	MAXFEE	DEF	26				118.46	7/1/2008	12/31/2299	N
70544	MR ANGIOGRAPHY HEAD W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70544	MR ANGIOGRAPHY HEAD W/O DYE	MAXFEE	DEF					386.56	1/1/2001	12/31/2299	N

70544	MR ANGIOGRAPHY HEAD W/O DYE	MAXFEE	DEF	TC				347.90	1/1/2001	12/31/2299	N
70544	MR ANGIOGRAPHY HEAD W/O DYE	MAXFEE	DEF	26				38.66	1/1/2001	12/31/2299	N
70545	MR ANGIOGRAPHY HEAD W/DYE	PRXOVR	DEF					NA	NA	NA	N
70545	MR ANGIOGRAPHY HEAD W/DYE	MAXFEE	DEF					386.56	1/1/2001	12/31/2299	N
70545	MR ANGIOGRAPHY HEAD W/DYE	MAXFEE	DEF	TC				347.90	1/1/2001	12/31/2299	N
70545	MR ANGIOGRAPHY HEAD W/DYE	MAXFEE	DEF	26				38.66	1/1/2001	12/31/2299	N
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	MAXFEE	DEF					575.43	7/1/2008	12/31/2299	N
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	MAXFEE	DEF	TC				517.89	7/1/2008	12/31/2299	N
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	MAXFEE	DEF	26				57.54	7/1/2008	12/31/2299	N
70547	MR ANGIOGRAPHY NECK W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70547	MR ANGIOGRAPHY NECK W/O DYE	MAXFEE	DEF					386.56	1/1/2001	12/31/2299	N
70547	MR ANGIOGRAPHY NECK W/O DYE	MAXFEE	DEF	TC				347.90	1/1/2001	12/31/2299	N
70547	MR ANGIOGRAPHY NECK W/O DYE	MAXFEE	DEF	26				38.66	1/1/2001	12/31/2299	N
70548	MR ANGIOGRAPHY NECK W/DYE	PRXOVR	DEF					NA	NA	NA	N
70548	MR ANGIOGRAPHY NECK W/DYE	MAXFEE	DEF					386.56	1/1/2001	12/31/2299	N
70548	MR ANGIOGRAPHY NECK W/DYE	MAXFEE	DEF	TC				347.90	1/1/2001	12/31/2299	N

70548	MR ANGIOGRAPHY NECK W/DYE	MAXFEE	DEF	26				38.66	1/1/2001	12/31/2299	N
70549	MR ANGIOGRAPH NECK W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
70549	MR ANGIOGRAPH NECK W/O&W/DYE	MAXFEE	DEF					575.43	7/1/2008	12/31/2299	N
70549	MR ANGIOGRAPH NECK W/O&W/DYE	MAXFEE	DEF	TC				517.89	7/1/2008	12/31/2299	N
70549	MR ANGIOGRAPH NECK W/O&W/DYE	MAXFEE	DEF	26				57.54	7/1/2008	12/31/2299	N
70551	MRI BRAIN STEM W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70551	MRI BRAIN STEM W/O DYE	MAXFEE	DEF					377.96	1/1/2000	12/31/2299	N
70551	MRI BRAIN STEM W/O DYE	MAXFEE	DEF	TC				302.37	1/1/2000	12/31/2299	N
70551	MRI BRAIN STEM W/O DYE	MAXFEE	DEF	26				75.59	1/1/2000	12/31/2299	N
70552	MRI BRAIN STEM W/DYE	PRXOVR	DEF					NA	NA	NA	N
70552	MRI BRAIN STEM W/DYE	MAXFEE	DEF					453.72	1/1/2000	12/31/2299	N
70552	MRI BRAIN STEM W/DYE	MAXFEE	DEF	TC				362.98	1/1/2000	12/31/2299	N
70552	MRI BRAIN STEM W/DYE	MAXFEE	DEF	26				90.74	1/1/2000	12/31/2299	N
70553	MRI BRAIN STEM W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
70553	MRI BRAIN STEM W/O & W/DYE	MAXFEE	DEF					601.51	7/1/2008	12/31/2299	N
70553	MRI BRAIN STEM W/O & W/DYE	MAXFEE	DEF	TC				481.21	7/1/2008	12/31/2299	N
70553	MRI BRAIN STEM W/O & W/DYE	MAXFEE	DEF	26				120.30	7/1/2008	12/31/2299	N
70554	FMRI BRAIN BY TECH	PRXOVR	DEF					NA	NA	NA	N
70554	FMRI BRAIN BY TECH	MAXFEE	DEF					426.09	1/1/2007	12/31/2299	N
70554	FMRI BRAIN BY TECH	MAXFEE	DEF	TC				340.87	1/1/2007	12/31/2299	N
70554	FMRI BRAIN BY TECH	MAXFEE	DEF	26				85.22	1/1/2007	12/31/2299	N
70555	FMRI BRAIN BY PHYS/PSYCH	PRXOVR	DEF					NA	NA	NA	N
70555	FMRI BRAIN BY PHYS/PSYCH	MANUAL	DEF					NA	NA	NA	N

70557	MRI BRAIN W/O DYE	PRXOVR	DEF					NA	NA	NA	N
70557	MRI BRAIN W/O DYE	MAXFEE	DEF					437.34	1/1/2004	12/31/2299	N
70557	MRI BRAIN W/O DYE	MAXFEE	DEF	TC				306.14	1/1/2004	12/31/2299	N
70557	MRI BRAIN W/O DYE	MAXFEE	DEF	26				131.20	1/1/2004	12/31/2299	N
70558	MRI BRAIN W/DYE	PRXOVR	DEF					NA	NA	NA	N
70558	MRI BRAIN W/DYE	MAXFEE	DEF					514.36	12/15/2005	12/31/2299	N
70558	MRI BRAIN W/DYE	MAXFEE	DEF	TC				360.05	12/15/2005	12/31/2299	N
70558	MRI BRAIN W/DYE	MAXFEE	DEF	26				154.31	12/15/2005	12/31/2299	N
70559	MRI BRAIN W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
70559	MRI BRAIN W/O & W/DYE	MAXFEE	DEF					851.08	1/1/2004	12/31/2299	N
70559	MRI BRAIN W/O & W/DYE	MAXFEE	DEF	TC				680.86	1/1/2004	12/31/2299	N
70559	MRI BRAIN W/O & W/DYE	MAXFEE	DEF	26				170.22	1/1/2004	12/31/2299	N
71010	CHEST X-RAY 1 VIEW FRONTAL	PRXOVR	DEF					NA	NA	NA	N
71010	CHEST X-RAY 1 VIEW FRONTAL	MAXFEE	DEF					20.10	1/1/2010	12/31/2299	N
71010	CHEST X-RAY 1 VIEW FRONTAL	MAXFEE	DEF	TC				14.07	1/1/2010	12/31/2299	N
71010	CHEST X-RAY 1 VIEW FRONTAL	MAXFEE	DEF	26				6.03	1/1/2010	12/31/2299	N
71015	CHEST X-RAY STEREO FRONTAL	PRXOVR	DEF					NA	NA	NA	N
71015	CHEST X-RAY STEREO FRONTAL	MAXFEE	DEF					23.37	7/26/2007	12/31/2299	N
71015	CHEST X-RAY STEREO FRONTAL	MAXFEE	DEF	TC				16.36	7/26/2007	12/31/2299	N
71015	CHEST X-RAY STEREO FRONTAL	MAXFEE	DEF	26				7.01	7/26/2007	12/31/2299	N
71020	CHEST X-RAY 2VW FRONTAL&LATL	PRXOVR	DEF					NA	NA	NA	N
71020	CHEST X-RAY 2VW FRONTAL&LATL	MAXFEE	DEF					25.69	1/1/2010	12/31/2299	N

71020	CHEST X-RAY 2VW FRONTAL&LATL	MAXFEE	DEF	TC				16.70	1/1/2010	12/31/2299	N
71020	CHEST X-RAY 2VW FRONTAL&LATL	MAXFEE	DEF	26				8.99	1/1/2010	12/31/2299	N
71021	CHEST X-RAY FRNT LAT LORDOTC	PRXOVR	DEF					NA	NA	NA	N
71021	CHEST X-RAY FRNT LAT LORDOTC	MAXFEE	DEF					31.98	1/1/2000	12/31/2299	N
71021	CHEST X-RAY FRNT LAT LORDOTC	MAXFEE	DEF	TC				20.79	1/1/2000	12/31/2299	N
71021	CHEST X-RAY FRNT LAT LORDOTC	MAXFEE	DEF	26				11.19	1/1/2000	12/31/2299	N
71022	CHEST X-RAY FRNT LAT OBLIQUE	PRXOVR	DEF					NA	NA	NA	N
71022	CHEST X-RAY FRNT LAT OBLIQUE	MAXFEE	DEF					33.54	7/26/2007	12/31/2299	N
71022	CHEST X-RAY FRNT LAT OBLIQUE	MAXFEE	DEF	TC				23.48	7/26/2007	12/31/2299	N
71022	CHEST X-RAY FRNT LAT OBLIQUE	MAXFEE	DEF	26				10.06	7/26/2007	12/31/2299	N
71023	CHEST X-RAY AND FLUOROSCOPY	PRXOVR	DEF					NA	NA	NA	N
71023	CHEST X-RAY AND FLUOROSCOPY	MAXFEE	DEF					37.75	7/26/2007	12/31/2299	N
71023	CHEST X-RAY AND FLUOROSCOPY	MAXFEE	DEF	TC				26.43	7/26/2007	12/31/2299	N
71023	CHEST X-RAY AND FLUOROSCOPY	MAXFEE	DEF	26				11.33	7/26/2007	12/31/2299	N
71030	CHEST X-RAY 4/> VIEWS	PRXOVR	DEF					NA	NA	NA	N
71030	CHEST X-RAY 4/> VIEWS	MAXFEE	DEF					34.97	7/26/2007	12/31/2299	N
71030	CHEST X-RAY 4/> VIEWS	MAXFEE	DEF	TC				24.48	7/26/2007	12/31/2299	N
71030	CHEST X-RAY 4/> VIEWS	MAXFEE	DEF	26				10.49	7/26/2007	12/31/2299	N
71034	CHEST X-RAY&FLUORO 4/> VIEWS	PRXOVR	DEF					NA	NA	NA	N

71034	CHEST X-RAY&FLUORO 4/> VIEWS	MAXFEE	DEF					59.63	1/1/2000	12/31/2299	N
71034	CHEST X-RAY&FLUORO 4/> VIEWS	MAXFEE	DEF	TC				38.76	1/1/2000	12/31/2299	N
71034	CHEST X-RAY&FLUORO 4/> VIEWS	MAXFEE	DEF	26				20.87	1/1/2000	12/31/2299	N
71035	CHEST X-RAY SPECIAL VIEWS	PRXOVR	DEF					NA	NA	NA	N
71035	CHEST X-RAY SPECIAL VIEWS	MAXFEE	DEF					22.09	1/1/2000	12/31/2299	N
71035	CHEST X-RAY SPECIAL VIEWS	MAXFEE	DEF	TC				14.36	1/1/2000	12/31/2299	N
71035	CHEST X-RAY SPECIAL VIEWS	MAXFEE	DEF	26				7.73	1/1/2000	12/31/2299	N
71036	X-RAY GUIDANCE FOR BIOPSY	PRXOVR	DEF					NA	NA	NA	N
71036	X-RAY GUIDANCE FOR BIOPSY	MAXFEE	DEF					NA			N
71040	CONTRAST X-RAY OF BRONCHI	PRXOVR	DEF					NA	NA	NA	N
71040	CONTRAST X-RAY OF BRONCHI	MAXFEE	DEF					NA			N
71060	CONTRAST X-RAY OF BRONCHI	PRXOVR	DEF					NA	NA	NA	N
71060	CONTRAST X-RAY OF BRONCHI	MAXFEE	DEF					NA			N
71090	X-RAY & PACEMAKER INSERTION	PRXOVR	DEF					NA	NA	NA	N
71090	X-RAY & PACEMAKER INSERTION	MAXFEE	DEF					NA			N
71100	X-RAY EXAM RIBS UNI 2 VIEWS	PRXOVR	DEF					NA	NA	NA	N
71100	X-RAY EXAM RIBS UNI 2 VIEWS	MAXFEE	DEF					24.72	1/1/2010	12/31/2299	N
71100	X-RAY EXAM RIBS UNI 2 VIEWS	MAXFEE	DEF	TC				17.30	1/1/2010	12/31/2299	N
71100	X-RAY EXAM RIBS UNI 2 VIEWS	MAXFEE	DEF	26				7.42	1/1/2010	12/31/2299	N

71101	X-RAY EXAM UNILAT RIBS/CHEST	PRXOVR	DEF					NA	NA	NA	N
71101	X-RAY EXAM UNILAT RIBS/CHEST	MAXFEE	DEF					29.28	1/1/2010	12/31/2299	N
71101	X-RAY EXAM UNILAT RIBS/CHEST	MAXFEE	DEF	TC				20.50	1/1/2010	12/31/2299	N
71101	X-RAY EXAM UNILAT RIBS/CHEST	MAXFEE	DEF	26				8.78	1/1/2010	12/31/2299	N
71110	X-RAY EXAM RIBS BIL 3 VIEWS	PRXOVR	DEF					NA	NA	NA	N
71110	X-RAY EXAM RIBS BIL 3 VIEWS	MAXFEE	DEF					33.61	1/1/2000	12/31/2299	N
71110	X-RAY EXAM RIBS BIL 3 VIEWS	MAXFEE	DEF	TC				21.85	1/1/2000	12/31/2299	N
71110	X-RAY EXAM RIBS BIL 3 VIEWS	MAXFEE	DEF	26				11.76	1/1/2000	12/31/2299	N
71111	X-RAY EXAM RIBS/CHEST4/> VWS	PRXOVR	DEF					NA	NA	NA	N
71111	X-RAY EXAM RIBS/CHEST4/> VWS	MAXFEE	DEF					38.61	1/1/2000	12/31/2299	N
71111	X-RAY EXAM RIBS/CHEST4/> VWS	MAXFEE	DEF	TC				25.10	1/1/2000	12/31/2299	N
71111	X-RAY EXAM RIBS/CHEST4/> VWS	MAXFEE	DEF	26				13.51	1/1/2000	12/31/2299	N
71120	X-RAY EXAM BREASTBONE 2/>VWS	PRXOVR	DEF					NA	NA	NA	N
71120	X-RAY EXAM BREASTBONE 2/>VWS	MAXFEE	DEF					26.52	1/1/2000	12/31/2299	N
71120	X-RAY EXAM BREASTBONE 2/>VWS	MAXFEE	DEF	TC				17.24	1/1/2000	12/31/2299	N
71120	X-RAY EXAM BREASTBONE 2/>VWS	MAXFEE	DEF	26				9.28	1/1/2000	12/31/2299	N
71130	X-RAY STRENOCLAVIC JT 3/>VWS	PRXOVR	DEF					NA	NA	NA	N

71130	X-RAY STRENOCLAVIC JT 3/>VWS	MAXFEE	DEF					28.83	1/1/2000	12/31/2299	N
71130	X-RAY STRENOCLAVIC JT 3/>VWS	MAXFEE	DEF	TC				18.74	1/1/2000	12/31/2299	N
71130	X-RAY STRENOCLAVIC JT 3/>VWS	MAXFEE	DEF	26				10.09	1/1/2000	12/31/2299	N
71250	CT THORAX W/O DYE	PRXOVR	DEF					NA	NA	NA	N
71250	CT THORAX W/O DYE	MAXFEE	DEF					214.38	1/1/2000	12/31/2299	N
71250	CT THORAX W/O DYE	MAXFEE	DEF	TC				160.79	1/1/2000	12/31/2299	N
71250	CT THORAX W/O DYE	MAXFEE	DEF	26				53.60	1/1/2000	12/31/2299	N
71260	CT THORAX W/DYE	PRXOVR	DEF					NA	NA	NA	N
71260	CT THORAX W/DYE	MAXFEE	DEF					250.79	1/1/2000	12/31/2299	N
71260	CT THORAX W/DYE	MAXFEE	DEF	TC				200.63	1/1/2000	12/31/2299	N
71260	CT THORAX W/DYE	MAXFEE	DEF	26				50.16	1/1/2000	12/31/2299	N
71270	CT THORAX W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
71270	CT THORAX W/O & W/DYE	MAXFEE	DEF					306.47	1/1/2000	12/31/2299	N
71270	CT THORAX W/O & W/DYE	MAXFEE	DEF	TC				245.18	1/1/2000	12/31/2299	N
71270	CT THORAX W/O & W/DYE	MAXFEE	DEF	26				61.29	1/1/2000	12/31/2299	N
71275	CT ANGIOGRAPHY CHEST	PRXOVR	DEF					NA	NA	NA	N
71275	CT ANGIOGRAPHY CHEST	MAXFEE	DEF					314.63	1/1/2001	12/31/2299	N
71275	CT ANGIOGRAPHY CHEST	MAXFEE	DEF	TC				251.70	1/1/2001	12/31/2299	N
71275	CT ANGIOGRAPHY CHEST	MAXFEE	DEF	26				62.93	1/1/2001	12/31/2299	N
71550	MRI CHEST W/O DYE	PRXOVR	DEF					NA	NA	NA	N
71550	MRI CHEST W/O DYE	MAXFEE	DEF					382.93	1/1/2000	12/31/2299	N
71550	MRI CHEST W/O DYE	MAXFEE	DEF	TC				306.34	1/1/2000	12/31/2299	N
71550	MRI CHEST W/O DYE	MAXFEE	DEF	26				76.59	1/1/2000	12/31/2299	N
71551	MRI CHEST W/DYE	PRXOVR	DEF					NA	NA	NA	N
71551	MRI CHEST W/DYE	MAXFEE	DEF					451.75	7/26/2007	12/31/2299	N
71551	MRI CHEST W/DYE	MAXFEE	DEF	TC				361.40	7/26/2007	12/31/2299	N
71551	MRI CHEST W/DYE	MAXFEE	DEF	26				90.35	7/26/2007	12/31/2299	N
71552	MRI CHEST W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N

71552	MRI CHEST W/O & W/DYE	MAXFEE	DEF	TC				477.34	7/1/2008	12/31/2299	N
71552	MRI CHEST W/O & W/DYE	MAXFEE	DEF	26				119.33	7/1/2008	12/31/2299	N
71552	MRI CHEST W/O & W/DYE	MAXFEE	DEF					596.67	7/1/2008	12/31/2299	N
71555	MRI ANGIO CHEST W OR W/O DYE	PRXOVR	DEF					NA	NA	NA	N
71555	MRI ANGIO CHEST W OR W/O DYE	MAXFEE	DEF					390.34	1/1/2000	12/31/2299	N
71555	MRI ANGIO CHEST W OR W/O DYE	MAXFEE	DEF	TC				312.27	1/1/2000	12/31/2299	N
71555	MRI ANGIO CHEST W OR W/O DYE	MAXFEE	DEF	26				78.07	1/1/2000	12/31/2299	N
72010	X-RAY EXAM SPINE AP&LAT	PRXOVR	DEF					NA	NA	NA	N
72010	X-RAY EXAM SPINE AP&LAT	MAXFEE	DEF					45.79	1/1/2010	12/31/2299	N
72010	X-RAY EXAM SPINE AP&LAT	MAXFEE	DEF	TC				27.47	1/1/2010	12/31/2299	N
72010	X-RAY EXAM SPINE AP&LAT	MAXFEE	DEF	26				18.32	1/1/2010	12/31/2299	N
72020	X-RAY EXAM OF SPINE 1 VIEW	PRXOVR	DEF					NA	NA	NA	N
72020	X-RAY EXAM OF SPINE 1 VIEW	MAXFEE	DEF					18.13	1/1/2000	12/31/2299	N
72020	X-RAY EXAM OF SPINE 1 VIEW	MAXFEE	DEF	TC				11.78	1/1/2000	12/31/2299	N
72020	X-RAY EXAM OF SPINE 1 VIEW	MAXFEE	DEF	26				6.35	1/1/2000	12/31/2299	N
72040	X-RAY EXAM NECK SPINE 3/<VWS	PRXOVR	DEF					NA	NA	NA	N
72040	X-RAY EXAM NECK SPINE 3/<VWS	MAXFEE	DEF					25.19	1/1/2010	12/31/2299	N
72040	X-RAY EXAM NECK SPINE 3/<VWS	MAXFEE	DEF	TC				16.37	1/1/2010	12/31/2299	N
72040	X-RAY EXAM NECK SPINE 3/<VWS	MAXFEE	DEF	26				8.82	1/1/2010	12/31/2299	N
72050	X-RAY EXAM NECK SPINE 4/5VWS	PRXOVR	DEF					NA	NA	NA	N
72050	X-RAY EXAM NECK SPINE 4/5VWS	MAXFEE	DEF					37	1/1/2010	12/31/2299	N
72050	X-RAY EXAM NECK SPINE 4/5VWS	MAXFEE	DEF	TC				24.05	1/1/2010	12/31/2299	N

72050	X-RAY EXAM NECK SPINE 4/5VWS	MAXFEE	DEF	26				12.95	1/1/2010	12/31/2299	N
72052	X-RAY EXAM NECK SPINE 6/>VWS	PRXOVR	DEF					NA	NA	NA	N
72052	X-RAY EXAM NECK SPINE 6/>VWS	MAXFEE	DEF					45.29	1/1/2010	12/31/2299	N
72052	X-RAY EXAM NECK SPINE 6/>VWS	MAXFEE	DEF	TC				29.44	1/1/2010	12/31/2299	N
72052	X-RAY EXAM NECK SPINE 6/>VWS	MAXFEE	DEF	26				15.85	1/1/2010	12/31/2299	N
72069	X-RAY EXAM TRUNK SPINE STAND	PRXOVR	DEF					NA	NA	NA	N
72069	X-RAY EXAM TRUNK SPINE STAND	MAXFEE	DEF					22.80	1/1/2000	12/31/2299	N
72069	X-RAY EXAM TRUNK SPINE STAND	MAXFEE	DEF	TC				13.68	1/1/2000	12/31/2299	N
72069	X-RAY EXAM TRUNK SPINE STAND	MAXFEE	DEF	26				9.12	1/1/2000	12/31/2299	N
72070	X-RAY EXAM THORAC SPINE 2VWS	PRXOVR	DEF					NA	NA	NA	N
72070	X-RAY EXAM THORAC SPINE 2VWS	MAXFEE	DEF					26.51	1/1/2010	12/31/2299	N
72070	X-RAY EXAM THORAC SPINE 2VWS	MAXFEE	DEF	TC				17.23	1/1/2010	12/31/2299	N
72070	X-RAY EXAM THORAC SPINE 2VWS	MAXFEE	DEF	26				9.28	1/1/2010	12/31/2299	N
72072	X-RAY EXAM THORAC SPINE 3VWS	PRXOVR	DEF					NA	NA	NA	N
72072	X-RAY EXAM THORAC SPINE 3VWS	MAXFEE	DEF					28.96	1/1/2010	12/31/2299	N
72072	X-RAY EXAM THORAC SPINE 3VWS	MAXFEE	DEF	TC				20.27	1/1/2010	12/31/2299	N
72072	X-RAY EXAM THORAC SPINE 3VWS	MAXFEE	DEF	26				8.69	1/1/2010	12/31/2299	N

72074	X-RAY EXAM THORAC SPINE4/>VW	PRXOVR	DEF					NA	NA	NA	N
72074	X-RAY EXAM THORAC SPINE4/>VW	MAXFEE	DEF					33.93	1/1/2010	12/31/2299	N
72074	X-RAY EXAM THORAC SPINE4/>VW	MAXFEE	DEF	TC				23.75	1/1/2010	12/31/2299	N
72074	X-RAY EXAM THORAC SPINE4/>VW	MAXFEE	DEF	26				10.18	1/1/2010	12/31/2299	N
72080	X-RAY EXAM TRUNK SPINE 2 VWS	PRXOVR	DEF					NA	NA	NA	N
72080	X-RAY EXAM TRUNK SPINE 2 VWS	MAXFEE	DEF					27.02	1/1/2010	12/31/2299	N
72080	X-RAY EXAM TRUNK SPINE 2 VWS	MAXFEE	DEF	TC				17.56	1/1/2010	12/31/2299	N
72080	X-RAY EXAM TRUNK SPINE 2 VWS	MAXFEE	DEF	26				9.46	1/1/2010	12/31/2299	N
72090	X-RAY EXAM SCLOIOSIS ERECT	PRXOVR	DEF					NA	NA	NA	N
72090	X-RAY EXAM SCLOIOSIS ERECT	MAXFEE	DEF					30.52	1/1/2000	12/31/2299	N
72090	X-RAY EXAM SCLOIOSIS ERECT	MAXFEE	DEF	TC				18.31	1/1/2000	12/31/2299	N
72090	X-RAY EXAM SCLOIOSIS ERECT	MAXFEE	DEF	26				12.21	1/1/2000	12/31/2299	N
72100	X-RAY EXAM L-S SPINE 2/3 VWS	PRXOVR	DEF					NA	NA	NA	N
72100	X-RAY EXAM L-S SPINE 2/3 VWS	MAXFEE	DEF					27.02	1/1/2010	12/31/2299	N
72100	X-RAY EXAM L-S SPINE 2/3 VWS	MAXFEE	DEF	TC				17.56	1/1/2010	12/31/2299	N
72100	X-RAY EXAM L-S SPINE 2/3 VWS	MAXFEE	DEF	26				9.46	1/1/2010	12/31/2299	N
72110	X-RAY EXAM L-2 SPINE 4/>VWS	PRXOVR	DEF					NA	NA	NA	N

72110	X-RAY EXAM L-2 SPINE 4/>VWS	MAXFEE	DEF					37.50	1/1/2010	12/31/2299	N
72110	X-RAY EXAM L-2 SPINE 4/>VWS	MAXFEE	DEF	TC				24.38	1/1/2010	12/31/2299	N
72110	X-RAY EXAM L-2 SPINE 4/>VWS	MAXFEE	DEF	26				13.13	1/1/2010	12/31/2299	N
72114	X-RAY EXAM L-S SPINE BENDING	PRXOVR	DEF					NA	NA	NA	N
72114	X-RAY EXAM L-S SPINE BENDING	MAXFEE	DEF					46.75	1/1/2010	12/31/2299	N
72114	X-RAY EXAM L-S SPINE BENDING	MAXFEE	DEF	TC				35.06	1/1/2010	12/31/2299	N
72114	X-RAY EXAM L-S SPINE BENDING	MAXFEE	DEF	26				11.69	1/1/2010	12/31/2299	N
72120	X-RAY BEND ONLY L-S SPINE	PRXOVR	DEF					NA	NA	NA	N
72120	X-RAY BEND ONLY L-S SPINE	MAXFEE	DEF					34.45	1/1/2000	12/31/2299	N
72120	X-RAY BEND ONLY L-S SPINE	MAXFEE	DEF	TC				24.12	1/1/2000	12/31/2299	N
72120	X-RAY BEND ONLY L-S SPINE	MAXFEE	DEF	26				10.34	1/1/2000	12/31/2299	N
72125	CT NECK SPINE W/O DYE	PRXOVR	DEF					NA	NA	NA	N
72125	CT NECK SPINE W/O DYE	MAXFEE	DEF					214.38	1/1/2000	12/31/2299	N
72125	CT NECK SPINE W/O DYE	MAXFEE	DEF	TC				160.79	1/1/2000	12/31/2299	N
72125	CT NECK SPINE W/O DYE	MAXFEE	DEF	26				53.60	1/1/2000	12/31/2299	N
72126	CT NECK SPINE W/DYE	PRXOVR	DEF					NA	NA	NA	N
72126	CT NECK SPINE W/DYE	MAXFEE	DEF					249.78	1/1/2000	12/31/2299	N
72126	CT NECK SPINE W/DYE	MAXFEE	DEF	TC				199.82	1/1/2000	12/31/2299	N
72126	CT NECK SPINE W/DYE	MAXFEE	DEF	26				49.96	1/1/2000	12/31/2299	N
72127	CT NECK SPINE W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72127	CT NECK SPINE W/O & W/DYE	MAXFEE	DEF					302.27	1/1/2000	12/31/2299	N
72127	CT NECK SPINE W/O & W/DYE	MAXFEE	DEF	TC				241.82	1/1/2000	12/31/2299	N
72127	CT NECK SPINE W/O & W/DYE	MAXFEE	DEF	26				60.45	1/1/2000	12/31/2299	N
72128	CT CHEST SPINE W/O DYE	PRXOVR	DEF					NA	NA	NA	N
72128	CT CHEST SPINE W/O DYE	MAXFEE	DEF					214.38	1/1/2000	12/31/2299	N

72128	CT CHEST SPINE W/O DYE	MAXFEE	DEF	TC				160.79	1/1/2000	12/31/2299	N
72128	CT CHEST SPINE W/O DYE	MAXFEE	DEF	26				53.60	1/1/2000	12/31/2299	N
72129	CT CHEST SPINE W/DYE	PRXOVR	DEF					NA	NA	NA	N
72129	CT CHEST SPINE W/DYE	MAXFEE	DEF					249.78	1/1/2000	12/31/2299	N
72129	CT CHEST SPINE W/DYE	MAXFEE	DEF	TC				199.82	1/1/2000	12/31/2299	N
72129	CT CHEST SPINE W/DYE	MAXFEE	DEF	26				49.96	1/1/2000	12/31/2299	N
72130	CT CHEST SPINE W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72130	CT CHEST SPINE W/O & W/DYE	MAXFEE	DEF					302.27	1/1/2000	12/31/2299	N
72130	CT CHEST SPINE W/O & W/DYE	MAXFEE	DEF	TC				241.82	1/1/2000	12/31/2299	N
72130	CT CHEST SPINE W/O & W/DYE	MAXFEE	DEF	26				60.45	1/1/2000	12/31/2299	N
72131	CT LUMBAR SPINE W/O DYE	PRXOVR	DEF					NA	NA	NA	N
72131	CT LUMBAR SPINE W/O DYE	MAXFEE	DEF					214.38	1/1/2000	12/31/2299	N
72131	CT LUMBAR SPINE W/O DYE	MAXFEE	DEF	TC				160.79	1/1/2000	12/31/2299	N
72131	CT LUMBAR SPINE W/O DYE	MAXFEE	DEF	26				53.60	1/1/2000	12/31/2299	N
72132	CT LUMBAR SPINE W/DYE	PRXOVR	DEF					NA	NA	NA	N
72132	CT LUMBAR SPINE W/DYE	MAXFEE	DEF					249.85	1/1/2000	12/31/2299	N
72132	CT LUMBAR SPINE W/DYE	MAXFEE	DEF	TC				199.88	1/1/2000	12/31/2299	N
72132	CT LUMBAR SPINE W/DYE	MAXFEE	DEF	26				49.97	1/1/2000	12/31/2299	N
72133	CT LUMBAR SPINE W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72133	CT LUMBAR SPINE W/O & W/DYE	MAXFEE	DEF					302.27	1/1/2000	12/31/2299	N
72133	CT LUMBAR SPINE W/O & W/DYE	MAXFEE	DEF	TC				241.82	1/1/2000	12/31/2299	N
72133	CT LUMBAR SPINE W/O & W/DYE	MAXFEE	DEF	26				60.45	1/1/2000	12/31/2299	N
72141	MRI NECK SPINE W/O DYE	PRXOVR	DEF					NA	NA	NA	N
72141	MRI NECK SPINE W/O DYE	MAXFEE	DEF					382.93	1/1/2000	12/31/2299	N
72141	MRI NECK SPINE W/O DYE	MAXFEE	DEF	TC				306.34	1/1/2000	12/31/2299	N
72141	MRI NECK SPINE W/O DYE	MAXFEE	DEF	26				76.59	1/1/2000	12/31/2299	N
72142	MRI NECK SPINE W/DYE	PRXOVR	DEF					NA	NA	NA	N

72142	MRI NECK SPINE W/DYE	MAXFEE	DEF					459.30	1/1/2000	12/31/2299	N
72142	MRI NECK SPINE W/DYE	MAXFEE	DEF	TC				367.44	1/1/2000	12/31/2299	N
72142	MRI NECK SPINE W/DYE	MAXFEE	DEF	26				91.86	1/1/2000	12/31/2299	N
72146	MRI CHEST SPINE W/O DYE	PRXOVR	DEF					NA	NA	NA	N
72146	MRI CHEST SPINE W/O DYE	MAXFEE	DEF					418.05	1/1/2000	12/31/2299	N
72146	MRI CHEST SPINE W/O DYE	MAXFEE	DEF	TC				334.44	1/1/2000	12/31/2299	N
72146	MRI CHEST SPINE W/O DYE	MAXFEE	DEF	26				83.61	1/1/2000	12/31/2299	N
72147	MRI CHEST SPINE W/DYE	PRXOVR	DEF					NA	NA	NA	N
72147	MRI CHEST SPINE W/DYE	MAXFEE	DEF					459.23	1/1/2000	12/31/2299	N
72147	MRI CHEST SPINE W/DYE	MAXFEE	DEF	TC				367.38	1/1/2000	12/31/2299	N
72147	MRI CHEST SPINE W/DYE	MAXFEE	DEF	26				91.85	1/1/2000	12/31/2299	N
72148	MRI LUMBAR SPINE W/O DYE	PRXOVR	DEF					NA	NA	NA	N
72148	MRI LUMBAR SPINE W/O DYE	MAXFEE	DEF					413.05	7/1/2008	12/31/2299	N
72148	MRI LUMBAR SPINE W/O DYE	MAXFEE	DEF	TC				330.44	7/1/2008	12/31/2299	N
72148	MRI LUMBAR SPINE W/O DYE	MAXFEE	DEF	26				82.61	7/1/2008	12/31/2299	N
72149	MRI LUMBAR SPINE W/DYE	PRXOVR	DEF					NA	NA	NA	N
72149	MRI LUMBAR SPINE W/DYE	MAXFEE	DEF					453.65	1/1/2000	12/31/2299	N
72149	MRI LUMBAR SPINE W/DYE	MAXFEE	DEF	TC				362.92	1/1/2000	12/31/2299	N
72149	MRI LUMBAR SPINE W/DYE	MAXFEE	DEF	26				90.73	1/1/2000	12/31/2299	N
72156	MRI NECK SPINE W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72156	MRI NECK SPINE W/O & W/DYE	MAXFEE	DEF					611.91	7/1/2008	12/31/2299	N
72156	MRI NECK SPINE W/O & W/DYE	MAXFEE	DEF	TC				489.53	7/1/2008	12/31/2299	N
72156	MRI NECK SPINE W/O & W/DYE	MAXFEE	DEF	26				122.38	7/1/2008	12/31/2299	N
72157	MRI CHEST SPINE W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72157	MRI CHEST SPINE W/O & W/DYE	MAXFEE	DEF					611.57	7/1/2008	12/31/2299	N

72157	MRI CHEST SPINE W/O & W/DYE	MAXFEE	DEF	TC				489.26	7/1/2008	12/31/2299	N
72157	MRI CHEST SPINE W/O & W/DYE	MAXFEE	DEF	26				122.31	7/1/2008	12/31/2299	N
72158	MRI LUMBAR SPINE W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72158	MRI LUMBAR SPINE W/O & W/DYE	MAXFEE	DEF					601.87	7/1/2008	12/31/2299	N
72158	MRI LUMBAR SPINE W/O & W/DYE	MAXFEE	DEF	TC				481.50	7/1/2008	12/31/2299	N
72158	MRI LUMBAR SPINE W/O & W/DYE	MAXFEE	DEF	26				120.37	7/1/2008	12/31/2299	N
72159	MR ANGIO SPINE W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
72159	MR ANGIO SPINE W/O&W/DYE	MAXFEE	DEF					423.71	1/1/2000	12/31/2299	N
72159	MR ANGIO SPINE W/O&W/DYE	MAXFEE	DEF	TC				338.97	1/1/2000	12/31/2299	N
72159	MR ANGIO SPINE W/O&W/DYE	MAXFEE	DEF	26				84.74	1/1/2000	12/31/2299	N
72170	X-RAY EXAM OF PELVIS	PRXOVR	DEF					NA	NA	NA	N
72170	X-RAY EXAM OF PELVIS	MAXFEE	DEF					20.91	1/1/2010	12/31/2299	N
72170	X-RAY EXAM OF PELVIS	MAXFEE	DEF	TC				13.59	1/1/2010	12/31/2299	N
72170	X-RAY EXAM OF PELVIS	MAXFEE	DEF	26				7.32	1/1/2010	12/31/2299	N
72190	X-RAY EXAM OF PELVIS	PRXOVR	DEF					NA	NA	NA	N
72190	X-RAY EXAM OF PELVIS	MAXFEE	DEF					27.58	1/1/2000	12/31/2299	N
72190	X-RAY EXAM OF PELVIS	MAXFEE	DEF	TC				17.93	1/1/2000	12/31/2299	N
72190	X-RAY EXAM OF PELVIS	MAXFEE	DEF	26				9.65	1/1/2000	12/31/2299	N
72191	CT ANGIOGRAPH PELV W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
72191	CT ANGIOGRAPH PELV W/O&W/DYE	MAXFEE	DEF					304.53	1/1/2001	12/31/2299	N
72191	CT ANGIOGRAPH PELV W/O&W/DYE	MAXFEE	DEF	TC				243.62	1/1/2001	12/31/2299	N
72191	CT ANGIOGRAPH PELV W/O&W/DYE	MAXFEE	DEF	26				60.91	1/1/2001	12/31/2299	N
72192	CT PELVIS W/O DYE	PRXOVR	DEF					NA	NA	NA	N

72192	CT PELVIS W/O DYE	MAXFEE	DEF					211.44	1/1/2000	12/31/2299	N
72192	CT PELVIS W/O DYE	MAXFEE	DEF	TC				158.58	1/1/2000	12/31/2299	N
72192	CT PELVIS W/O DYE	MAXFEE	DEF	26				52.86	1/1/2000	12/31/2299	N
72193	CT PELVIS W/DYE	PRXOVR	DEF					NA	NA	NA	N
72193	CT PELVIS W/DYE	MAXFEE	DEF					240.88	1/1/2000	12/31/2299	N
72193	CT PELVIS W/DYE	MAXFEE	DEF	TC				192.70	1/1/2000	12/31/2299	N
72193	CT PELVIS W/DYE	MAXFEE	DEF	26				48.18	1/1/2000	12/31/2299	N
72194	CT PELVIS W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72194	CT PELVIS W/O & W/DYE	MAXFEE	DEF					289.63	1/1/2000	12/31/2299	N
72194	CT PELVIS W/O & W/DYE	MAXFEE	DEF	TC				231.70	1/1/2000	12/31/2299	N
72194	CT PELVIS W/O & W/DYE	MAXFEE	DEF	26				57.93	1/1/2000	12/31/2299	N
72195	MRI PELVIS W/O DYE	PRXOVR	DEF					NA	NA	NA	N
72195	MRI PELVIS W/O DYE	MAXFEE	DEF					377.68	7/26/2007	12/31/2299	N
72195	MRI PELVIS W/O DYE	MAXFEE	DEF	TC				302.14	7/26/2007	12/31/2299	N
72195	MRI PELVIS W/O DYE	MAXFEE	DEF	26				75.54	7/26/2007	12/31/2299	N
72196	MRI PELVIS W/DYE	PRXOVR	DEF					NA	NA	NA	N
72196	MRI PELVIS W/DYE	MAXFEE	DEF					382.86	1/1/2000	12/31/2299	N
72196	MRI PELVIS W/DYE	MAXFEE	DEF	TC				306.29	1/1/2000	12/31/2299	N
72196	MRI PELVIS W/DYE	MAXFEE	DEF	26				76.57	1/1/2000	12/31/2299	N
72197	MRI PELVIS W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72197	MRI PELVIS W/O & W/DYE	MAXFEE	DEF					596.82	7/1/2008	12/31/2299	N
72197	MRI PELVIS W/O & W/DYE	MAXFEE	DEF	TC				477.46	7/1/2008	12/31/2299	N
72197	MRI PELVIS W/O & W/DYE	MAXFEE	DEF	26				119.36	7/1/2008	12/31/2299	N
72198	MR ANGIO PELVIS W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
72198	MR ANGIO PELVIS W/O & W/DYE	MAXFEE	DEF					390.06	1/1/2000	12/31/2299	N
72200	X-RAY EXAM SI JOINTS	PRXOVR	DEF					NA	NA	NA	N
72200	X-RAY EXAM SI JOINTS	MAXFEE	DEF					21.75	1/1/2000	12/31/2299	N
72200	X-RAY EXAM SI JOINTS	MAXFEE	DEF	TC				14.14	1/1/2000	12/31/2299	N
72200	X-RAY EXAM SI JOINTS	MAXFEE	DEF	26				7.61	1/1/2000	12/31/2299	N

72202	X-RAY EXAM SI JOINTS 3/> VWS	PRXOVR	DEF					NA	NA	NA	N
72202	X-RAY EXAM SI JOINTS 3/> VWS	MAXFEE	DEF					25.40	1/1/2000	12/31/2299	N
72202	X-RAY EXAM SI JOINTS 3/> VWS	MAXFEE	DEF	TC				16.51	1/1/2000	12/31/2299	N
72202	X-RAY EXAM SI JOINTS 3/> VWS	MAXFEE	DEF	26				8.89	1/1/2000	12/31/2299	N
72220	X-RAY EXAM SACRUM TAILBONE	PRXOVR	DEF					NA	NA	NA	N
72220	X-RAY EXAM SACRUM TAILBONE	MAXFEE	DEF					22.59	1/1/2010	12/31/2299	N
72220	X-RAY EXAM SACRUM TAILBONE	MAXFEE	DEF	TC				14.68	1/1/2010	12/31/2299	N
72220	X-RAY EXAM SACRUM TAILBONE	MAXFEE	DEF	26				7.91	1/1/2010	12/31/2299	N
72240	MYELOGRAPHY NECK SPINE	PRXOVR	DEF					NA	NA	NA	N
72240	MYELOGRAPHY NECK SPINE	MAXFEE	DEF					137.12	1/1/2010	12/31/2299	N
72240	MYELOGRAPHY NECK SPINE	MAXFEE	DEF	TC				102.84	1/1/2010	12/31/2299	N
72240	MYELOGRAPHY NECK SPINE	MAXFEE	DEF	26				34.28	1/1/2010	12/31/2299	N
72255	MYELOGRAPHY THORACIC SPINE	PRXOVR	DEF					NA	NA	NA	N
72255	MYELOGRAPHY THORACIC SPINE	MAXFEE	DEF					125.39	1/1/2010	12/31/2299	N
72255	MYELOGRAPHY THORACIC SPINE	MAXFEE	DEF	TC				94.04	1/1/2010	12/31/2299	N
72255	MYELOGRAPHY THORACIC SPINE	MAXFEE	DEF	26				31.35	1/1/2010	12/31/2299	N
72265	MYELOGRAPHY L-S SPINE	PRXOVR	DEF					NA	NA	NA	N
72265	MYELOGRAPHY L-S SPINE	MAXFEE	DEF					134.72	1/1/2012	12/31/2299	N
72265	MYELOGRAPHY L-S SPINE	MAXFEE	DEF	TC				101.04	1/1/2012	12/31/2299	N
72265	MYELOGRAPHY L-S SPINE	MAXFEE	DEF	26				33.68	1/1/2012	12/31/2299	N

72270	MYELOGPHY 2/> SPINE REGIONS	PRXOVR	DEF					NA	NA	NA	N
72270	MYELOGPHY 2/> SPINE REGIONS	MAXFEE	DEF					198.39	1/1/2010	12/31/2299	N
72270	MYELOGPHY 2/> SPINE REGIONS	MAXFEE	DEF	TC				148.79	1/1/2010	12/31/2299	N
72270	MYELOGPHY 2/> SPINE REGIONS	MAXFEE	DEF	26				49.60	1/1/2010	12/31/2299	N
72275	EPIDUROGRAPHY	PRXOVR	DEF					NA	NA	NA	N
72275	EPIDUROGRAPHY	MAXFEE	DEF					66.80	7/1/2008	12/31/2299	N
72275	EPIDUROGRAPHY	MAXFEE	DEF	TC				50.10	7/1/2008	12/31/2299	N
72275	EPIDUROGRAPHY	MAXFEE	DEF	26				16.70	7/1/2008	12/31/2299	N
72285	DISCOGRAPHY CERV/THOR SPINE	PRXOVR	DEF					NA	NA	NA	N
72285	DISCOGRAPHY CERV/THOR SPINE	MAXFEE	DEF					144.39	1/1/2012	12/31/2299	N
72285	DISCOGRAPHY CERV/THOR SPINE	MAXFEE	DEF	TC				115.51	1/1/2012	12/31/2299	N
72285	DISCOGRAPHY CERV/THOR SPINE	MAXFEE	DEF	26				28.88	1/1/2012	12/31/2299	N
72291	PERQ VERTE/SACROPLSTY FLUOR	PRXOVR	DEF					NA	NA	NA	N
72291	PERQ VERTE/SACROPLSTY FLUOR	MANUAL	DEF					NA	NA	NA	N
72292	PERQ VERTE/SACROPLSTY CT	PRXOVR	DEF					NA	NA	NA	N
72292	PERQ VERTE/SACROPLSTY CT	MANUAL	DEF					NA	NA	NA	N
72295	X-RAY OF LOWER SPINE DISK	PRXOVR	DEF					NA	NA	NA	N
72295	X-RAY OF LOWER SPINE DISK	MAXFEE	DEF					126.89	1/1/2012	12/31/2299	N
72295	X-RAY OF LOWER SPINE DISK	MAXFEE	DEF	TC				101.51	1/1/2012	12/31/2299	N
72295	X-RAY OF LOWER SPINE DISK	MAXFEE	DEF	26				25.38	1/1/2012	12/31/2299	N
73000	X-RAY EXAM OF COLLAR BONE	PRXOVR	DEF					NA	NA	NA	N

73000	X-RAY EXAM OF COLLAR BONE	MAXFEE	DEF					21.28	1/1/2000	12/31/2299	N
73000	X-RAY EXAM OF COLLAR BONE	MAXFEE	DEF	TC				13.83	1/1/2000	12/31/2299	N
73000	X-RAY EXAM OF COLLAR BONE	MAXFEE	DEF	26				7.45	1/1/2000	12/31/2299	N
73010	X-RAY EXAM OF SHOULDER BLADE	PRXOVR	DEF					NA	NA	NA	N
73010	X-RAY EXAM OF SHOULDER BLADE	MAXFEE	DEF					21.75	1/1/2000	12/31/2299	N
73010	X-RAY EXAM OF SHOULDER BLADE	MAXFEE	DEF	TC				14.14	1/1/2000	12/31/2299	N
73010	X-RAY EXAM OF SHOULDER BLADE	MAXFEE	DEF	26				7.61	1/1/2000	12/31/2299	N
73020	X-RAY EXAM OF SHOULDER	PRXOVR	DEF					NA	NA	NA	N
73020	X-RAY EXAM OF SHOULDER	MAXFEE	DEF					19.63	1/1/2000	12/31/2299	N
73020	X-RAY EXAM OF SHOULDER	MAXFEE	DEF	TC				12.76	1/1/2000	12/31/2299	N
73020	X-RAY EXAM OF SHOULDER	MAXFEE	DEF	26				6.87	1/1/2000	12/31/2299	N
73030	X-RAY EXAM OF SHOULDER	PRXOVR	DEF					NA	NA	NA	N
73030	X-RAY EXAM OF SHOULDER	MAXFEE	DEF					22.92	1/1/2010	12/31/2299	N
73030	X-RAY EXAM OF SHOULDER	MAXFEE	DEF	TC				14.90	1/1/2010	12/31/2299	N
73030	X-RAY EXAM OF SHOULDER	MAXFEE	DEF	26				8.02	1/1/2010	12/31/2299	N
73040	CONTRAST X-RAY OF SHOULDER	PRXOVR	DEF					NA	NA	NA	N
73040	CONTRAST X-RAY OF SHOULDER	MAXFEE	DEF					81.61	1/1/2000	12/31/2299	N
73040	CONTRAST X-RAY OF SHOULDER	MAXFEE	DEF	TC				57.13	1/1/2000	12/31/2299	N
73040	CONTRAST X-RAY OF SHOULDER	MAXFEE	DEF	26				24.48	1/1/2000	12/31/2299	N
73050	X-RAY EXAM OF SHOULDERS	PRXOVR	DEF					NA	NA	NA	N
73050	X-RAY EXAM OF SHOULDERS	MAXFEE	DEF					27.05	1/1/2000	12/31/2299	N
73050	X-RAY EXAM OF SHOULDERS	MAXFEE	DEF	TC				17.58	1/1/2000	12/31/2299	N

73050	X-RAY EXAM OF SHOULDERS	MAXFEE	DEF	26				9.47	1/1/2000	12/31/2299	N
73060	X-RAY EXAM OF HUMERUS	PRXOVR	DEF					NA	NA	NA	N
73060	X-RAY EXAM OF HUMERUS	MAXFEE	DEF					22.59	1/1/2010	12/31/2299	N
73060	X-RAY EXAM OF HUMERUS	MAXFEE	DEF	TC				14.68	1/1/2010	12/31/2299	N
73060	X-RAY EXAM OF HUMERUS	MAXFEE	DEF	26				7.91	1/1/2010	12/31/2299	N
73070	X-RAY EXAM OF ELBOW	PRXOVR	DEF					NA	NA	NA	N
73070	X-RAY EXAM OF ELBOW	MAXFEE	DEF					20.37	1/1/2010	12/31/2299	N
73070	X-RAY EXAM OF ELBOW	MAXFEE	DEF	TC				14.26	1/1/2010	12/31/2299	N
73070	X-RAY EXAM OF ELBOW	MAXFEE	DEF	26				6.11	1/1/2010	12/31/2299	N
73080	X-RAY EXAM OF ELBOW	PRXOVR	DEF					NA	NA	NA	N
73080	X-RAY EXAM OF ELBOW	MAXFEE	DEF					22.59	1/1/2010	12/31/2299	N
73080	X-RAY EXAM OF ELBOW	MAXFEE	DEF	TC				16.94	1/1/2010	12/31/2299	N
73080	X-RAY EXAM OF ELBOW	MAXFEE	DEF	26				5.65	1/1/2010	12/31/2299	N
73085	CONTRAST X-RAY OF ELBOW	PRXOVR	DEF					NA	NA	NA	N
73085	CONTRAST X-RAY OF ELBOW	MAXFEE	DEF					81.68	1/1/2000	12/31/2299	N
73085	CONTRAST X-RAY OF ELBOW	MAXFEE	DEF	TC				57.18	1/1/2000	12/31/2299	N
73085	CONTRAST X-RAY OF ELBOW	MAXFEE	DEF	26				24.50	1/1/2000	12/31/2299	N
73090	X-RAY EXAM OF FOREARM	PRXOVR	DEF					NA	NA	NA	N
73090	X-RAY EXAM OF FOREARM	MAXFEE	DEF					20.64	1/1/2010	12/31/2299	N
73090	X-RAY EXAM OF FOREARM	MAXFEE	DEF	TC				13.42	1/1/2010	12/31/2299	N
73090	X-RAY EXAM OF FOREARM	MAXFEE	DEF	26				7.22	1/1/2010	12/31/2299	N
73092	X-RAY EXAM OF ARM INFANT	PRXOVR	DEF					NA	NA	NA	N
73092	X-RAY EXAM OF ARM INFANT	MAXFEE	DEF					20.43	1/1/2000	12/31/2299	N
73092	X-RAY EXAM OF ARM INFANT	MAXFEE	DEF	TC				13.28	1/1/2000	12/31/2299	N
73092	X-RAY EXAM OF ARM INFANT	MAXFEE	DEF	26				7.15	1/1/2000	12/31/2299	N
73100	X-RAY EXAM OF WRIST	PRXOVR	DEF					NA	NA	NA	N
73100	X-RAY EXAM OF WRIST	MAXFEE	DEF					20.43	1/1/2000	12/31/2299	N
73100	X-RAY EXAM OF WRIST	MAXFEE	DEF	TC				13.28	1/1/2000	12/31/2299	N
73100	X-RAY EXAM OF WRIST	MAXFEE	DEF	26				7.15	1/1/2000	12/31/2299	N
73110	X-RAY EXAM OF WRIST	PRXOVR	DEF					NA	NA	NA	N

73110	X-RAY EXAM OF WRIST	MAXFEE	DEF					21.35	1/1/2010	12/31/2299	N
73110	X-RAY EXAM OF WRIST	MAXFEE	DEF	TC				13.88	1/1/2010	12/31/2299	N
73110	X-RAY EXAM OF WRIST	MAXFEE	DEF	26				7.47	1/1/2010	12/31/2299	N
73115	CONTRAST X-RAY OF WRIST	PRXOVR	DEF					NA	NA	NA	N
73115	CONTRAST X-RAY OF WRIST	MAXFEE	DEF					66.93	1/1/2000	12/31/2299	N
73115	CONTRAST X-RAY OF WRIST	MAXFEE	DEF	TC				43.50	1/1/2000	12/31/2299	N
73115	CONTRAST X-RAY OF WRIST	MAXFEE	DEF	26				23.43	1/1/2000	12/31/2299	N
73120	X-RAY EXAM OF HAND	PRXOVR	DEF					NA	NA	NA	N
73120	X-RAY EXAM OF HAND	MAXFEE	DEF					19.82	1/1/2010	12/31/2299	N
73120	X-RAY EXAM OF HAND	MAXFEE	DEF	TC				12.88	1/1/2010	12/31/2299	N
73120	X-RAY EXAM OF HAND	MAXFEE	DEF	26				6.94	1/1/2010	12/31/2299	N
73130	X-RAY EXAM OF HAND	PRXOVR	DEF					NA	NA	NA	N
73130	X-RAY EXAM OF HAND	MAXFEE	DEF					21.35	1/1/2010	12/31/2299	N
73130	X-RAY EXAM OF HAND	MAXFEE	DEF	TC				13.88	1/1/2010	12/31/2299	N
73130	X-RAY EXAM OF HAND	MAXFEE	DEF	26				7.47	1/1/2010	12/31/2299	N
73140	X-RAY EXAM OF FINGER(S)	PRXOVR	DEF					NA	NA	NA	N
73140	X-RAY EXAM OF FINGER(S)	MAXFEE	DEF					17.32	1/1/2000	12/31/2299	N
73140	X-RAY EXAM OF FINGER(S)	MAXFEE	DEF	TC				11.26	1/1/2000	12/31/2299	N
73140	X-RAY EXAM OF FINGER(S)	MAXFEE	DEF	26				6.06	1/1/2000	12/31/2299	N
73200	CT UPPER EXTREMITY W/O DYE	PRXOVR	DEF					NA	NA	NA	N
73200	CT UPPER EXTREMITY W/O DYE	MAXFEE	DEF					184.38	1/1/2000	12/31/2299	N
73200	CT UPPER EXTREMITY W/O DYE	MAXFEE	DEF	TC				138.29	1/1/2000	12/31/2299	N
73200	CT UPPER EXTREMITY W/O DYE	MAXFEE	DEF	26				46.10	1/1/2000	12/31/2299	N
73201	CT UPPER EXTREMITY W/DYE	PRXOVR	DEF					NA	NA	NA	N
73201	CT UPPER EXTREMITY W/DYE	MAXFEE	DEF					214.38	1/1/2000	12/31/2299	N
73201	CT UPPER EXTREMITY W/DYE	MAXFEE	DEF	TC				160.79	1/1/2000	12/31/2299	N
73201	CT UPPER EXTREMITY W/DYE	MAXFEE	DEF	26				53.60	1/1/2000	12/31/2299	N

970

73202	CT UPPR EXTREMITY W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73202	CT UPPR EXTREMITY W/O&W/DYE	MAXFEE	DEF					259.86	1/1/2000	12/31/2299	N
73202	CT UPPR EXTREMITY W/O&W/DYE	MAXFEE	DEF	TC				207.89	1/1/2000	12/31/2299	N
73202	CT UPPR EXTREMITY W/O&W/DYE	MAXFEE	DEF	26				51.97	1/1/2000	12/31/2299	N
73206	CT ANGIO UPR EXTRM W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73206	CT ANGIO UPR EXTRM W/O&W/DYE	MAXFEE	DEF					273.93	1/1/2001	12/31/2299	N
73206	CT ANGIO UPR EXTRM W/O&W/DYE	MAXFEE	DEF	TC				219.14	1/1/2001	12/31/2299	N
73206	CT ANGIO UPR EXTRM W/O&W/DYE	MAXFEE	DEF	26				54.79	1/1/2001	12/31/2299	N
73218	MRI UPPER EXTREMITY W/O DYE	PRXOVR	DEF					NA	NA	NA	N
73218	MRI UPPER EXTREMITY W/O DYE	MAXFEE	DEF					371.56	7/26/2007	12/31/2299	N
73218	MRI UPPER EXTREMITY W/O DYE	MAXFEE	DEF	TC				297.25	7/26/2007	12/31/2299	N
73218	MRI UPPER EXTREMITY W/O DYE	MAXFEE	DEF	26				74.31	7/26/2007	12/31/2299	N
73219	MRI UPPER EXTREMITY W/DYE	PRXOVR	DEF					NA	NA	NA	N
73219	MRI UPPER EXTREMITY W/DYE	MAXFEE	DEF					445.02	7/26/2007	12/31/2299	N
73219	MRI UPPER EXTREMITY W/DYE	MAXFEE	DEF	TC				356.02	7/26/2007	12/31/2299	N
73219	MRI UPPER EXTREMITY W/DYE	MAXFEE	DEF	26				89	7/26/2007	12/31/2299	N
73220	MRI UPPR EXTREMITY W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N

73220	MRI UPPR EXTREMITY W/O&W/DYE	MAXFEE	DEF					377.96	1/1/2000	12/31/2299	N
73220	MRI UPPR EXTREMITY W/O&W/DYE	MAXFEE	DEF	TC				302.37	1/1/2000	12/31/2299	N
73220	MRI UPPR EXTREMITY W/O&W/DYE	MAXFEE	DEF	26				75.59	1/1/2000	12/31/2299	N
73221	MRI JOINT UPR EXTREM W/O DYE	PRXOVR	DEF					NA	NA	NA	N
73221	MRI JOINT UPR EXTREM W/O DYE	MAXFEE	DEF					372.17	1/1/2000	12/31/2299	N
73221	MRI JOINT UPR EXTREM W/O DYE	MAXFEE	DEF	TC				297.74	1/1/2000	12/31/2299	N
73221	MRI JOINT UPR EXTREM W/O DYE	MAXFEE	DEF	26				74.43	1/1/2000	12/31/2299	N
73222	MRI JOINT UPR EXTREM W/DYE	PRXOVR	DEF					NA	NA	NA	N
73222	MRI JOINT UPR EXTREM W/DYE	MAXFEE	DEF					445.02	7/26/2007	12/31/2299	N
73222	MRI JOINT UPR EXTREM W/DYE	MAXFEE	DEF	TC				356.02	7/26/2007	12/31/2299	N
73222	MRI JOINT UPR EXTREM W/DYE	MAXFEE	DEF	26				89	7/26/2007	12/31/2299	N
73223	MRI JOINT UPR EXTR W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73223	MRI JOINT UPR EXTR W/O&W/DYE	MAXFEE	DEF					592.63	7/1/2008	12/31/2299	N
73223	MRI JOINT UPR EXTR W/O&W/DYE	MAXFEE	DEF	TC				474.10	7/1/2008	12/31/2299	N
73223	MRI JOINT UPR EXTR W/O&W/DYE	MAXFEE	DEF	26				118.53	7/1/2008	12/31/2299	N
73225	MR ANGIO UPR EXTR W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73225	MR ANGIO UPR EXTR W/O&W/DYE	MAXFEE	DEF					386.47	1/1/2000	12/31/2299	N

73225	MR ANGIO UPR EXTR W/O&W/DYE	MAXFEE	DEF	TC				309.18	1/1/2000	12/31/2299	N
73225	MR ANGIO UPR EXTR W/O&W/DYE	MAXFEE	DEF	26				77.29	1/1/2000	12/31/2299	N
73500	X-RAY EXAM OF HIP	PRXOVR	DEF					NA	NA	NA	N
73500	X-RAY EXAM OF HIP	MAXFEE	DEF					20.38	1/1/2000	12/31/2299	N
73500	X-RAY EXAM OF HIP	MAXFEE	DEF	TC				13.25	1/1/2000	12/31/2299	N
73500	X-RAY EXAM OF HIP	MAXFEE	DEF	26				7.13	1/1/2000	12/31/2299	N
73510	X-RAY EXAM OF HIP	PRXOVR	DEF					NA	NA	NA	N
73510	X-RAY EXAM OF HIP	MAXFEE	DEF					24.16	1/1/2010	12/31/2299	N
73510	X-RAY EXAM OF HIP	MAXFEE	DEF	TC				15.70	1/1/2010	12/31/2299	N
73510	X-RAY EXAM OF HIP	MAXFEE	DEF	26				8.46	1/1/2010	12/31/2299	N
73520	X-RAY EXAM OF HIPS	PRXOVR	DEF					NA	NA	NA	N
73520	X-RAY EXAM OF HIPS	MAXFEE	DEF					29.71	1/1/2000	12/31/2299	N
73520	X-RAY EXAM OF HIPS	MAXFEE	DEF	TC				17.83	1/1/2000	12/31/2299	N
73520	X-RAY EXAM OF HIPS	MAXFEE	DEF	26				11.88	1/1/2000	12/31/2299	N
73525	CONTRAST X-RAY OF HIP	PRXOVR	DEF					NA	NA	NA	N
73525	CONTRAST X-RAY OF HIP	MAXFEE	DEF					81.61	1/1/2000	12/31/2299	N
73525	CONTRAST X-RAY OF HIP	MAXFEE	DEF	TC				57.13	1/1/2000	12/31/2299	N
73525	CONTRAST X-RAY OF HIP	MAXFEE	DEF	26				24.48	1/1/2000	12/31/2299	N
73530	X-RAY EXAM OF HIP	PRXOVR	DEF					NA	NA	NA	N
73530	X-RAY EXAM OF HIP	MAXFEE	DEF					26.59	1/1/2000	12/31/2299	N
73530	X-RAY EXAM OF HIP	MAXFEE	DEF	TC				13.30	1/1/2000	12/31/2299	N
73530	X-RAY EXAM OF HIP	MAXFEE	DEF	26				13.30	1/1/2000	12/31/2299	N
73540	X-RAY EXAM OF PELVIS & HIPS	PRXOVR	DEF					NA	NA	NA	N
73540	X-RAY EXAM OF PELVIS & HIPS	MAXFEE	DEF					24.57	1/1/2000	12/31/2299	N
73540	X-RAY EXAM OF PELVIS & HIPS	MAXFEE	DEF	TC				15.97	1/1/2000	12/31/2299	N
73540	X-RAY EXAM OF PELVIS & HIPS	MAXFEE	DEF	26				8.60	1/1/2000	12/31/2299	N

73542	X-RAY EXAM SACROILIAC JOINT	PRXOVR	DEF					NA	NA	NA	N
73542	X-RAY EXAM SACROILIAC JOINT	MAXFEE	DEF					NA			N
73550	X-RAY EXAM OF THIGH	PRXOVR	DEF					NA	NA	NA	N
73550	X-RAY EXAM OF THIGH	MAXFEE	DEF					22.59	1/1/2010	12/31/2299	N
73550	X-RAY EXAM OF THIGH	MAXFEE	DEF	TC				14.68	1/1/2010	12/31/2299	N
73550	X-RAY EXAM OF THIGH	MAXFEE	DEF	26				7.91	1/1/2010	12/31/2299	N
73560	X-RAY EXAM OF KNEE 1 OR 2	PRXOVR	DEF					NA	NA	NA	N
73560	X-RAY EXAM OF KNEE 1 OR 2	MAXFEE	DEF					20.97	1/1/2010	12/31/2299	N
73560	X-RAY EXAM OF KNEE 1 OR 2	MAXFEE	DEF	TC				13.63	1/1/2010	12/31/2299	N
73560	X-RAY EXAM OF KNEE 1 OR 2	MAXFEE	DEF	26				7.34	1/1/2010	12/31/2299	N
73562	X-RAY EXAM OF KNEE 3	PRXOVR	DEF					NA	NA	NA	N
73562	X-RAY EXAM OF KNEE 3	MAXFEE	DEF					23.82	1/1/2000	12/31/2299	N
73562	X-RAY EXAM OF KNEE 3	MAXFEE	DEF	TC				15.48	1/1/2000	12/31/2299	N
73562	X-RAY EXAM OF KNEE 3	MAXFEE	DEF	26				8.34	1/1/2000	12/31/2299	N
73564	X-RAY EXAM KNEE 4 OR MORE	PRXOVR	DEF					NA	NA	NA	N
73564	X-RAY EXAM KNEE 4 OR MORE	MAXFEE	DEF					26.79	1/1/2000	12/31/2299	N
73564	X-RAY EXAM KNEE 4 OR MORE	MAXFEE	DEF	TC				17.41	1/1/2000	12/31/2299	N
73564	X-RAY EXAM KNEE 4 OR MORE	MAXFEE	DEF	26				9.38	1/1/2000	12/31/2299	N
73565	X-RAY EXAM OF KNEES	PRXOVR	DEF					NA	NA	NA	N
73565	X-RAY EXAM OF KNEES	MAXFEE	DEF					20.77	1/1/2000	12/31/2299	N
73565	X-RAY EXAM OF KNEES	MAXFEE	DEF	TC				13.50	1/1/2000	12/31/2299	N
73565	X-RAY EXAM OF KNEES	MAXFEE	DEF	26				7.27	1/1/2000	12/31/2299	N
73580	CONTRAST X-RAY OF KNEE JOINT	PRXOVR	DEF					NA	NA	NA	N
73580	CONTRAST X-RAY OF KNEE JOINT	MAXFEE	DEF					96.66	1/1/2000	12/31/2299	N

73580	CONTRAST X-RAY OF KNEE JOINT	MAXFEE	DEF	TC				72.50	1/1/2000	12/31/2299	N
73580	CONTRAST X-RAY OF KNEE JOINT	MAXFEE	DEF	26				24.17	1/1/2000	12/31/2299	N
73590	X-RAY EXAM OF LOWER LEG	PRXOVR	DEF					NA	NA	NA	N
73590	X-RAY EXAM OF LOWER LEG	MAXFEE	DEF					20.91	1/1/2010	12/31/2299	N
73590	X-RAY EXAM OF LOWER LEG	MAXFEE	DEF	TC				13.59	1/1/2010	12/31/2299	N
73590	X-RAY EXAM OF LOWER LEG	MAXFEE	DEF	26				7.32	1/1/2010	12/31/2299	N
73592	X-RAY EXAM OF LEG INFANT	PRXOVR	DEF					NA	NA	NA	N
73592	X-RAY EXAM OF LEG INFANT	MAXFEE	DEF					20.43	1/1/2000	12/31/2299	N
73592	X-RAY EXAM OF LEG INFANT	MAXFEE	DEF	TC				13.28	1/1/2000	12/31/2299	N
73592	X-RAY EXAM OF LEG INFANT	MAXFEE	DEF	26				7.15	1/1/2000	12/31/2299	N
73600	X-RAY EXAM OF ANKLE	PRXOVR	DEF					NA	NA	NA	N
73600	X-RAY EXAM OF ANKLE	MAXFEE	DEF					20.43	1/1/2000	12/31/2299	N
73600	X-RAY EXAM OF ANKLE	MAXFEE	DEF	TC				13.28	1/1/2000	12/31/2299	N
73600	X-RAY EXAM OF ANKLE	MAXFEE	DEF	26				7.15	1/1/2000	12/31/2299	N
73610	X-RAY EXAM OF ANKLE	PRXOVR	DEF					NA	NA	NA	N
73610	X-RAY EXAM OF ANKLE	MAXFEE	DEF					21.35	1/1/2010	12/31/2299	N
73610	X-RAY EXAM OF ANKLE	MAXFEE	DEF	TC				13.88	1/1/2010	12/31/2299	N
73610	X-RAY EXAM OF ANKLE	MAXFEE	DEF	26				7.47	1/1/2010	12/31/2299	N
73615	CONTRAST X-RAY OF ANKLE	PRXOVR	DEF					NA	NA	NA	N
73615	CONTRAST X-RAY OF ANKLE	MAXFEE	DEF					81.81	1/1/2000	12/31/2299	N
73615	CONTRAST X-RAY OF ANKLE	MAXFEE	DEF	TC				57.27	1/1/2000	12/31/2299	N
73615	CONTRAST X-RAY OF ANKLE	MAXFEE	DEF	26				24.54	1/1/2000	12/31/2299	N
73620	X-RAY EXAM OF FOOT	PRXOVR	DEF					NA	NA	NA	N
73620	X-RAY EXAM OF FOOT	MAXFEE	DEF					19.82	1/1/2010	12/31/2299	N
73620	X-RAY EXAM OF FOOT	MAXFEE	DEF	TC				12.88	1/1/2010	12/31/2299	N
73620	X-RAY EXAM OF FOOT	MAXFEE	DEF	26				6.94	1/1/2010	12/31/2299	N
73630	X-RAY EXAM OF FOOT	PRXOVR	DEF					NA	NA	NA	N
73630	X-RAY EXAM OF FOOT	MAXFEE	DEF					21.35	1/1/2010	12/31/2299	N
73630	X-RAY EXAM OF FOOT	MAXFEE	DEF	TC				13.88	1/1/2010	12/31/2299	N

73630	X-RAY EXAM OF FOOT	MAXFEE	DEF	26				7.47	1/1/2010	12/31/2299	N
73650	X-RAY EXAM OF HEEL	PRXOVR	DEF					NA	NA	NA	N
73650	X-RAY EXAM OF HEEL	MAXFEE	DEF					19.91	1/1/2000	12/31/2299	N
73650	X-RAY EXAM OF HEEL	MAXFEE	DEF	TC				12.94	1/1/2000	12/31/2299	N
73650	X-RAY EXAM OF HEEL	MAXFEE	DEF	26				6.97	1/1/2000	12/31/2299	N
73660	X-RAY EXAM OF TOE(S)	PRXOVR	DEF					NA	NA	NA	N
73660	X-RAY EXAM OF TOE(S)	MAXFEE	DEF					17.32	1/1/2000	12/31/2299	N
73660	X-RAY EXAM OF TOE(S)	MAXFEE	DEF	TC				11.26	1/1/2000	12/31/2299	N
73660	X-RAY EXAM OF TOE(S)	MAXFEE	DEF	26				6.06	1/1/2000	12/31/2299	N
73700	CT LOWER EXTREMITY W/O DYE	PRXOVR	DEF					NA	NA	NA	N
73700	CT LOWER EXTREMITY W/O DYE	MAXFEE	DEF					184.38	1/1/2000	12/31/2299	N
73700	CT LOWER EXTREMITY W/O DYE	MAXFEE	DEF	TC				138.29	1/1/2000	12/31/2299	N
73700	CT LOWER EXTREMITY W/O DYE	MAXFEE	DEF	26				46.10	1/1/2000	12/31/2299	N
73701	CT LOWER EXTREMITY W/DYE	PRXOVR	DEF					NA	NA	NA	N
73701	CT LOWER EXTREMITY W/DYE	MAXFEE	DEF					214.38	1/1/2000	12/31/2299	N
73701	CT LOWER EXTREMITY W/DYE	MAXFEE	DEF	TC				160.79	1/1/2000	12/31/2299	N
73701	CT LOWER EXTREMITY W/DYE	MAXFEE	DEF	26				53.60	1/1/2000	12/31/2299	N
73702	CT LWR EXTREMITY W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73702	CT LWR EXTREMITY W/O&W/DYE	MAXFEE	DEF					259.86	1/1/2000	12/31/2299	N
73702	CT LWR EXTREMITY W/O&W/DYE	MAXFEE	DEF	TC				207.89	1/1/2000	12/31/2299	N
73702	CT LWR EXTREMITY W/O&W/DYE	MAXFEE	DEF	26				51.97	1/1/2000	12/31/2299	N

73706	CT ANGIO LWR EXTR W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73706	CT ANGIO LWR EXTR W/O&W/DYE	MAXFEE	DEF					273.93	1/1/2001	12/31/2299	N
73706	CT ANGIO LWR EXTR W/O&W/DYE	MAXFEE	DEF	TC				219.14	1/1/2001	12/31/2299	N
73706	CT ANGIO LWR EXTR W/O&W/DYE	MAXFEE	DEF	26				54.79	1/1/2001	12/31/2299	N
73718	MRI LOWER EXTREMITY W/O DYE	PRXOVR	DEF					NA	NA	NA	N
73718	MRI LOWER EXTREMITY W/O DYE	MAXFEE	DEF					371.56	7/26/2007	12/31/2299	N
73718	MRI LOWER EXTREMITY W/O DYE	MAXFEE	DEF	TC				297.25	7/26/2007	12/31/2299	N
73718	MRI LOWER EXTREMITY W/O DYE	MAXFEE	DEF	26				74.31	7/26/2007	12/31/2299	N
73719	MRI LOWER EXTREMITY W/DYE	PRXOVR	DEF					NA	NA	NA	N
73719	MRI LOWER EXTREMITY W/DYE	MAXFEE	DEF					445.02	7/26/2007	12/31/2299	N
73719	MRI LOWER EXTREMITY W/DYE	MAXFEE	DEF	TC				356.02	7/26/2007	12/31/2299	N
73719	MRI LOWER EXTREMITY W/DYE	MAXFEE	DEF	26				89	7/26/2007	12/31/2299	N
73720	MRI LWR EXTREMITY W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73720	MRI LWR EXTREMITY W/O&W/DYE	MAXFEE	DEF					377.90	1/1/2000	12/31/2299	N
73720	MRI LWR EXTREMITY W/O&W/DYE	MAXFEE	DEF	TC				302.32	1/1/2000	12/31/2299	N
73720	MRI LWR EXTREMITY W/O&W/DYE	MAXFEE	DEF	26				75.58	1/1/2000	12/31/2299	N
73721	MRI JNT OF LWR EXTRE W/O DYE	PRXOVR	DEF					NA	NA	NA	N

73721	MRI JNT OF LWR EXTRE W/O DYE	MAXFEE	DEF					372.17	1/1/2000	12/31/2299	N
73721	MRI JNT OF LWR EXTRE W/O DYE	MAXFEE	DEF	TC				297.74	1/1/2000	12/31/2299	N
73721	MRI JNT OF LWR EXTRE W/O DYE	MAXFEE	DEF	26				74.43	1/1/2000	12/31/2299	N
73722	MRI JOINT OF LWR EXTR W/DYE	PRXOVR	DEF					NA	NA	NA	N
73722	MRI JOINT OF LWR EXTR W/DYE	MAXFEE	DEF					445.02	7/26/2007	12/31/2299	N
73722	MRI JOINT OF LWR EXTR W/DYE	MAXFEE	DEF	TC				356.02	7/26/2007	12/31/2299	N
73722	MRI JOINT OF LWR EXTR W/DYE	MAXFEE	DEF	26				89	7/26/2007	12/31/2299	N
73723	MRI JOINT LWR EXTR W/O&W/DYE	PRXOVR	DEF					NA	NA	NA	N
73723	MRI JOINT LWR EXTR W/O&W/DYE	MAXFEE	DEF					591.92	7/1/2008	12/31/2299	N
73723	MRI JOINT LWR EXTR W/O&W/DYE	MAXFEE	DEF	TC				473.54	7/1/2008	12/31/2299	N
73723	MRI JOINT LWR EXTR W/O&W/DYE	MAXFEE	DEF	26				118.38	7/1/2008	12/31/2299	N
73725	MR ANG LWR EXT W OR W/O DYE	PRXOVR	DEF					NA	NA	NA	N
73725	MR ANG LWR EXT W OR W/O DYE	MAXFEE	DEF					387.90	1/1/2000	12/31/2299	N
73725	MR ANG LWR EXT W OR W/O DYE	MAXFEE	DEF	TC				310.32	1/1/2000	12/31/2299	N
73725	MR ANG LWR EXT W OR W/O DYE	MAXFEE	DEF	26				77.58	1/1/2000	12/31/2299	N
74000	X-RAY EXAM OF ABDOMEN	PRXOVR	DEF					NA	NA	NA	N
74000	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF					21.42	1/1/2010	12/31/2299	N
74000	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF	TC				13.92	1/1/2010	12/31/2299	N
74000	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF	26				7.50	1/1/2010	12/31/2299	N

74010	X-RAY EXAM OF ABDOMEN	PRXOVR	DEF					NA	NA	NA	N
74010	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF					25.95	1/1/2000	12/31/2299	N
74010	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF	TC				15.57	1/1/2000	12/31/2299	N
74010	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF	26				10.38	1/1/2000	12/31/2299	N
74020	X-RAY EXAM OF ABDOMEN	PRXOVR	DEF					NA	NA	NA	N
74020	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF					27.95	1/1/2010	12/31/2299	N
74020	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF	TC				16.77	1/1/2010	12/31/2299	N
74020	X-RAY EXAM OF ABDOMEN	MAXFEE	DEF	26				11.18	1/1/2010	12/31/2299	N
74022	X-RAY EXAM SERIES ABDOMEN	PRXOVR	DEF					NA	NA	NA	N
74022	X-RAY EXAM SERIES ABDOMEN	MAXFEE	DEF					34.01	1/1/2000	12/31/2299	N
74022	X-RAY EXAM SERIES ABDOMEN	MAXFEE	DEF	TC				20.41	1/1/2000	12/31/2299	N
74022	X-RAY EXAM SERIES ABDOMEN	MAXFEE	DEF	26				13.60	1/1/2000	12/31/2299	N
74150	CT ABDOMEN W/O DYE	PRXOVR	DEF					NA	NA	NA	N
74150	CT ABDOMEN W/O DYE	MAXFEE	DEF					208.39	1/1/2000	12/31/2299	N
74150	CT ABDOMEN W/O DYE	MAXFEE	DEF	TC				156.29	1/1/2000	12/31/2299	N
74150	CT ABDOMEN W/O DYE	MAXFEE	DEF	26				52.10	1/1/2000	12/31/2299	N
74160	CT ABDOMEN W/DYE	PRXOVR	DEF					NA	NA	NA	N
74160	CT ABDOMEN W/DYE	MAXFEE	DEF					245.58	1/1/2000	12/31/2299	N
74160	CT ABDOMEN W/DYE	MAXFEE	DEF	TC				184.19	1/1/2000	12/31/2299	N
74160	CT ABDOMEN W/DYE	MAXFEE	DEF	26				61.40	1/1/2000	12/31/2299	N
74170	CT ABDOMEN W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
74170	CT ABDOMEN W/O & W/DYE	MAXFEE	DEF					297.26	1/1/2000	12/31/2299	N
74170	CT ABDOMEN W/O & W/DYE	MAXFEE	DEF	TC				237.81	1/1/2000	12/31/2299	N
74170	CT ABDOMEN W/O & W/DYE	MAXFEE	DEF	26				59.45	1/1/2000	12/31/2299	N
74175	CT ANGIO ABDOM W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
74175	CT ANGIO ABDOM W/O & W/DYE	MAXFEE	DEF					304.53	1/1/2001	12/31/2299	N

74175	CT ANGIO ABDOM W/O & W/DYE	MAXFEE	DEF	TC				243.62	1/1/2001	12/31/2299	N
74175	CT ANGIO ABDOM W/O & W/DYE	MAXFEE	DEF	26				60.91	1/1/2001	12/31/2299	N
74176	CT ABD & PELVIS	PRXOVR	DEF					NA	NA	NA	N
74176	CT ABD & PELVIS	MAXFEE	DEF					128.73	1/1/2011	12/31/2299	N
74176	CT ABD & PELVIS	MAXFEE	DEF	TC				77.24	1/1/2011	12/31/2299	N
74176	CT ABD & PELVIS	MAXFEE	DEF	26				51.49	1/1/2011	12/31/2299	N
74177	CT ABD & PELV W/CONTRAST	PRXOVR	DEF					NA	NA	NA	N
74177	CT ABD & PELV W/CONTRAST	MAXFEE	DEF					185.57	1/1/2011	12/31/2299	N
74177	CT ABD & PELV W/CONTRAST	MAXFEE	DEF	TC				139.18	1/1/2011	12/31/2299	N
74177	CT ABD & PELV W/CONTRAST	MAXFEE	DEF	26				46.39	1/1/2011	12/31/2299	N
74178	CT ABD & PELV 1/> REGNS	PRXOVR	DEF					NA	NA	NA	N
74178	CT ABD & PELV 1/> REGNS	MAXFEE	DEF					220.22	1/1/2011	12/31/2299	N
74178	CT ABD & PELV 1/> REGNS	MAXFEE	DEF	TC				176.18	1/1/2011	12/31/2299	N
74178	CT ABD & PELV 1/> REGNS	MAXFEE	DEF	26				44.04	1/1/2011	12/31/2299	N
74181	MRI ABDOMEN W/O DYE	PRXOVR	DEF					NA	NA	NA	N
74181	MRI ABDOMEN W/O DYE	MAXFEE	DEF					382.93	1/1/2000	12/31/2299	N
74181	MRI ABDOMEN W/O DYE	MAXFEE	DEF	TC				306.34	1/1/2000	12/31/2299	N
74181	MRI ABDOMEN W/O DYE	MAXFEE	DEF	26				76.59	1/1/2000	12/31/2299	N
74182	MRI ABDOMEN W/DYE	PRXOVR	DEF					NA	NA	NA	N
74182	MRI ABDOMEN W/DYE	MAXFEE	DEF					451.75	7/26/2007	12/31/2299	N
74182	MRI ABDOMEN W/DYE	MAXFEE	DEF	TC				361.40	7/26/2007	12/31/2299	N
74182	MRI ABDOMEN W/DYE	MAXFEE	DEF	26				90.35	7/26/2007	12/31/2299	N
74183	MRI ABDOMEN W/O & W/DYE	PRXOVR	DEF					NA	NA	NA	N
74183	MRI ABDOMEN W/O & W/DYE	MAXFEE	DEF					596.82	7/1/2008	12/31/2299	N
74183	MRI ABDOMEN W/O & W/DYE	MAXFEE	DEF	TC				477.46	7/1/2008	12/31/2299	N
74183	MRI ABDOMEN W/O & W/DYE	MAXFEE	DEF	26				119.36	7/1/2008	12/31/2299	N
74185	MRI ANGIO ABDOM W ORW/O DYE	PRXOVR	DEF					NA	NA	NA	N

74185	MRI ANGIO ABDOM W ORW/O DYE	MAXFEE	DEF					390.06	1/1/2000	12/31/2299	N
74185	MRI ANGIO ABDOM W ORW/O DYE	MAXFEE	DEF	TC				312.05	1/1/2000	12/31/2299	N
74185	MRI ANGIO ABDOM W ORW/O DYE	MAXFEE	DEF	26				78.01	1/1/2000	12/31/2299	N
74190	X-RAY EXAM OF PERITONEUM	PRXOVR	DEF					NA	NA	NA	N
74190	X-RAY EXAM OF PERITONEUM	MAXFEE	DEF					54.27	1/1/2000	12/31/2299	N
74190	X-RAY EXAM OF PERITONEUM	MAXFEE	DEF	TC				43.42	1/1/2000	12/31/2299	N
74190	X-RAY EXAM OF PERITONEUM	MAXFEE	DEF	26				10.85	1/1/2000	12/31/2299	N
74210	CONTRST X-RAY EXAM OF THROAT	PRXOVR	DEF					NA	NA	NA	N
74210	CONTRST X-RAY EXAM OF THROAT	MAXFEE	DEF					48	7/26/2007	12/31/2299	N
74210	CONTRST X-RAY EXAM OF THROAT	MAXFEE	DEF	TC				36	7/26/2007	12/31/2299	N
74210	CONTRST X-RAY EXAM OF THROAT	MAXFEE	DEF	26				12	7/26/2007	12/31/2299	N
74220	CONTRAST X-RAY ESOPHAGUS	PRXOVR	DEF					NA	NA	NA	N
74220	CONTRAST X-RAY ESOPHAGUS	MAXFEE	DEF					52.12	7/26/2007	12/31/2299	N
74220	CONTRAST X-RAY ESOPHAGUS	MAXFEE	DEF	TC				36.48	7/26/2007	12/31/2299	N
74220	CONTRAST X-RAY ESOPHAGUS	MAXFEE	DEF	26				15.64	7/26/2007	12/31/2299	N
74230	CINE/VID X-RAY THROAT/ESOPH	PRXOVR	DEF					NA	NA	NA	N
74230	CINE/VID X-RAY THROAT/ESOPH	MAXFEE	DEF					58.62	7/26/2007	12/31/2299	N
74230	CINE/VID X-RAY THROAT/ESOPH	MAXFEE	DEF	TC				41.03	7/26/2007	12/31/2299	N
74230	CINE/VID X-RAY THROAT/ESOPH	MAXFEE	DEF	26				17.59	7/26/2007	12/31/2299	N

74235	REMOVE ESOPHAGUS OBSTRUCTION	PRXOVR	DEF					NA	NA	NA	N
74235	REMOVE ESOPHAGUS OBSTRUCTION	MAXFEE	DEF					122.48	1/1/2000	12/31/2299	N
74235	REMOVE ESOPHAGUS OBSTRUCTION	MAXFEE	DEF	TC				73.49	1/1/2000	12/31/2299	N
74235	REMOVE ESOPHAGUS OBSTRUCTION	MAXFEE	DEF	26				48.99	1/1/2000	12/31/2299	N
74240	X-RAY UPPER GI DELAY W/O KUB	PRXOVR	DEF					NA	NA	NA	N
74240	X-RAY UPPER GI DELAY W/O KUB	MAXFEE	DEF					69.81	1/1/2000	12/31/2299	N
74240	X-RAY UPPER GI DELAY W/O KUB	MAXFEE	DEF	TC				41.89	1/1/2000	12/31/2299	N
74240	X-RAY UPPER GI DELAY W/O KUB	MAXFEE	DEF	26				27.92	1/1/2000	12/31/2299	N
74241	X-RAYUPPER GI DELAY W/KUB	PRXOVR	DEF					NA	NA	NA	N
74241	X-RAYUPPER GI DELAY W/KUB	MAXFEE	DEF					70.59	1/1/2000	12/31/2299	N
74241	X-RAYUPPER GI DELAY W/KUB	MAXFEE	DEF	TC				42.35	1/1/2000	12/31/2299	N
74241	X-RAYUPPER GI DELAY W/KUB	MAXFEE	DEF	26				28.24	1/1/2000	12/31/2299	N
74245	X-RAY UPPER GI&SMALL INTEST	PRXOVR	DEF					NA	NA	NA	N
74245	X-RAY UPPER GI&SMALL INTEST	MAXFEE	DEF					104.59	7/26/2007	12/31/2299	N
74245	X-RAY UPPER GI&SMALL INTEST	MAXFEE	DEF	TC				73.21	7/26/2007	12/31/2299	N
74245	X-RAY UPPER GI&SMALL INTEST	MAXFEE	DEF	26				31.38	7/26/2007	12/31/2299	N
74246	CONTRST X-RAY UPPR GI TRACT	PRXOVR	DEF					NA	NA	NA	N

74246	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF					75	7/26/2007	12/31/2299	N
74246	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF	TC				52.50	7/26/2007	12/31/2299	N
74246	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF	26				22.50	7/26/2007	12/31/2299	N
74247	CONTRST X-RAY UPPR GI TRACT	PRXOVR	DEF					NA	NA	NA	N
74247	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF					76.34	7/26/2007	12/31/2299	N
74247	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF	TC				53.44	7/26/2007	12/31/2299	N
74247	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF	26				22.90	7/26/2007	12/31/2299	N
74249	CONTRST X-RAY UPPR GI TRACT	PRXOVR	DEF					NA	NA	NA	N
74249	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF					110.04	1/1/2000	12/31/2299	N
74249	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF	TC				71.53	1/1/2000	12/31/2299	N
74249	CONTRST X-RAY UPPR GI TRACT	MAXFEE	DEF	26				38.51	1/1/2000	12/31/2299	N
74250	X-RAY EXAM OF SMALL BOWEL	PRXOVR	DEF					NA	NA	NA	N
74250	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF					55.76	7/26/2007	12/31/2299	N
74250	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF	TC				39.03	7/26/2007	12/31/2299	N
74250	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF	26				16.73	7/26/2007	12/31/2299	N
74251	X-RAY EXAM OF SMALL BOWEL	PRXOVR	DEF					NA	NA	NA	N
74251	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF					68.28	7/1/2008	12/31/2299	N

74251	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF	TC				54.62	7/1/2008	12/31/2299	N
74251	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF	26				13.66	7/1/2008	12/31/2299	N
74260	X-RAY EXAM OF SMALL BOWEL	PRXOVR	DEF					NA	NA	NA	N
74260	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF					65.92	7/1/2008	12/31/2299	N
74260	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF	TC				52.74	7/1/2008	12/31/2299	N
74260	X-RAY EXAM OF SMALL BOWEL	MAXFEE	DEF	26				13.18	7/1/2008	12/31/2299	N
74261	CT COLONOGRAPHY DX	PRXOVR	DEF					NA	NA	NA	N
74261	CT COLONOGRAPHY DX	MAXFEE	DEF					328.87	1/1/2010	12/31/2299	N
74261	CT COLONOGRAPHY DX	MAXFEE	DEF	TC				263.10	1/1/2010	12/31/2299	N
74261	CT COLONOGRAPHY DX	MAXFEE	DEF	26				65.77	1/1/2010	12/31/2299	N
74262	CT COLONOGRAPHY DX W/DYE	PRXOVR	DEF					NA	NA	NA	N
74262	CT COLONOGRAPHY DX W/DYE	MAXFEE	DEF					368.10	1/1/2010	12/31/2299	N
74262	CT COLONOGRAPHY DX W/DYE	MAXFEE	DEF	TC				294.48	1/1/2010	12/31/2299	N
74262	CT COLONOGRAPHY DX W/DYE	MAXFEE	DEF	26				73.62	1/1/2010	12/31/2299	N
74263	CT COLONOGRAPHY SCREENING	PRXOVR	DEF					NA	NA	NA	N
74263	CT COLONOGRAPHY SCREENING	MAXFEE	DEF					381.64	1/1/2010	12/31/2299	N
74263	CT COLONOGRAPHY SCREENING	MAXFEE	DEF	TC				305.31	1/1/2010	12/31/2299	N
74263	CT COLONOGRAPHY SCREENING	MAXFEE	DEF	26				76.33	1/1/2010	12/31/2299	N
74270	CONTRAST X-RAY EXAM OF COLON	PRXOVR	DEF					NA	NA	NA	N

74270	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF					76.93	7/26/2007	12/31/2299	N
74270	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF	TC				53.85	7/26/2007	12/31/2299	N
74270	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF	26				23.08	7/26/2007	12/31/2299	N
74280	CONTRAST X-RAY EXAM OF COLON	PRXOVR	DEF					NA	NA	NA	N
74280	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF					103.62	7/26/2007	12/31/2299	N
74280	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF	TC				72.53	7/26/2007	12/31/2299	N
74280	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF	26				31.09	7/26/2007	12/31/2299	N
74283	CONTRAST X-RAY EXAM OF COLON	PRXOVR	DEF					NA	NA	NA	N
74283	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF					154.56	7/26/2007	12/31/2299	N
74283	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF	TC				77.28	7/26/2007	12/31/2299	N
74283	CONTRAST X-RAY EXAM OF COLON	MAXFEE	DEF	26				77.28	7/26/2007	12/31/2299	N
74290	CONTRAST X-RAY GALLBLADDER	PRXOVR	DEF					NA	NA	NA	N
74290	CONTRAST X-RAY GALLBLADDER	MAXFEE	DEF					34.01	7/26/2007	12/31/2299	N
74290	CONTRAST X-RAY GALLBLADDER	MAXFEE	DEF	TC				23.81	7/26/2007	12/31/2299	N
74290	CONTRAST X-RAY GALLBLADDER	MAXFEE	DEF	26				10.20	7/26/2007	12/31/2299	N
74291	CONTRAST X-RAYS GALLBLADDER	PRXOVR	DEF					NA	NA	NA	N
74291	CONTRAST X-RAYS GALLBLADDER	MAXFEE	DEF					20.89	7/1/2008	12/31/2299	N

74291	CONTRAST X-RAYS GALLBLADDER	MAXFEE	DEF	TC				15.67	7/1/2008	12/31/2299	N
74291	CONTRAST X-RAYS GALLBLADDER	MAXFEE	DEF	26				5.22	7/1/2008	12/31/2299	N
74300	X-RAY BILE DUCTS/PANCREAS	PRXOVR	DEF					NA	NA	NA	N
74300	X-RAY BILE DUCTS/PANCREAS	MAXFEE	DEF					73.04	1/1/2000	12/31/2299	N
74300	X-RAY BILE DUCTS/PANCREAS	MAXFEE	DEF	TC				58.43	1/1/2000	12/31/2299	N
74300	X-RAY BILE DUCTS/PANCREAS	MAXFEE	DEF	26				14.61	1/1/2000	12/31/2299	N
74301	X-RAYS AT SURGERY ADD-ON	PRXOVR	DEF					NA	NA	NA	N
74301	X-RAYS AT SURGERY ADD-ON	MAXFEE	DEF					8.55	1/1/2000	12/31/2299	N
74301	X-RAYS AT SURGERY ADD-ON	MAXFEE	DEF	TC				5.13	1/1/2000	12/31/2299	N
74301	X-RAYS AT SURGERY ADD-ON	MAXFEE	DEF	26				3.42	1/1/2000	12/31/2299	N
74305	X-RAY BILE DUCTS/PANCREAS	PRXOVR	DEF					NA	NA	NA	N
74305	X-RAY BILE DUCTS/PANCREAS	MAXFEE	DEF					39.37	1/1/2000	12/31/2299	N
74305	X-RAY BILE DUCTS/PANCREAS	MAXFEE	DEF	TC				19.68	1/1/2000	12/31/2299	N
74305	X-RAY BILE DUCTS/PANCREAS	MAXFEE	DEF	26				19.68	1/1/2000	12/31/2299	N
74320	CONTRAST X-RAY OF BILE DUCTS	PRXOVR	DEF					NA	NA	NA	N
74320	CONTRAST X-RAY OF BILE DUCTS	MAXFEE	DEF					98.55	1/1/2010	12/31/2299	N
74320	CONTRAST X-RAY OF BILE DUCTS	MAXFEE	DEF	TC				78.84	1/1/2010	12/31/2299	N
74320	CONTRAST X-RAY OF BILE DUCTS	MAXFEE	DEF	26				19.71	1/1/2010	12/31/2299	N
74327	X-RAY BILE STONE REMOVAL	PRXOVR	DEF					NA	NA	NA	N
74327	X-RAY BILE STONE REMOVAL	MAXFEE	DEF					78.77	7/26/2007	12/31/2299	N

74327	X-RAY BILE STONE REMOVAL	MAXFEE	DEF	TC				55.14	7/26/2007	12/31/2299	N
74327	X-RAY BILE STONE REMOVAL	MAXFEE	DEF	26				23.63	7/26/2007	12/31/2299	N
74328	X-RAY BILE DUCT ENDOSCOPY	PRXOVR	DEF					NA	NA	NA	N
74328	X-RAY BILE DUCT ENDOSCOPY	MAXFEE	DEF					118.07	1/1/2000	12/31/2299	N
74328	X-RAY BILE DUCT ENDOSCOPY	MAXFEE	DEF	TC				88.55	1/1/2000	12/31/2299	N
74328	X-RAY BILE DUCT ENDOSCOPY	MAXFEE	DEF	26				29.52	1/1/2000	12/31/2299	N
74329	X-RAY FOR PANCREAS ENDOSCOPY	PRXOVR	DEF					NA	NA	NA	N
74329	X-RAY FOR PANCREAS ENDOSCOPY	MAXFEE	DEF					118.07	1/1/2000	12/31/2299	N
74329	X-RAY FOR PANCREAS ENDOSCOPY	MAXFEE	DEF	TC				88.55	1/1/2000	12/31/2299	N
74329	X-RAY FOR PANCREAS ENDOSCOPY	MAXFEE	DEF	26				29.52	1/1/2000	12/31/2299	N
74330	X-RAY BILE/PANC ENDOSCOPY	PRXOVR	DEF					NA	NA	NA	N
74330	X-RAY BILE/PANC ENDOSCOPY	MAXFEE	DEF					123.89	1/1/2000	12/31/2299	N
74330	X-RAY BILE/PANC ENDOSCOPY	MAXFEE	DEF	TC				92.92	1/1/2000	12/31/2299	N
74330	X-RAY BILE/PANC ENDOSCOPY	MAXFEE	DEF	26				30.97	1/1/2000	12/31/2299	N
74340	X-RAY GUIDE FOR GI TUBE	PRXOVR	DEF					NA	NA	NA	N
74340	X-RAY GUIDE FOR GI TUBE	MAXFEE	DEF					96.66	1/1/2000	12/31/2299	N
74340	X-RAY GUIDE FOR GI TUBE	MAXFEE	DEF	TC				72.50	1/1/2000	12/31/2299	N
74340	X-RAY GUIDE FOR GI TUBE	MAXFEE	DEF	26				24.17	1/1/2000	12/31/2299	N
74350	X-RAY GUIDE; STOMACH TUBE	PRXOVR	DEF					NA	NA	NA	N
74350	X-RAY GUIDE; STOMACH TUBE	MAXFEE	DEF					NA			N

74355	X-RAY GUIDE INTESTINAL TUBE	PRXOVR	DEF					NA	NA	NA	N
74355	X-RAY GUIDE INTESTINAL TUBE	MAXFEE	DEF					105.62	1/1/2000	12/31/2299	N
74355	X-RAY GUIDE INTESTINAL TUBE	MAXFEE	DEF	TC				73.93	1/1/2000	12/31/2299	N
74355	X-RAY GUIDE INTESTINAL TUBE	MAXFEE	DEF	26				31.69	1/1/2000	12/31/2299	N
74360	X-RAY GUIDE GI DILATION	PRXOVR	DEF					NA	NA	NA	N
74360	X-RAY GUIDE GI DILATION	MAXFEE	DEF					111.74	1/1/2000	12/31/2299	N
74360	X-RAY GUIDE GI DILATION	MAXFEE	DEF	TC				89.39	1/1/2000	12/31/2299	N
74360	X-RAY GUIDE GI DILATION	MAXFEE	DEF	26				22.35	1/1/2000	12/31/2299	N
74363	X-RAY BILE DUCT DILATION	PRXOVR	DEF					NA	NA	NA	N
74363	X-RAY BILE DUCT DILATION	MAXFEE	DEF					209.09	1/1/2000	12/31/2299	N
74363	X-RAY BILE DUCT DILATION	MAXFEE	DEF	TC				41.82	1/1/2000	12/31/2299	N
74363	X-RAY BILE DUCT DILATION	MAXFEE	DEF	26				167.27	1/1/2000	12/31/2299	N
74400	CONTRST X-RAY URINARY TRACT	PRXOVR	DEF					NA	NA	NA	N
74400	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF					67.70	7/26/2007	12/31/2299	N
74400	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	TC				50.78	7/26/2007	12/31/2299	N
74400	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	26				16.93	7/26/2007	12/31/2299	N
74410	CONTRST X-RAY URINARY TRACT	PRXOVR	DEF					NA	NA	NA	N
74410	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF					75.01	1/1/2000	12/31/2299	N
74410	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	TC				52.51	1/1/2000	12/31/2299	N
74410	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	26				22.50	1/1/2000	12/31/2299	N

74415	CONTRST X-RAY URINARY TRACT	PRXOVR	DEF					NA	NA	NA	N
74415	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF					79.81	7/26/2007	12/31/2299	N
74415	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	TC				63.85	7/26/2007	12/31/2299	N
74415	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	26				15.96	7/26/2007	12/31/2299	N
74420	CONTRST X-RAY URINARY TRACT	PRXOVR	DEF					NA	NA	NA	N
74420	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF					89.19	1/1/2000	12/31/2299	N
74420	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	TC				71.35	1/1/2000	12/31/2299	N
74420	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	26				17.84	1/1/2000	12/31/2299	N
74425	CONTRST X-RAY URINARY TRACT	PRXOVR	DEF					NA	NA	NA	N
74425	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF					51.36	1/1/2000	12/31/2299	N
74425	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	TC				35.95	1/1/2000	12/31/2299	N
74425	CONTRST X-RAY URINARY TRACT	MAXFEE	DEF	26				15.41	1/1/2000	12/31/2299	N
74430	CONTRAST X-RAY BLADDER	PRXOVR	DEF					NA	NA	NA	N
74430	CONTRAST X-RAY BLADDER	MAXFEE	DEF					42.92	7/26/2007	12/31/2299	N
74430	CONTRAST X-RAY BLADDER	MAXFEE	DEF	TC				32.19	7/26/2007	12/31/2299	N
74430	CONTRAST X-RAY BLADDER	MAXFEE	DEF	26				10.73	7/26/2007	12/31/2299	N
74440	X-RAY MALE GENITAL TRACT	PRXOVR	DEF					NA	NA	NA	N
74440	X-RAY MALE GENITAL TRACT	MAXFEE	DEF					47.31	7/26/2007	12/31/2299	N
74440	X-RAY MALE GENITAL TRACT	MAXFEE	DEF	TC				35.48	7/26/2007	12/31/2299	N
74440	X-RAY MALE GENITAL TRACT	MAXFEE	DEF	26				11.83	7/26/2007	12/31/2299	N
74445	X-RAY EXAM OF PENIS	PRXOVR	DEF					NA	NA	NA	N

74445	X-RAY EXAM OF PENIS	MAXFEE	DEF					78.02	1/1/2008	12/31/2299	N
74445	X-RAY EXAM OF PENIS	MAXFEE	DEF	TC				31.21	1/1/2008	12/31/2299	N
74445	X-RAY EXAM OF PENIS	MAXFEE	DEF	26				46.81	1/1/2008	12/31/2299	N
74450	X-RAY URETHRA/BLADDER	PRXOVR	DEF					NA	NA	NA	N
74450	X-RAY URETHRA/BLADDER	MAXFEE	DEF					54.94	1/1/2000	12/31/2299	N
74450	X-RAY URETHRA/BLADDER	MAXFEE	DEF	TC				41.21	1/1/2000	12/31/2299	N
74450	X-RAY URETHRA/BLADDER	MAXFEE	DEF	26				13.74	1/1/2000	12/31/2299	N
74455	X-RAY URETHRA/BLADDER	PRXOVR	DEF					NA	NA	NA	N
74455	X-RAY URETHRA/BLADDER	MAXFEE	DEF					58.31	1/1/2000	12/31/2299	N
74455	X-RAY URETHRA/BLADDER	MAXFEE	DEF	TC				43.73	1/1/2000	12/31/2299	N
74455	X-RAY URETHRA/BLADDER	MAXFEE	DEF	26				14.58	1/1/2000	12/31/2299	N
74470	X-RAY EXAM OF KIDNEY LESION	PRXOVR	DEF					NA	NA	NA	N
74470	X-RAY EXAM OF KIDNEY LESION	MAXFEE	DEF					57.46	1/1/2000	12/31/2299	N
74470	X-RAY EXAM OF KIDNEY LESION	MAXFEE	DEF	TC				34.48	1/1/2000	12/31/2299	N
74470	X-RAY EXAM OF KIDNEY LESION	MAXFEE	DEF	26				22.98	1/1/2000	12/31/2299	N
74475	X-RAY CONTROL CATH INSERT	PRXOVR	DEF					NA	NA	NA	N
74475	X-RAY CONTROL CATH INSERT	MAXFEE	DEF					107.17	1/1/2010	12/31/2299	N
74475	X-RAY CONTROL CATH INSERT	MAXFEE	DEF	TC				85.74	1/1/2010	12/31/2299	N
74475	X-RAY CONTROL CATH INSERT	MAXFEE	DEF	26				21.43	1/1/2010	12/31/2299	N
74480	X-RAY CONTROL CATH INSERT	PRXOVR	DEF					NA	NA	NA	N
74480	X-RAY CONTROL CATH INSERT	MAXFEE	DEF					107.47	1/1/2010	12/31/2299	N
74480	X-RAY CONTROL CATH INSERT	MAXFEE	DEF	TC				85.98	1/1/2010	12/31/2299	N

74480	X-RAY CONTROL CATH INSERT	MAXFEE	DEF	26				21.49	1/1/2010	12/31/2299	N
74485	X-RAY GUIDE GU DILATION	PRXOVR	DEF					NA	NA	NA	N
74485	X-RAY GUIDE GU DILATION	MAXFEE	DEF					101.96	1/1/2010	12/31/2299	N
74485	X-RAY GUIDE GU DILATION	MAXFEE	DEF	TC				81.57	1/1/2010	12/31/2299	N
74485	X-RAY GUIDE GU DILATION	MAXFEE	DEF	26				20.39	1/1/2010	12/31/2299	N
74710	X-RAY MEASUREMENT OF PELVIS	PRXOVR	DEF					NA	NA	NA	N
74710	X-RAY MEASUREMENT OF PELVIS	MAXFEE	DEF					38.82	1/1/2012	12/31/2299	N
74710	X-RAY MEASUREMENT OF PELVIS	MAXFEE	DEF	TC				25.23	1/1/2012	12/31/2299	N
74710	X-RAY MEASUREMENT OF PELVIS	MAXFEE	DEF	26				13.59	1/1/2012	12/31/2299	N
74740	X-RAY FEMALE GENITAL TRACT	PRXOVR	DEF					NA	NA	NA	N
74740	X-RAY FEMALE GENITAL TRACT	MAXFEE	DEF					52.17	1/1/2000	12/31/2299	N
74740	X-RAY FEMALE GENITAL TRACT	MAXFEE	DEF	TC				36.52	1/1/2000	12/31/2299	N
74740	X-RAY FEMALE GENITAL TRACT	MAXFEE	DEF	26				15.65	1/1/2000	12/31/2299	N
74742	X-RAY FALLOPIAN TUBE	PRXOVR	DEF					NA	NA	NA	N
74742	X-RAY FALLOPIAN TUBE	MAXFEE	DEF					113.60	1/1/2000	12/31/2299	N
74742	X-RAY FALLOPIAN TUBE	MAXFEE	DEF	TC				85.20	1/1/2000	12/31/2299	N
74742	X-RAY FALLOPIAN TUBE	MAXFEE	DEF	26				28.40	1/1/2000	12/31/2299	N
74775	X-RAY EXAM OF PERINEUM	PRXOVR	DEF					NA	NA	NA	N
74775	X-RAY EXAM OF PERINEUM	MAXFEE	DEF					66.74	1/1/2000	12/31/2299	N
74775	X-RAY EXAM OF PERINEUM	MAXFEE	DEF	TC				40.04	1/1/2000	12/31/2299	N
74775	X-RAY EXAM OF PERINEUM	MAXFEE	DEF	26				26.70	1/1/2000	12/31/2299	N
75552	HEART MRI FOR MORPH W/O DYE	PRXOVR	DEF					NA	NA	NA	N

75552	HEART MRI FOR MORPH W/O DYE	MAXFEE	DEF					NA			N
75553	HEART MRI FOR MORPH W/DYE	PRXOVR	DEF					NA	NA	NA	N
75553	HEART MRI FOR MORPH W/DYE	MAXFEE	DEF					NA			N
75554	CARDIAC MRI/FUNCTION	PRXOVR	DEF					NA	NA	NA	N
75554	CARDIAC MRI/FUNCTION	MAXFEE	DEF					NA			N
75555	CARDIAC MRI/LIMITED STUDY	PRXOVR	DEF					NA	NA	NA	N
75555	CARDIAC MRI/LIMITED STUDY	MAXFEE	DEF					NA			N
75557	CARDIAC MRI FOR MORPH	PRXOVR	DEF					NA	NA	NA	N
75557	CARDIAC MRI FOR MORPH	MAXFEE	DEF					370.10	1/1/2008	12/31/2299	N
75557	CARDIAC MRI FOR MORPH	MAXFEE	DEF	TC				296.08	1/1/2008	12/31/2299	N
75557	CARDIAC MRI FOR MORPH	MAXFEE	DEF	26				74.02	1/1/2008	12/31/2299	N
75559	CARDIAC MRI W/STRESS IMG	PRXOVR	DEF					NA	NA	NA	N
75559	CARDIAC MRI W/STRESS IMG	MAXFEE	DEF					536.21	1/1/2008	12/31/2299	N
75559	CARDIAC MRI W/STRESS IMG	MAXFEE	DEF	TC				428.97	1/1/2008	12/31/2299	N
75559	CARDIAC MRI W/STRESS IMG	MAXFEE	DEF	26				107.24	1/1/2008	12/31/2299	N
75561	CARDIAC MRI FOR MORPH W/DYE	PRXOVR	DEF					NA	NA	NA	N
75561	CARDIAC MRI FOR MORPH W/DYE	MAXFEE	DEF					498.17	1/1/2008	12/31/2299	N
75561	CARDIAC MRI FOR MORPH W/DYE	MAXFEE	DEF	TC				398.54	1/1/2008	12/31/2299	N
75561	CARDIAC MRI FOR MORPH W/DYE	MAXFEE	DEF	26				99.63	1/1/2008	12/31/2299	N
75563	CARD MRI W/STRESS IMG & DYE	PRXOVR	DEF					NA	NA	NA	N
75563	CARD MRI W/STRESS IMG & DYE	MAXFEE	DEF					615.72	1/1/2008	12/31/2299	N
75563	CARD MRI W/STRESS IMG & DYE	MAXFEE	DEF	TC				492.58	1/1/2008	12/31/2299	N

75563	CARD MRI W/STRESS IMG & DYE	MAXFEE	DEF	26				123.14	1/1/2008	12/31/2299	N
75565	CARD MRI VELOC FLOW MAPPING	PRXOVR	DEF					NA	NA	NA	N
75565	CARD MRI VELOC FLOW MAPPING	MAXFEE	DEF					49.56	1/1/2010	12/31/2299	N
75565	CARD MRI VELOC FLOW MAPPING	MAXFEE	DEF	TC				44.60	1/1/2010	12/31/2299	N
75565	CARD MRI VELOC FLOW MAPPING	MAXFEE	DEF	26				4.96	1/1/2010	12/31/2299	N
75571	CT HRT W/O DYE W/CA TEST	PRXOVR	DEF					NA	NA	NA	N
75571	CT HRT W/O DYE W/CA TEST	MAXFEE	DEF					65.29	1/1/2010	12/31/2299	N
75571	CT HRT W/O DYE W/CA TEST	MAXFEE	DEF	TC				48.97	1/1/2010	12/31/2299	N
75571	CT HRT W/O DYE W/CA TEST	MAXFEE	DEF	26				16.32	1/1/2010	12/31/2299	N
75572	CT HRT W/3D IMAGE	PRXOVR	DEF					NA	NA	NA	N
75572	CT HRT W/3D IMAGE	MAXFEE	DEF					76.18	1/1/2010	12/31/2299	N
75572	CT HRT W/3D IMAGE	MAXFEE	DEF	TC				30.47	1/1/2010	12/31/2299	N
75572	CT HRT W/3D IMAGE	MAXFEE	DEF	26				45.71	1/1/2010	12/31/2299	N
75573	CT HRT W/3D IMAGE CONGEN	PRXOVR	DEF					NA	NA	NA	N
75573	CT HRT W/3D IMAGE CONGEN	MAXFEE	DEF					102.52	1/1/2010	12/31/2299	N
75573	CT HRT W/3D IMAGE CONGEN	MAXFEE	DEF	TC				30.76	1/1/2010	12/31/2299	N
75573	CT HRT W/3D IMAGE CONGEN	MAXFEE	DEF	26				71.76	1/1/2010	12/31/2299	N
75574	CT ANGIO HRT W/3D IMAGE	PRXOVR	DEF					NA	NA	NA	N
75574	CT ANGIO HRT W/3D IMAGE	MAXFEE	DEF					314.47	1/1/2010	12/31/2299	N
75574	CT ANGIO HRT W/3D IMAGE	MAXFEE	DEF	TC				251.58	1/1/2010	12/31/2299	N
75574	CT ANGIO HRT W/3D IMAGE	MAXFEE	DEF	26				62.89	1/1/2010	12/31/2299	N
75600	CONTRAST EXAM THORACIC AORTA	PRXOVR	DEF					NA	NA	NA	N
75600	CONTRAST EXAM THORACIC AORTA	MAXFEE	DEF					261.45	1/1/2012	12/31/2299	N
75600	CONTRAST EXAM THORACIC AORTA	MAXFEE	DEF	TC				235.31	1/1/2012	12/31/2299	N

75600	CONTRAST EXAM THORACIC AORTA	MAXFEE	DEF	26				26.15	1/1/2012	12/31/2299	N
75605	CONTRAST EXAM THORACIC AORTA	PRXOVR	DEF					NA	NA	NA	N
75605	CONTRAST EXAM THORACIC AORTA	MAXFEE	DEF					209.49	1/1/2012	12/31/2299	N
75605	CONTRAST EXAM THORACIC AORTA	MAXFEE	DEF	TC				188.54	1/1/2012	12/31/2299	N
75605	CONTRAST EXAM THORACIC AORTA	MAXFEE	DEF	26				20.95	1/1/2012	12/31/2299	N
75625	CONTRAST EXAM ABDOMINL AORTA	PRXOVR	DEF					NA	NA	NA	N
75625	CONTRAST EXAM ABDOMINL AORTA	MAXFEE	DEF					210.09	1/1/2012	12/31/2299	N
75625	CONTRAST EXAM ABDOMINL AORTA	MAXFEE	DEF	TC				189.08	1/1/2012	12/31/2299	N
75625	CONTRAST EXAM ABDOMINL AORTA	MAXFEE	DEF	26				21.01	1/1/2012	12/31/2299	N
75630	X-RAY AORTA LEG ARTERIES	PRXOVR	DEF					NA	NA	NA	N
75630	X-RAY AORTA LEG ARTERIES	MAXFEE	DEF					245.23	1/1/2012	12/31/2299	N
75630	X-RAY AORTA LEG ARTERIES	MAXFEE	DEF	TC				196.18	1/1/2012	12/31/2299	N
75630	X-RAY AORTA LEG ARTERIES	MAXFEE	DEF	26				49.05	1/1/2012	12/31/2299	N
75635	CT ANGIO ABDOMINAL ARTERIES	PRXOVR	DEF					NA	NA	NA	N
75635	CT ANGIO ABDOMINAL ARTERIES	MAXFEE	DEF					333.30	1/1/2001	12/31/2299	N
75635	CT ANGIO ABDOMINAL ARTERIES	MAXFEE	DEF	TC				249.98	1/1/2001	12/31/2299	N
75635	CT ANGIO ABDOMINAL ARTERIES	MAXFEE	DEF	26				83.33	1/1/2001	12/31/2299	N
75650	ARTERY X-RAYS HEAD & NECK	PRXOVR	DEF					NA	NA	NA	N
75650	ARTERY X-RAYS HEAD & NECK	MAXFEE	DEF					NA			N

75656	ANGIGO CERVICOCEREBRAL 3/4 VESSEL SUP IN	PRXOVR	DEF					NA	NA	NA	N
75656	ANGIGO CERVICOCEREBRAL 3/4 VESSEL SUP IN	MAXFEE	DEF					76.61	4/13/1989	12/31/2299	N
75656	ANGIGO CERVICOCEREBRAL 3/4 VESSEL SUP IN	MAXFEE	DEF	TC				45.97	4/13/1989	12/31/2299	N
75656	ANGIGO CERVICOCEREBRAL 3/4 VESSEL SUP IN	MAXFEE	DEF	26				30.64	4/13/1989	12/31/2299	N
75658	ARTERY X-RAYS ARM	PRXOVR	DEF					NA	NA	NA	N
75658	ARTERY X-RAYS ARM	MAXFEE	DEF					233.31	1/1/2012	12/31/2299	N
75658	ARTERY X-RAYS ARM	MAXFEE	DEF	TC				186.65	1/1/2012	12/31/2299	N
75658	ARTERY X-RAYS ARM	MAXFEE	DEF	26				46.66	1/1/2012	12/31/2299	N
75660	ARTERY X-RAYS HEAD & NECK	PRXOVR	DEF					NA	NA	NA	N
75660	ARTERY X-RAYS HEAD & NECK	MAXFEE	DEF					NA			N
75662	ARTERY X-RAYS HEAD & NECK	PRXOVR	DEF					NA	NA	NA	N
75662	ARTERY X-RAYS HEAD & NECK	MAXFEE	DEF					NA			N
75665	ARTERY X-RAYS HEAD & NECK	PRXOVR	DEF					NA	NA	NA	N
75665	ARTERY X-RAYS HEAD & NECK	MAXFEE	DEF					NA			N
75671	ARTERY X-RAYS HEAD & NECK	PRXOVR	DEF					NA	NA	NA	N
75671	ARTERY X-RAYS HEAD & NECK	MAXFEE	DEF					NA			N
75676	ARTERY X-RAYS NECK	PRXOVR	DEF					NA	NA	NA	N
75676	ARTERY X-RAYS NECK	MAXFEE	DEF					NA			N
75680	ARTERY X-RAYS NECK	PRXOVR	DEF					NA	NA	NA	N
75680	ARTERY X-RAYS NECK	MAXFEE	DEF					NA			N
75685	ARTERY X-RAYS SPINE	PRXOVR	DEF					NA	NA	NA	N

75685	ARTERY X-RAYS SPINE	MAXFEE	DEF					NA			N
75705	ARTERY X-RAYS SPINE	PRXOVR	DEF					NA	NA	NA	N
75705	ARTERY X-RAYS SPINE	MAXFEE	DEF					277.79	1/1/2012	12/31/2299	N
75705	ARTERY X-RAYS SPINE	MAXFEE	DEF	TC				222.23	1/1/2012	12/31/2299	N
75705	ARTERY X-RAYS SPINE	MAXFEE	DEF	26				55.56	1/1/2012	12/31/2299	N
75710	ARTERY X-RAYS ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
75710	ARTERY X-RAYS ARM/LEG	MAXFEE	DEF					226.93	1/1/2012	12/31/2299	N
75710	ARTERY X-RAYS ARM/LEG	MAXFEE	DEF	TC				204.24	1/1/2012	12/31/2299	N
75710	ARTERY X-RAYS ARM/LEG	MAXFEE	DEF	26				22.69	1/1/2012	12/31/2299	N
75716	ARTERY X-RAYS ARMS/LEGS	PRXOVR	DEF					NA	NA	NA	N
75716	ARTERY X-RAYS ARMS/LEGS	MAXFEE	DEF					263.04	1/1/2012	12/31/2299	N
75716	ARTERY X-RAYS ARMS/LEGS	MAXFEE	DEF	TC				210.43	1/1/2012	12/31/2299	N
75716	ARTERY X-RAYS ARMS/LEGS	MAXFEE	DEF	26				52.61	1/1/2012	12/31/2299	N
75722	ARTERY X-RAYS KIDNEY	PRXOVR	DEF					NA	NA	NA	N
75722	ARTERY X-RAYS KIDNEY	MAXFEE	DEF					220.26	1/1/2012	12/31/2299	N
75722	ARTERY X-RAYS KIDNEY	MAXFEE	DEF	TC				198.23	1/1/2012	12/31/2299	N
75722	ARTERY X-RAYS KIDNEY	MAXFEE	DEF	26				22.03	1/1/2012	12/31/2299	N
75724	ARTERY X-RAYS KIDNEYS	PRXOVR	DEF					NA	NA	NA	N
75724	ARTERY X-RAYS KIDNEYS	MAXFEE	DEF					261.19	1/1/2012	12/31/2299	N
75724	ARTERY X-RAYS KIDNEYS	MAXFEE	DEF	TC				208.95	1/1/2012	12/31/2299	N
75724	ARTERY X-RAYS KIDNEYS	MAXFEE	DEF	26				52.24	1/1/2012	12/31/2299	N
75726	ARTERY X-RAYS ABDOMEN	PRXOVR	DEF					NA	NA	NA	N
75726	ARTERY X-RAYS ABDOMEN	MAXFEE	DEF					225.57	1/1/2012	12/31/2299	N
75726	ARTERY X-RAYS ABDOMEN	MAXFEE	DEF	TC				203.01	1/1/2012	12/31/2299	N
75726	ARTERY X-RAYS ABDOMEN	MAXFEE	DEF	26				22.56	1/1/2012	12/31/2299	N
75731	ARTERY X-RAYS ADRENAL GLAND	PRXOVR	DEF					NA	NA	NA	N
75731	ARTERY X-RAYS ADRENAL GLAND	MAXFEE	DEF					228.47	1/1/2012	12/31/2299	N
75731	ARTERY X-RAYS ADRENAL GLAND	MAXFEE	DEF	TC				205.62	1/1/2012	12/31/2299	N

75731	ARTERY X-RAYS ADRENAL GLAND	MAXFEE	DEF	26				22.85	1/1/2012	12/31/2299	N
75733	ARTERY X-RAYS ADRENALS	PRXOVR	DEF					NA	NA	NA	N
75733	ARTERY X-RAYS ADRENALS	MAXFEE	DEF					263.15	1/1/2012	12/31/2299	N
75733	ARTERY X-RAYS ADRENALS	MAXFEE	DEF	TC				210.52	1/1/2012	12/31/2299	N
75733	ARTERY X-RAYS ADRENALS	MAXFEE	DEF	26				52.63	1/1/2012	12/31/2299	N
75736	ARTERY X-RAYS PELVIS	PRXOVR	DEF					NA	NA	NA	N
75736	ARTERY X-RAYS PELVIS	MAXFEE	DEF					224.32	1/1/2012	12/31/2299	N
75736	ARTERY X-RAYS PELVIS	MAXFEE	DEF	TC				201.89	1/1/2012	12/31/2299	N
75736	ARTERY X-RAYS PELVIS	MAXFEE	DEF	26				22.43	1/1/2012	12/31/2299	N
75741	ARTERY X-RAYS LUNG	PRXOVR	DEF					NA	NA	NA	N
75741	ARTERY X-RAYS LUNG	MAXFEE	DEF					213.72	1/1/2012	12/31/2299	N
75741	ARTERY X-RAYS LUNG	MAXFEE	DEF	TC				170.98	1/1/2012	12/31/2299	N
75741	ARTERY X-RAYS LUNG	MAXFEE	DEF	26				42.74	1/1/2012	12/31/2299	N
75743	ARTERY X-RAYS LUNGS	PRXOVR	DEF					NA	NA	NA	N
75743	ARTERY X-RAYS LUNGS	MAXFEE	DEF					239.51	1/1/2012	12/31/2299	N
75743	ARTERY X-RAYS LUNGS	MAXFEE	DEF	TC				191.61	1/1/2012	12/31/2299	N
75743	ARTERY X-RAYS LUNGS	MAXFEE	DEF	26				47.90	1/1/2012	12/31/2299	N
75746	ARTERY X-RAYS LUNG	PRXOVR	DEF					NA	NA	NA	N
75746	ARTERY X-RAYS LUNG	MAXFEE	DEF					218.30	1/1/2012	12/31/2299	N
75746	ARTERY X-RAYS LUNG	MAXFEE	DEF	TC				196.47	1/1/2012	12/31/2299	N
75746	ARTERY X-RAYS LUNG	MAXFEE	DEF	26				21.83	1/1/2012	12/31/2299	N
75756	ARTERY X-RAYS CHEST	PRXOVR	DEF					NA	NA	NA	N
75756	ARTERY X-RAYS CHEST	MAXFEE	DEF					236.64	1/1/2012	12/31/2299	N
75756	ARTERY X-RAYS CHEST	MAXFEE	DEF	TC				212.98	1/1/2012	12/31/2299	N
75756	ARTERY X-RAYS CHEST	MAXFEE	DEF	26				23.66	1/1/2012	12/31/2299	N
75774	ARTERY X-RAY EACH VESSEL	PRXOVR	DEF					NA	NA	NA	N
75774	ARTERY X-RAY EACH VESSEL	MAXFEE	DEF					154.23	1/1/2012	12/31/2299	N
75774	ARTERY X-RAY EACH VESSEL	MAXFEE	DEF	TC				138.81	1/1/2012	12/31/2299	N
75774	ARTERY X-RAY EACH VESSEL	MAXFEE	DEF	26				15.42	1/1/2012	12/31/2299	N

75790	VISUALIZE A-V SHUNT	PRXOVR	DEF					NA	NA	NA	N
75790	VISUALIZE A-V SHUNT	MAXFEE	DEF					NA			N
75791	AV DIALYSIS SHUNT IMAGING	PRXOVR	DEF					NA	NA	NA	N
75791	AV DIALYSIS SHUNT IMAGING	MAXFEE	DEF					166.76	1/1/2010	12/31/2299	N
75791	AV DIALYSIS SHUNT IMAGING	MAXFEE	DEF	TC				116.73	1/1/2010	12/31/2299	N
75791	AV DIALYSIS SHUNT IMAGING	MAXFEE	DEF	26				50.03	1/1/2010	12/31/2299	N
75801	LYMPH VESSEL X-RAY ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
75801	LYMPH VESSEL X-RAY ARM/LEG	MAXFEE	DEF					186.80	1/1/2000	12/31/2299	N
75801	LYMPH VESSEL X-RAY ARM/LEG	MAXFEE	DEF	TC				149.44	1/1/2000	12/31/2299	N
75801	LYMPH VESSEL X-RAY ARM/LEG	MAXFEE	DEF	26				37.36	1/1/2000	12/31/2299	N
75803	LYMPH VESSEL X-RAY ARMS/LEGS	PRXOVR	DEF					NA	NA	NA	N
75803	LYMPH VESSEL X-RAY ARMS/LEGS	MAXFEE	DEF					200.75	1/1/2000	12/31/2299	N
75803	LYMPH VESSEL X-RAY ARMS/LEGS	MAXFEE	DEF	TC				150.56	1/1/2000	12/31/2299	N
75803	LYMPH VESSEL X-RAY ARMS/LEGS	MAXFEE	DEF	26				50.19	1/1/2000	12/31/2299	N
75805	LYMPH VESSEL X-RAY TRUNK	PRXOVR	DEF					NA	NA	NA	N
75805	LYMPH VESSEL X-RAY TRUNK	MAXFEE	DEF					206.15	1/1/2000	12/31/2299	N
75805	LYMPH VESSEL X-RAY TRUNK	MAXFEE	DEF	TC				164.92	1/1/2000	12/31/2299	N
75805	LYMPH VESSEL X-RAY TRUNK	MAXFEE	DEF	26				41.23	1/1/2000	12/31/2299	N
75807	LYMPH VESSEL X-RAY TRUNK	PRXOVR	DEF					NA	NA	NA	N
75807	LYMPH VESSEL X-RAY TRUNK	MAXFEE	DEF					220.17	1/1/2000	12/31/2299	N
75807	LYMPH VESSEL X-RAY TRUNK	MAXFEE	DEF	TC				165.13	1/1/2000	12/31/2299	N
75807	LYMPH VESSEL X-RAY TRUNK	MAXFEE	DEF	26				55.04	1/1/2000	12/31/2299	N
75809	NONVASCULAR SHUNT X-RAY	PRXOVR	DEF					NA	NA	NA	N
75809	NONVASCULAR SHUNT X-RAY	MAXFEE	DEF					40.81	7/26/2007	12/31/2299	N

75809	NONVASCULAR SHUNT X-RAY	MAXFEE	DEF	TC				26.53	7/26/2007	12/31/2299	N
75809	NONVASCULAR SHUNT X-RAY	MAXFEE	DEF	26				14.28	7/26/2007	12/31/2299	N
75810	VEIN X-RAY SPLEEN/LIVER	PRXOVR	DEF					NA	NA	NA	N
75810	VEIN X-RAY SPLEEN/LIVER	MAXFEE	DEF					403.56	1/1/2000	12/31/2299	N
75810	VEIN X-RAY SPLEEN/LIVER	MAXFEE	DEF	TC				322.85	1/1/2000	12/31/2299	N
75810	VEIN X-RAY SPLEEN/LIVER	MAXFEE	DEF	26				80.71	1/1/2000	12/31/2299	N
75820	VEIN X-RAY ARM/LEG	PRXOVR	DEF					NA	NA	NA	N
75820	VEIN X-RAY ARM/LEG	MAXFEE	DEF					55.60	7/26/2007	12/31/2299	N
75820	VEIN X-RAY ARM/LEG	MAXFEE	DEF	TC				33.36	7/26/2007	12/31/2299	N
75820	VEIN X-RAY ARM/LEG	MAXFEE	DEF	26				22.24	7/26/2007	12/31/2299	N
75822	VEIN X-RAY ARMS/LEGS	PRXOVR	DEF					NA	NA	NA	N
75822	VEIN X-RAY ARMS/LEGS	MAXFEE	DEF					84.59	7/26/2007	12/31/2299	N
75822	VEIN X-RAY ARMS/LEGS	MAXFEE	DEF	TC				50.75	7/26/2007	12/31/2299	N
75822	VEIN X-RAY ARMS/LEGS	MAXFEE	DEF	26				33.84	7/26/2007	12/31/2299	N
75825	VEIN X-RAY TRUNK	PRXOVR	DEF					NA	NA	NA	N
75825	VEIN X-RAY TRUNK	MAXFEE	DEF					201.10	1/1/2012	12/31/2299	N
75825	VEIN X-RAY TRUNK	MAXFEE	DEF	TC				180.99	1/1/2012	12/31/2299	N
75825	VEIN X-RAY TRUNK	MAXFEE	DEF	26				20.11	1/1/2012	12/31/2299	N
75827	VEIN X-RAY CHEST	PRXOVR	DEF					NA	NA	NA	N
75827	VEIN X-RAY CHEST	MAXFEE	DEF					203.29	1/1/2012	12/31/2299	N
75827	VEIN X-RAY CHEST	MAXFEE	DEF	TC				182.96	1/1/2012	12/31/2299	N
75827	VEIN X-RAY CHEST	MAXFEE	DEF	26				20.33	1/1/2012	12/31/2299	N
75831	VEIN X-RAY KIDNEY	PRXOVR	DEF					NA	NA	NA	N
75831	VEIN X-RAY KIDNEY	MAXFEE	DEF					211.37	1/1/2012	12/31/2299	N
75831	VEIN X-RAY KIDNEY	MAXFEE	DEF	TC				190.23	1/1/2012	12/31/2299	N
75831	VEIN X-RAY KIDNEY	MAXFEE	DEF	26				21.14	1/1/2012	12/31/2299	N
75833	VEIN X-RAY KIDNEYS	PRXOVR	DEF					NA	NA	NA	N
75833	VEIN X-RAY KIDNEYS	MAXFEE	DEF					235.83	1/1/2012	12/31/2299	N
75833	VEIN X-RAY KIDNEYS	MAXFEE	DEF	TC				188.66	1/1/2012	12/31/2299	N
75833	VEIN X-RAY KIDNEYS	MAXFEE	DEF	26				47.17	1/1/2012	12/31/2299	N

75840	VEIN X-RAY ADRENAL GLAND	PRXOVR	DEF					NA	NA	NA	N
75840	VEIN X-RAY ADRENAL GLAND	MAXFEE	DEF					207.45	1/1/2012	12/31/2299	N
75840	VEIN X-RAY ADRENAL GLAND	MAXFEE	DEF	TC				186.70	1/1/2012	12/31/2299	N
75840	VEIN X-RAY ADRENAL GLAND	MAXFEE	DEF	26				20.75	1/1/2012	12/31/2299	N
75842	VEIN X-RAY ADRENAL GLANDS	PRXOVR	DEF					NA	NA	NA	N
75842	VEIN X-RAY ADRENAL GLANDS	MAXFEE	DEF					236.48	1/1/2012	12/31/2299	N
75842	VEIN X-RAY ADRENAL GLANDS	MAXFEE	DEF	TC				189.18	1/1/2012	12/31/2299	N
75842	VEIN X-RAY ADRENAL GLANDS	MAXFEE	DEF	26				47.30	1/1/2012	12/31/2299	N
75860	VEIN X-RAY NECK	PRXOVR	DEF					NA	NA	NA	N
75860	VEIN X-RAY NECK	MAXFEE	DEF					207.62	1/1/2012	12/31/2299	N
75860	VEIN X-RAY NECK	MAXFEE	DEF	TC				186.86	1/1/2012	12/31/2299	N
75860	VEIN X-RAY NECK	MAXFEE	DEF	26				20.76	1/1/2012	12/31/2299	N
75870	VEIN X-RAY SKULL	PRXOVR	DEF					NA	NA	NA	N
75870	VEIN X-RAY SKULL	MAXFEE	DEF					204.92	1/1/2012	12/31/2299	N
75870	VEIN X-RAY SKULL	MAXFEE	DEF	TC				184.43	1/1/2012	12/31/2299	N
75870	VEIN X-RAY SKULL	MAXFEE	DEF	26				20.49	1/1/2012	12/31/2299	N
75872	VEIN X-RAY SKULL EPIDURAL	PRXOVR	DEF					NA	NA	NA	N
75872	VEIN X-RAY SKULL EPIDURAL	MAXFEE	DEF					275.74	1/1/2012	12/31/2299	N
75872	VEIN X-RAY SKULL EPIDURAL	MAXFEE	DEF	TC				248.17	1/1/2012	12/31/2299	N
75872	VEIN X-RAY SKULL EPIDURAL	MAXFEE	DEF	26				27.57	1/1/2012	12/31/2299	N
75880	VEIN X-RAY EYE SOCKET	PRXOVR	DEF					NA	NA	NA	N
75880	VEIN X-RAY EYE SOCKET	MAXFEE	DEF					55.60	7/26/2007	12/31/2299	N
75880	VEIN X-RAY EYE SOCKET	MAXFEE	DEF	TC				33.36	7/26/2007	12/31/2299	N
75880	VEIN X-RAY EYE SOCKET	MAXFEE	DEF	26				22.24	7/26/2007	12/31/2299	N
75885	VEIN X-RAY LIVER W/HEMODYNAM	PRXOVR	DEF					NA	NA	NA	N
75885	VEIN X-RAY LIVER W/HEMODYNAM	MAXFEE	DEF					219.45	1/1/2012	12/31/2299	N

75885	VEIN X-RAY LIVER W/HEMODYNAM	MAXFEE	DEF	TC				175.56	1/1/2012	12/31/2299	N
75885	VEIN X-RAY LIVER W/HEMODYNAM	MAXFEE	DEF	26				43.89	1/1/2012	12/31/2299	N
75887	VEIN X-RAY LIVER W/O HEMODYN	PRXOVR	DEF					NA	NA	NA	N
75887	VEIN X-RAY LIVER W/O HEMODYN	MAXFEE	DEF					220.80	1/1/2012	12/31/2299	N
75887	VEIN X-RAY LIVER W/O HEMODYN	MAXFEE	DEF	TC				176.64	1/1/2012	12/31/2299	N
75887	VEIN X-RAY LIVER W/O HEMODYN	MAXFEE	DEF	26				44.16	1/1/2012	12/31/2299	N
75889	VEIN X-RAY LIVER W/HEMODYNAM	PRXOVR	DEF					NA	NA	NA	N
75889	VEIN X-RAY LIVER W/HEMODYNAM	MAXFEE	DEF					204.59	1/1/2012	12/31/2299	N
75889	VEIN X-RAY LIVER W/HEMODYNAM	MAXFEE	DEF	TC				184.13	1/1/2012	12/31/2299	N
75889	VEIN X-RAY LIVER W/HEMODYNAM	MAXFEE	DEF	26				20.46	1/1/2012	12/31/2299	N
75891	VEIN X-RAY LIVER	PRXOVR	DEF					NA	NA	NA	N
75891	VEIN X-RAY LIVER	MAXFEE	DEF					204.92	1/1/2012	12/31/2299	N
75891	VEIN X-RAY LIVER	MAXFEE	DEF	TC				184.43	1/1/2012	12/31/2299	N
75891	VEIN X-RAY LIVER	MAXFEE	DEF	26				20.49	1/1/2012	12/31/2299	N
75893	VENOUS SAMPLING BY CATHETER	PRXOVR	DEF					NA	NA	NA	N
75893	VENOUS SAMPLING BY CATHETER	MAXFEE	DEF					172.56	1/1/2012	12/31/2299	N
75893	VENOUS SAMPLING BY CATHETER	MAXFEE	DEF	TC				155.30	1/1/2012	12/31/2299	N
75893	VENOUS SAMPLING BY CATHETER	MAXFEE	DEF	26				17.26	1/1/2012	12/31/2299	N
75894	X-RAYS TRANSCATH THERAPY	PRXOVR	DEF					NA	NA	NA	N

75894	X-RAYS TRANSCATH THERAPY	MAXFEE	DEF					738.32	1/1/2000	12/31/2299	N
75894	X-RAYS TRANSCATH THERAPY	MAXFEE	DEF	TC				590.66	1/1/2000	12/31/2299	N
75894	X-RAYS TRANSCATH THERAPY	MAXFEE	DEF	26				147.66	1/1/2000	12/31/2299	N
75896	X-RAYS TRANSCATH THERAPY	PRXOVR	DEF					NA	NA	NA	N
75896	X-RAYS TRANSCATH THERAPY	MAXFEE	DEF					649.25	1/1/2000	12/31/2299	N
75896	X-RAYS TRANSCATH THERAPY	MAXFEE	DEF	TC				519.40	1/1/2000	12/31/2299	N
75896	X-RAYS TRANSCATH THERAPY	MAXFEE	DEF	26				129.85	1/1/2000	12/31/2299	N
75898	FOLLOW-UP ANGIOGRAPHY	PRXOVR	DEF					NA	NA	NA	N
75898	FOLLOW-UP ANGIOGRAPHY	MAXFEE	DEF					96.72	1/1/2000	12/31/2299	N
75898	FOLLOW-UP ANGIOGRAPHY	MAXFEE	DEF	TC				29.02	1/1/2000	12/31/2299	N
75898	FOLLOW-UP ANGIOGRAPHY	MAXFEE	DEF	26				67.70	1/1/2000	12/31/2299	N
75900	INTRAVASCULAR CATH EXCHANGE	PRXOVR	DEF					NA	NA	NA	N
75900	INTRAVASCULAR CATH EXCHANGE	MAXFEE	DEF					NA			N
75901	REMOVE CVA DEVICE OBSTRUCT	PRXOVR	DEF					NA	NA	NA	N
75901	REMOVE CVA DEVICE OBSTRUCT	MAXFEE	DEF					70.57	7/1/2003	12/31/2299	N
75901	REMOVE CVA DEVICE OBSTRUCT	MAXFEE	DEF	TC				52.93	7/1/2003	12/31/2299	N
75901	REMOVE CVA DEVICE OBSTRUCT	MAXFEE	DEF	26				17.64	7/1/2003	12/31/2299	N
75902	REMOVE CVA LUMEN OBSTRUCT	PRXOVR	DEF					NA	NA	NA	N
75902	REMOVE CVA LUMEN OBSTRUCT	MAXFEE	DEF					66.69	7/1/2003	12/31/2299	N

75902	REMOVE CVA LUMEN OBSTRUCT	MAXFEE	DEF	TC				53.35	7/1/2003	12/31/2299	N
75902	REMOVE CVA LUMEN OBSTRUCT	MAXFEE	DEF	26				13.34	7/1/2003	12/31/2299	N
75940	X-RAY PLACEMENT VEIN FILTER	PRXOVR	DEF					NA	NA	NA	N
75940	X-RAY PLACEMENT VEIN FILTER	MAXFEE	DEF					NA			N
75942	LLIAC ANEURYSM ENDOVAS RPR	PRXOVR	DEF					NA	NA	NA	N
75942	LLIAC ANEURYSM ENDOVAS RPR	MAXFEE	DEF					339	7/1/2003	12/31/2299	N
75942	LLIAC ANEURYSM ENDOVAS RPR	MAXFEE	DEF	TC				271.20	7/1/2003	12/31/2299	N
75942	LLIAC ANEURYSM ENDOVAS RPR	MAXFEE	DEF	26				67.80	7/1/2003	12/31/2299	N
75945	INTRAVASCULAR US	PRXOVR	DEF					NA	NA	NA	N
75945	INTRAVASCULAR US	MAXFEE	DEF					146.99	1/1/2000	12/31/2299	N
75945	INTRAVASCULAR US	MAXFEE	DEF	TC				88.19	1/1/2000	12/31/2299	N
75945	INTRAVASCULAR US	MAXFEE	DEF	26				58.80	1/1/2000	12/31/2299	N
75946	INTRAVASCULAR US ADD-ON	PRXOVR	DEF					NA	NA	NA	N
75946	INTRAVASCULAR US ADD-ON	MAXFEE	DEF					82.46	1/1/2000	12/31/2299	N
75946	INTRAVASCULAR US ADD-ON	MAXFEE	DEF	TC				41.23	1/1/2000	12/31/2299	N
75946	INTRAVASCULAR US ADD-ON	MAXFEE	DEF	26				41.23	1/1/2000	12/31/2299	N
75952	ENDOVASC REPAIR ABDOM AORTA	PRXOVR	DEF					NA	NA	NA	N
75952	ENDOVASC REPAIR ABDOM AORTA	MAXFEE	DEF					188.23	1/1/2001	12/31/2299	N
75952	ENDOVASC REPAIR ABDOM AORTA	MAXFEE	DEF	26				188.23	1/1/2001	12/31/2299	N
75953	ABDOM ANEURYSM ENDOVAS RPR	PRXOVR	DEF					NA	NA	NA	N

75953	ABDOM ANEURYSM ENDOVAS RPR	MAXFEE	DEF					77.74	1/1/2001	12/31/2299	N
75953	ABDOM ANEURYSM ENDOVAS RPR	MAXFEE	DEF	26				77.74	1/1/2001	12/31/2299	N
75954	ILIAC ANEURYSM ENDOVAS RPR	PRXOVR	DEF					NA	NA	NA	N
75954	ILIAC ANEURYSM ENDOVAS RPR	MAXFEE	DEF					339	1/1/2007	12/31/2299	N
75954	ILIAC ANEURYSM ENDOVAS RPR	MAXFEE	DEF	TC				271.20	1/1/2007	12/31/2299	N
75954	ILIAC ANEURYSM ENDOVAS RPR	MAXFEE	DEF	26				67.80	1/1/2007	12/31/2299	N
75956	XRAY ENDOVASC THOR AO REPR	PRXOVR	DEF					NA	NA	NA	N
75956	XRAY ENDOVASC THOR AO REPR	MANUAL	DEF					NA	NA	NA	N
75957	XRAY ENDOVASC THOR AO REPR	PRXOVR	DEF					NA	NA	NA	N
75957	XRAY ENDOVASC THOR AO REPR	MANUAL	DEF					NA	NA	NA	N
75958	XRAY PLACE PROX EXT THOR AO	PRXOVR	DEF					NA	NA	NA	N
75958	XRAY PLACE PROX EXT THOR AO	MANUAL	DEF					NA	NA	NA	N
75959	XRAY PLACE DIST EXT THOR AO	PRXOVR	DEF					NA	NA	NA	N
75959	XRAY PLACE DIST EXT THOR AO	MANUAL	DEF					NA	NA	NA	N
75960	TRANSCATH IV STENT RS&I	PRXOVR	DEF					NA	NA	NA	N
75960	TRANSCATH IV STENT RS&I	MAXFEE	DEF					188.32	1/1/2012	12/31/2299	N
75960	TRANSCATH IV STENT RS&I	MAXFEE	DEF	TC				150.66	1/1/2012	12/31/2299	N
75960	TRANSCATH IV STENT RS&I	MAXFEE	DEF	26				37.66	1/1/2012	12/31/2299	N
75961	RETRIEVAL BROKEN CATHETER	PRXOVR	DEF					NA	NA	NA	N

75961	RETRIEVAL BROKEN CATHETER	MAXFEE	DEF					NA			N
75962	REPAIR ARTERIAL BLOCKAGE	PRXOVR	DEF					NA	NA	NA	N
75962	REPAIR ARTERIAL BLOCKAGE	MAXFEE	DEF					205.71	1/1/2012	12/31/2299	N
75962	REPAIR ARTERIAL BLOCKAGE	MAXFEE	DEF	TC				185.14	1/1/2012	12/31/2299	N
75962	REPAIR ARTERIAL BLOCKAGE	MAXFEE	DEF	26				20.57	1/1/2012	12/31/2299	N
75964	REPAIR ARTERY BLOCKAGE EACH	PRXOVR	DEF					NA	NA	NA	N
75964	REPAIR ARTERY BLOCKAGE EACH	MAXFEE	DEF					128.54	1/1/2012	12/31/2299	N
75964	REPAIR ARTERY BLOCKAGE EACH	MAXFEE	DEF	TC				115.69	1/1/2012	12/31/2299	N
75964	REPAIR ARTERY BLOCKAGE EACH	MAXFEE	DEF	26				12.85	1/1/2012	12/31/2299	N
75966	REPAIR ARTERIAL BLOCKAGE	PRXOVR	DEF					NA	NA	NA	N
75966	REPAIR ARTERIAL BLOCKAGE	MAXFEE	DEF					248.55	1/1/2012	12/31/2299	N
75966	REPAIR ARTERIAL BLOCKAGE	MAXFEE	DEF	TC				198.84	1/1/2012	12/31/2299	N
75966	REPAIR ARTERIAL BLOCKAGE	MAXFEE	DEF	26				49.71	1/1/2012	12/31/2299	N
75968	REPAIR ARTERY BLOCKAGE EACH	PRXOVR	DEF					NA	NA	NA	N
75968	REPAIR ARTERY BLOCKAGE EACH	MAXFEE	DEF					125.66	1/1/2012	12/31/2299	N
75968	REPAIR ARTERY BLOCKAGE EACH	MAXFEE	DEF	TC				113.09	1/1/2012	12/31/2299	N
75968	REPAIR ARTERY BLOCKAGE EACH	MAXFEE	DEF	26				12.57	1/1/2012	12/31/2299	N
75970	VASCULAR BIOPSY	PRXOVR	DEF					NA	NA	NA	N
75970	VASCULAR BIOPSY	MAXFEE	DEF					361.87	1/1/2000	12/31/2299	N
75970	VASCULAR BIOPSY	MAXFEE	DEF	TC				289.50	1/1/2000	12/31/2299	N
75970	VASCULAR BIOPSY	MAXFEE	DEF	26				72.37	1/1/2000	12/31/2299	N
75978	REPAIR VENOUS BLOCKAGE	PRXOVR	DEF					NA	NA	NA	N
75978	REPAIR VENOUS BLOCKAGE	MAXFEE	DEF					206.03	1/1/2012	12/31/2299	N

75978	REPAIR VENOUS BLOCKAGE	MAXFEE	DEF	TC				185.43	1/1/2012	12/31/2299	N
75978	REPAIR VENOUS BLOCKAGE	MAXFEE	DEF	26				20.60	1/1/2012	12/31/2299	N
75980	CONTRAST XRAY EXAM BILE DUCT	PRXOVR	DEF					NA	NA	NA	N
75980	CONTRAST XRAY EXAM BILE DUCT	MAXFEE	DEF					211.97	1/1/2000	12/31/2299	N
75980	CONTRAST XRAY EXAM BILE DUCT	MAXFEE	DEF	TC				148.38	1/1/2000	12/31/2299	N
75980	CONTRAST XRAY EXAM BILE DUCT	MAXFEE	DEF	26				63.59	1/1/2000	12/31/2299	N
75982	CONTRAST XRAY EXAM BILE DUCT	PRXOVR	DEF					NA	NA	NA	N
75982	CONTRAST XRAY EXAM BILE DUCT	MAXFEE	DEF					231.39	1/1/2000	12/31/2299	N
75982	CONTRAST XRAY EXAM BILE DUCT	MAXFEE	DEF	TC				161.97	1/1/2000	12/31/2299	N
75982	CONTRAST XRAY EXAM BILE DUCT	MAXFEE	DEF	26				69.42	1/1/2000	12/31/2299	N
75984	XRAY CONTROL CATHETER CHANGE	PRXOVR	DEF					NA	NA	NA	N
75984	XRAY CONTROL CATHETER CHANGE	MAXFEE	DEF					84.74	1/1/2000	12/31/2299	N
75984	XRAY CONTROL CATHETER CHANGE	MAXFEE	DEF	TC				50.84	1/1/2000	12/31/2299	N
75984	XRAY CONTROL CATHETER CHANGE	MAXFEE	DEF	26				33.90	1/1/2000	12/31/2299	N
75989	ABSCESS DRAINAGE UNDER X-RAY	PRXOVR	DEF					NA	NA	NA	N
75989	ABSCESS DRAINAGE UNDER X-RAY	MAXFEE	DEF					125.36	1/1/2010	12/31/2299	N
75989	ABSCESS DRAINAGE UNDER X-RAY	MAXFEE	DEF	TC				75.22	1/1/2010	12/31/2299	N
75989	ABSCESS DRAINAGE UNDER X-RAY	MAXFEE	DEF	26				50.14	1/1/2010	12/31/2299	N

75992	ATHERECTOMY; X-RAY EXAM	PRXOVR	DEF					NA	NA	NA	N
75992	ATHERECTOMY; X-RAY EXAM	MAXFEE	DEF					NA			N
75993	ATHERECTOMY; X-RAY EXAM	PRXOVR	DEF					NA	NA	NA	N
75993	ATHERECTOMY; X-RAY EXAM	MAXFEE	DEF					NA			N
75994	ATHERECTOMY; X-RAY EXAM	PRXOVR	DEF					NA	NA	NA	N
75994	ATHERECTOMY; X-RAY EXAM	MAXFEE	DEF					NA			N
75995	ATHERECTOMY; X-RAY EXAM	PRXOVR	DEF					NA	NA	NA	N
75995	ATHERECTOMY; X-RAY EXAM	MAXFEE	DEF					NA			N
75996	ATHERECTOMY; X-RAY EXAM	PRXOVR	DEF					NA	NA	NA	N
75996	ATHERECTOMY; X-RAY EXAM	MAXFEE	DEF					NA			N
75998	FLUOROGUIDE FOR VEIN DEVICE	PRXOVR	DEF					NA	NA	NA	N
75998	FLUOROGUIDE FOR VEIN DEVICE	MAXFEE	DEF					NA			N
76000	FLUOROSCOPE EXAMINATION	PRXOVR	DEF					NA	NA	NA	N
76000	FLUOROSCOPE EXAMINATION	MAXFEE	DEF					43.75	7/26/2007	12/31/2299	N
76000	FLUOROSCOPE EXAMINATION	MAXFEE	DEF	TC				39.38	7/26/2007	12/31/2299	N
76000	FLUOROSCOPE EXAMINATION	MAXFEE	DEF	26				4.38	7/26/2007	12/31/2299	N
76001	FLUOROSCOPE EXAM EXTENSIVE	PRXOVR	DEF					NA	NA	NA	N
76001	FLUOROSCOPE EXAM EXTENSIVE	MAXFEE	DEF					102.23	1/1/2000	12/31/2299	N
76001	FLUOROSCOPE EXAM EXTENSIVE	MAXFEE	DEF	TC				71.56	1/1/2000	12/31/2299	N
76001	FLUOROSCOPE EXAM EXTENSIVE	MAXFEE	DEF	26				30.67	1/1/2000	12/31/2299	N
76003	NEEDLE LOCALIZATION BY X-RAY	PRXOVR	DEF					NA	NA	NA	N
76003	NEEDLE LOCALIZATION BY X-RAY	MAXFEE	DEF					NA			N
76005	FLUOROGUIDE FOR SPINE INJECT	PRXOVR	DEF					NA	NA	NA	N

76005	FLUOROGUIDE FOR SPINE INJECT	MAXFEE	DEF					NA			N
76006	X-RAY STRESS VIEW	PRXOVR	DEF					NA	NA	NA	N
76006	X-RAY STRESS VIEW	MAXFEE	DEF					NA			N
76010	X-RAY NOSE TO RECTUM	PRXOVR	DEF					NA	NA	NA	N
76010	X-RAY NOSE TO RECTUM	MAXFEE	DEF					22.09	1/1/2000	12/31/2299	N
76010	X-RAY NOSE TO RECTUM	MAXFEE	DEF	TC				14.36	1/1/2000	12/31/2299	N
76010	X-RAY NOSE TO RECTUM	MAXFEE	DEF	26				7.73	1/1/2000	12/31/2299	N
76012	PERCUT VERTEBROPLASTY FLUOR	PRXOVR	DEF					NA	NA	NA	N
76012	PERCUT VERTEBROPLASTY FLUOR	MAXFEE	DEF					NA			N
76013	PERCUT VERTEBROPLASTY; CT	PRXOVR	DEF					NA	NA	NA	N
76013	PERCUT VERTEBROPLASTY; CT	MAXFEE	DEF					NA			N
76020	X-RAYS FOR BONE AGE	PRXOVR	DEF					NA	NA	NA	N
76020	X-RAYS FOR BONE AGE	MAXFEE	DEF					NA			N
76040	X-RAYS; BONE EVALUATION	PRXOVR	DEF					NA	NA	NA	N
76040	X-RAYS; BONE EVALUATION	MAXFEE	DEF					NA			N
76061	X-RAYS; BONE SURVEY	PRXOVR	DEF					NA	NA	NA	N
76061	X-RAYS; BONE SURVEY	MAXFEE	DEF					NA			N
76062	X-RAYS; BONE SURVEY	PRXOVR	DEF					NA	NA	NA	N
76062	X-RAYS; BONE SURVEY	MAXFEE	DEF					NA			N
76065	X-RAYS; BONE EVALUATION	PRXOVR	DEF					NA	NA	NA	N
76065	X-RAYS; BONE EVALUATION	MAXFEE	DEF					NA			N
76066	JOINT SURVEY; SINGLE VIEW	PRXOVR	DEF					NA	NA	NA	N
76066	JOINT SURVEY; SINGLE VIEW	MAXFEE	DEF					NA			N
76070	CT BONE DENSITY; AXIAL	PRXOVR	DEF					NA	NA	NA	N
76070	CT BONE DENSITY; AXIAL	MAXFEE	DEF					NA			N
76075	DXA BONE DENSITY; AXIAL	PRXOVR	DEF					NA	NA	NA	N

76075	DXA BONE DENSITY; AXIAL	MAXFEE	DEF					NA			N
76076	DXA BONE DENSITY/PERIPHERAL	PRXOVR	DEF					NA	NA	NA	N
76076	DXA BONE DENSITY/PERIPHERAL	MAXFEE	DEF					NA			N
76077	DXA BONE DENSITY/V-FRACTURE	PRXOVR	DEF					NA	NA	NA	N
76077	DXA BONE DENSITY/V-FRACTURE	MAXFEE	DEF					NA			N
76078	RADIOGRAPHIC ABSORPTIOMETRY	PRXOVR	DEF					NA	NA	NA	N
76078	RADIOGRAPHIC ABSORPTIOMETRY	MAXFEE	DEF					NA			N
76080	X-RAY EXAM OF FISTULA	PRXOVR	DEF					NA	NA	NA	N
76080	X-RAY EXAM OF FISTULA	MAXFEE	DEF					51.81	7/26/2007	12/31/2299	N
76080	X-RAY EXAM OF FISTULA	MAXFEE	DEF	TC				31.09	7/26/2007	12/31/2299	N
76080	X-RAY EXAM OF FISTULA	MAXFEE	DEF	26				20.72	7/26/2007	12/31/2299	N
76082	COMPUTER MAMMOGRAM ADD-ON	PRXOVR	DEF					NA	NA	NA	N
76082	COMPUTER MAMMOGRAM ADD-ON	MAXFEE	DEF					NA			N
76083	COMPUTER MAMMOGRAM ADD-ON	PRXOVR	DEF					NA	NA	NA	N
76083	COMPUTER MAMMOGRAM ADD-ON	MAXFEE	DEF					NA			N
76085	COMPUTER MAMMOGRAM ADD-ON	PRXOVR	DEF					NA	NA	NA	N
76085	COMPUTER MAMMOGRAM ADD-ON	MAXFEE	DEF					NA			N
76086	X-RAY OF MAMMARY DUCT	PRXOVR	DEF					NA	NA	NA	N
76086	X-RAY OF MAMMARY DUCT	MAXFEE	DEF					NA			N
76088	X-RAY OF MAMMARY DUCTS	PRXOVR	DEF					NA	NA	NA	N
76088	X-RAY OF MAMMARY DUCTS	MAXFEE	DEF					NA			N

76090	MAMMOGRAM; ONE BREAST	PRXOVR	DEF					NA	NA	NA	N
76090	MAMMOGRAM; ONE BREAST	MAXFEE	DEF					NA			N
76091	MAMMOGRAM; BOTH BREASTS	PRXOVR	DEF					NA	NA	NA	N
76091	MAMMOGRAM; BOTH BREASTS	MAXFEE	DEF					NA			N
76092	MAMMOGRAM; SCREENING	PRXOVR	DEF					NA	NA	NA	N
76092	MAMMOGRAM; SCREENING	MAXFEE	DEF					NA			N
76093	MAGNETIC IMAGE; BREAST	PRXOVR	DEF					NA	NA	NA	N
76093	MAGNETIC IMAGE; BREAST	MAXFEE	DEF					NA			N
76094	MAGNETIC IMAGE; BOTH BREASTS	PRXOVR	DEF					NA	NA	NA	N
76094	MAGNETIC IMAGE; BOTH BREASTS	MAXFEE	DEF					NA			N
76095	STEREOTACTIC BREAST BIOPSY	PRXOVR	DEF					NA	NA	NA	N
76095	STEREOTACTIC BREAST BIOPSY	MAXFEE	DEF					NA			N
76096	X-RAY OF NEEDLE WIRE; BREAST	PRXOVR	DEF					NA	NA	NA	N
76096	X-RAY OF NEEDLE WIRE; BREAST	MAXFEE	DEF					NA			N
76098	X-RAY EXAM BREAST SPECIMEN	PRXOVR	DEF					NA	NA	NA	N
76098	X-RAY EXAM BREAST SPECIMEN	MAXFEE	DEF					17.23	1/1/2010	12/31/2299	N
76098	X-RAY EXAM BREAST SPECIMEN	MAXFEE	DEF	TC				10.34	1/1/2010	12/31/2299	N
76098	X-RAY EXAM BREAST SPECIMEN	MAXFEE	DEF	26				6.89	1/1/2010	12/31/2299	N
76100	X-RAY EXAM OF BODY SECTION	PRXOVR	DEF					NA	NA	NA	N
76100	X-RAY EXAM OF BODY SECTION	MAXFEE	DEF					59.01	7/26/2007	12/31/2299	N

76100	X-RAY EXAM OF BODY SECTION	MAXFEE	DEF	TC				41.31	7/26/2007	12/31/2299	N
76100	X-RAY EXAM OF BODY SECTION	MAXFEE	DEF	26				17.70	7/26/2007	12/31/2299	N
88300	SURGICAL PATH GROSS	PRXOVR	DEF					NA	NA	NA	N
88300	SURGICAL PATH GROSS	MAXFEE	DEF					9.40	7/1/2008	12/31/2299	N
88300	SURGICAL PATH GROSS	MAXFEE	DEF	TC				7.52	7/1/2008	12/31/2299	N
88300	SURGICAL PATH GROSS	MAXFEE	DEF	26				1.88	7/1/2008	12/31/2299	N
88302	TISSUE EXAM BY PATHOLOGIST	PRXOVR	DEF					NA	NA	NA	N
88302	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF					20.05	7/1/2008	12/31/2299	N
88302	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	TC				16.04	7/1/2008	12/31/2299	N
88302	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	26				4.01	7/1/2008	12/31/2299	N
88304	TISSUE EXAM BY PATHOLOGIST	PRXOVR	DEF					NA	NA	NA	N
88304	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF					25.60	7/1/2008	12/31/2299	N
88304	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	TC				20.48	7/1/2008	12/31/2299	N
88304	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	26				5.12	7/1/2008	12/31/2299	N
88305	TISSUE EXAM BY PATHOLOGIST	PRXOVR	DEF					NA	NA	NA	N
88305	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF					50.79	7/1/2008	12/31/2299	N
88305	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	TC				30.47	7/1/2008	12/31/2299	N
88305	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	26				20.32	7/1/2008	12/31/2299	N
88307	TISSUE EXAM BY PATHOLOGIST	PRXOVR	DEF					NA	NA	NA	N

88307	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF					94.50	7/1/2008	12/31/2299	N
88307	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	TC				56.70	7/1/2008	12/31/2299	N
88307	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	26				37.80	7/1/2008	12/31/2299	N
88309	TISSUE EXAM BY PATHOLOGIST	PRXOVR	DEF					NA	NA	NA	N
88309	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF					136.04	7/1/2008	12/31/2299	N
88309	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	TC				68.02	7/1/2008	12/31/2299	N
88309	TISSUE EXAM BY PATHOLOGIST	MAXFEE	DEF	26				68.02	7/1/2008	12/31/2299	N
88311	DECALCIFY TISSUE	PRXOVR	DEF					NA	NA	NA	N
88311	DECALCIFY TISSUE	MAXFEE	DEF					13.29	1/1/2010	12/31/2299	N
88311	DECALCIFY TISSUE	MAXFEE	DEF	TC				5.32	1/1/2010	12/31/2299	N
88311	DECALCIFY TISSUE	MAXFEE	DEF	26				7.97	1/1/2010	12/31/2299	N
88312	SPECIAL STAINS GROUP 1	PRXOVR	DEF					NA	NA	NA	N
88312	SPECIAL STAINS GROUP 1	MAXFEE	DEF					36.65	7/1/2008	12/31/2299	N
88312	SPECIAL STAINS GROUP 1	MAXFEE	DEF	TC				23.82	7/1/2008	12/31/2299	N
88312	SPECIAL STAINS GROUP 1	MAXFEE	DEF	26				12.83	7/1/2008	12/31/2299	N
88313	SPECIAL STAINS GROUP 2	PRXOVR	DEF					NA	NA	NA	N
88313	SPECIAL STAINS GROUP 2	MAXFEE	DEF					26.45	7/1/2008	12/31/2299	N
88313	SPECIAL STAINS GROUP 2	MAXFEE	DEF	TC				21.16	7/1/2008	12/31/2299	N
88313	SPECIAL STAINS GROUP 2	MAXFEE	DEF	26				5.29	7/1/2008	12/31/2299	N
88314	HISTOCHEMICAL STAINS ADD-ON	PRXOVR	DEF					NA	NA	NA	N
88314	HISTOCHEMICAL STAINS ADD-ON	MAXFEE	DEF					40	7/1/2008	12/31/2299	N
88314	HISTOCHEMICAL STAINS ADD-ON	MAXFEE	DEF	TC				30	7/1/2008	12/31/2299	N

88314	HISTOCHEMICAL STAINS ADD-ON	MAXFEE	DEF	26				10	7/1/2008	12/31/2299	N
88318	CHEMICAL HISTOCHEMISTRY	PRXOVR	DEF					NA	NA	NA	N
88318	CHEMICAL HISTOCHEMISTRY	MAXFEE	DEF					NA			N
88319	ENZYME HISTOCHEMISTRY	PRXOVR	DEF					NA	NA	NA	N
88319	ENZYME HISTOCHEMISTRY	MAXFEE	DEF					61.80	7/1/2008	12/31/2299	N
88319	ENZYME HISTOCHEMISTRY	MAXFEE	DEF	TC				49.44	7/1/2008	12/31/2299	N
88319	ENZYME HISTOCHEMISTRY	MAXFEE	DEF	26				12.36	7/1/2008	12/31/2299	N
88321	MICROSLIDE CONSULTATION	PRXOVR	DEF					NA	NA	NA	N
88321	MICROSLIDE CONSULTATION	MAXFEE	DEF					37.95	7/1/2008	12/31/2299	N
88321	MICROSLIDE CONSULTATION	MAXFEE	DEF	26				37.95	7/1/2008	12/31/2299	N
88323	MICROSLIDE CONSULTATION	PRXOVR	DEF					NA	NA	NA	N
88323	MICROSLIDE CONSULTATION	MAXFEE	DEF					68.50	7/1/2008	12/31/2299	N
88323	MICROSLIDE CONSULTATION	MAXFEE	DEF	TC				27.40	7/1/2008	12/31/2299	N
88323	MICROSLIDE CONSULTATION	MAXFEE	DEF	26				41.10	7/1/2008	12/31/2299	N
88325	COMPREHENSIVE REVIEW OF DATA	PRXOVR	DEF					NA	NA	NA	N
88325	COMPREHENSIVE REVIEW OF DATA	MAXFEE	DEF					82.95	7/1/2008	12/31/2299	N
88325	COMPREHENSIVE REVIEW OF DATA	MAXFEE	DEF	26				82.95	7/1/2008	12/31/2299	N
88329	PATH CONSULT INTROP	PRXOVR	DEF					NA	NA	NA	N
88329	PATH CONSULT INTROP	MAXFEE	DEF					29.47	1/1/2010	12/31/2299	N
88329	PATH CONSULT INTROP	MAXFEE	DEF	26				29.47	1/1/2010	12/31/2299	N
88331	PATH CONSULT INTRAOP 1 BLOC	PRXOVR	DEF					NA	NA	NA	N
88331	PATH CONSULT INTRAOP 1 BLOC	MAXFEE	DEF					66.06	1/1/2010	12/31/2299	N
88331	PATH CONSULT INTRAOP 1 BLOC	MAXFEE	DEF	TC				19.82	1/1/2010	12/31/2299	N
88331	PATH CONSULT INTRAOP 1 BLOC	MAXFEE	DEF	26				46.24	1/1/2010	12/31/2299	N

88332	PATH CONSULT INTRAOP ADDL	PRXOVR	DEF					NA	NA	NA	N
88332	PATH CONSULT INTRAOP ADDL	MAXFEE	DEF					34.20	7/1/2003	12/31/2299	N
88332	PATH CONSULT INTRAOP ADDL	MAXFEE	DEF	TC				6.84	7/1/2003	12/31/2299	N
88332	PATH CONSULT INTRAOP ADDL	MAXFEE	DEF	26				27.36	7/1/2003	12/31/2299	N
88333	INTRAOP CYTO PATH CONSULT 1	PRXOVR	DEF					NA	NA	NA	N
88333	INTRAOP CYTO PATH CONSULT 1	MAXFEE	DEF					79.46	1/1/2010	12/31/2299	N
88333	INTRAOP CYTO PATH CONSULT 1	MAXFEE	DEF	TC				19.86	1/1/2010	12/31/2299	N
88333	INTRAOP CYTO PATH CONSULT 1	MAXFEE	DEF	26				59.60	1/1/2010	12/31/2299	N
88334	INTRAOP CYTO PATH CONSULT 2	PRXOVR	DEF					NA	NA	NA	N
88334	INTRAOP CYTO PATH CONSULT 2	MAXFEE	DEF					43.05	1/1/2006	12/31/2299	N
88334	INTRAOP CYTO PATH CONSULT 2	MAXFEE	DEF	TC				10.76	1/1/2006	12/31/2299	N
88334	INTRAOP CYTO PATH CONSULT 2	MAXFEE	DEF	26				32.29	1/1/2006	12/31/2299	N
88342	IMMUNOHISTOCHEMISTRY	PRXOVR	DEF					NA	NA	NA	N
88342	IMMUNOHISTOCHEMISTRY	MAXFEE	DEF					46.90	7/1/2008	12/31/2299	N
88342	IMMUNOHISTOCHEMISTRY	MAXFEE	DEF	TC				23.45	7/1/2008	12/31/2299	N
88342	IMMUNOHISTOCHEMISTRY	MAXFEE	DEF	26				23.45	7/1/2008	12/31/2299	N
88346	IMMUNOFLUORESCENT STUDY	PRXOVR	DEF					NA	NA	NA	N
88346	IMMUNOFLUORESCENT STUDY	MAXFEE	DEF					46.85	7/1/2008	12/31/2299	N
88346	IMMUNOFLUORESCENT STUDY	MAXFEE	DEF	TC				23.43	7/1/2008	12/31/2299	N

88346	IMMUNOFLUORESCENT STUDY	MAXFEE	DEF	26				23.43	7/1/2008	12/31/2299	N
88347	IMMUNOFLUORESCENT STUDY	PRXOVR	DEF					NA	NA	NA	N
88347	IMMUNOFLUORESCENT STUDY	MAXFEE	DEF					40	7/1/2008	12/31/2299	N
88347	IMMUNOFLUORESCENT STUDY	MAXFEE	DEF	TC				20	7/1/2008	12/31/2299	N
88347	IMMUNOFLUORESCENT STUDY	MAXFEE	DEF	26				20	7/1/2008	12/31/2299	N
88348	ELECTRON MICROSCOPY	PRXOVR	DEF					NA	NA	NA	N
88348	ELECTRON MICROSCOPY	MAXFEE	DEF					189.49	7/1/2008	12/31/2299	N
88348	ELECTRON MICROSCOPY	MAXFEE	DEF	TC				151.59	7/1/2008	12/31/2299	N
88348	ELECTRON MICROSCOPY	MAXFEE	DEF	26				37.90	7/1/2008	12/31/2299	N
88349	SCANNING ELECTRON MICROSCOPY	PRXOVR	DEF					NA	NA	NA	N
88349	SCANNING ELECTRON MICROSCOPY	MAXFEE	DEF					79.75	7/1/2008	12/31/2299	N
88349	SCANNING ELECTRON MICROSCOPY	MAXFEE	DEF	TC				63.80	7/1/2008	12/31/2299	N
88349	SCANNING ELECTRON MICROSCOPY	MAXFEE	DEF	26				15.95	7/1/2008	12/31/2299	N
88355	ANALYSIS SKELETAL MUSCLE	PRXOVR	DEF					NA	NA	NA	N
88355	ANALYSIS SKELETAL MUSCLE	MAXFEE	DEF					132.95	7/1/2008	12/31/2299	N
88355	ANALYSIS SKELETAL MUSCLE	MAXFEE	DEF	TC				99.71	7/1/2008	12/31/2299	N
88355	ANALYSIS SKELETAL MUSCLE	MAXFEE	DEF	26				33.24	7/1/2008	12/31/2299	N
88356	ANALYSIS NERVE	PRXOVR	DEF					NA	NA	NA	N
88356	ANALYSIS NERVE	MAXFEE	DEF					171.55	7/26/2007	12/31/2299	N
88356	ANALYSIS NERVE	MAXFEE	DEF	TC				85.78	7/26/2007	12/31/2299	N
88356	ANALYSIS NERVE	MAXFEE	DEF	26				85.78	7/26/2007	12/31/2299	N
88358	ANALYSIS TUMOR	PRXOVR	DEF					NA	NA	NA	N
88358	ANALYSIS TUMOR	MAXFEE	DEF					68.49	1/1/2010	12/31/2299	N

88358	ANALYSIS TUMOR	MAXFEE	DEF	TC				20.55	1/1/2010	12/31/2299	N
88358	ANALYSIS TUMOR	MAXFEE	DEF	26				47.94	1/1/2010	12/31/2299	N
88360	TUMOR IMMUNOHISTOCHEM/MANUAL	PRXOVR	DEF					NA	NA	NA	N
88360	TUMOR IMMUNOHISTOCHEM/MANUAL	MAXFEE	DEF					102.93	1/1/2010	12/31/2299	N
88360	TUMOR IMMUNOHISTOCHEM/MANUAL	MAXFEE	DEF	TC				51.47	1/1/2010	12/31/2299	N
88360	TUMOR IMMUNOHISTOCHEM/MANUAL	MAXFEE	DEF	26				51.47	1/1/2010	12/31/2299	N
88361	TUMOR IMMUNOHISTOCHEM/COMPUT	PRXOVR	DEF					NA	NA	NA	N
88361	TUMOR IMMUNOHISTOCHEM/COMPUT	MAXFEE	DEF					122.01	1/1/2010	12/31/2299	N
88361	TUMOR IMMUNOHISTOCHEM/COMPUT	MAXFEE	DEF	TC				73.21	1/1/2010	12/31/2299	N
88361	TUMOR IMMUNOHISTOCHEM/COMPUT	MAXFEE	DEF	26				48.80	1/1/2010	12/31/2299	N
88362	NERVE TEASING PREPARATIONS	PRXOVR	DEF					NA	NA	NA	N
88362	NERVE TEASING PREPARATIONS	MAXFEE	DEF					123.25	7/26/2007	12/31/2299	N
88362	NERVE TEASING PREPARATIONS	MAXFEE	DEF	TC				73.95	7/26/2007	12/31/2299	N
88362	NERVE TEASING PREPARATIONS	MAXFEE	DEF	26				49.30	7/26/2007	12/31/2299	N
88363	XM ARCHIVE TISSUE MOLEC ANAL	PRXOVR	DEF					NA	NA	NA	N
88363	XM ARCHIVE TISSUE MOLEC ANAL	MAXFEE	DEF					16.74	1/1/2011	12/31/2299	N

88363	XM ARCHIVE TISSUE MOLEC ANAL	MAXFEE	DEF	26				16.74	1/1/2011	12/31/2299	N
88365	INSITU HYBRIDIZATION (FISH)	PRXOVR	DEF					NA	NA	NA	N
88365	INSITU HYBRIDIZATION (FISH)	MAXFEE	DEF					56.80	7/1/2008	12/31/2299	N
88365	INSITU HYBRIDIZATION (FISH)	MAXFEE	DEF	TC				28.40	7/1/2008	12/31/2299	N
88365	INSITU HYBRIDIZATION (FISH)	MAXFEE	DEF	26				28.40	7/1/2008	12/31/2299	N
88367	INSITU HYBRIDIZATION AUTO	PRXOVR	DEF					NA	NA	NA	N
88367	INSITU HYBRIDIZATION AUTO	MAXFEE	DEF					193.73	1/1/2010	12/31/2299	N
88367	INSITU HYBRIDIZATION AUTO	MAXFEE	DEF	TC				125.92	1/1/2010	12/31/2299	N
88367	INSITU HYBRIDIZATION AUTO	MAXFEE	DEF	26				67.81	1/1/2010	12/31/2299	N
88368	INSITU HYBRIDIZATION MANUAL	PRXOVR	DEF					NA	NA	NA	N
88368	INSITU HYBRIDIZATION MANUAL	MAXFEE	DEF					176.45	1/1/2010	12/31/2299	N
88368	INSITU HYBRIDIZATION MANUAL	MAXFEE	DEF	TC				105.87	1/1/2010	12/31/2299	N
88368	INSITU HYBRIDIZATION MANUAL	MAXFEE	DEF	26				70.58	1/1/2010	12/31/2299	N
88371	PROTEIN WESTERN BLOT TISSUE	PRXOVR	DEF					NA	NA	NA	N
88371	PROTEIN WESTERN BLOT TISSUE	MAXFEE	DEF					18.71	7/1/2003	12/31/2299	N
88371	PROTEIN WESTERN BLOT TISSUE	MAXFEE	DEF	26				18.15	7/1/2003	12/31/2299	N
88372	PROTEIN ANALYSIS W/PROBE	PRXOVR	DEF					NA	NA	NA	N
88372	PROTEIN ANALYSIS W/PROBE	MAXFEE	DEF					19.79	7/1/2003	12/31/2299	N
88372	PROTEIN ANALYSIS W/PROBE	MAXFEE	DEF	26				18.46	7/1/2003	12/31/2299	N
88375	OPTICAL ENDOMICROSCPY INTERP	PRXOVR	DEF					NA	NA	NA	N
88375	OPTICAL ENDOMICROSCPY INTERP	MANUAL	DEF					NA	NA	NA	N
88380	MICRODISSECTION LASER	PRXOVR	DEF					NA	NA	NA	N
88380	MICRODISSECTION LASER	MAXFEE	DEF					5	7/1/2003	12/31/2299	N

88380	MICRODISSECTION LASER	MAXFEE	DEF	TC				1	7/1/2003	12/31/2299	N
88380	MICRODISSECTION LASER	MAXFEE	DEF	26				4	7/1/2003	12/31/2299	N
88381	MICRODISSECTION MANUAL	PRXOVR	DEF					NA	NA	NA	N
88381	MICRODISSECTION MANUAL	MAXFEE	DEF					89.87	1/1/2008	12/31/2299	N
88381	MICRODISSECTION MANUAL	MAXFEE	DEF	TC				67.40	1/1/2008	12/31/2299	N
88381	MICRODISSECTION MANUAL	MAXFEE	DEF	26				22.47	1/1/2008	12/31/2299	N
88384	EVAL MOLECULAR PROBES 11-50	PRXOVR	DEF					NA	NA	NA	N
88384	EVAL MOLECULAR PROBES 11-50	MANUAL	DEF					NA	NA	NA	N
88385	EVAL MOLECUL PROBES 51-250	PRXOVR	DEF					NA	NA	NA	N
88385	EVAL MOLECUL PROBES 51-250	MAXFEE	DEF					NA			N
88386	EVAL MOLECUL PROBES 251-500	PRXOVR	DEF					NA	NA	NA	N
88386	EVAL MOLECUL PROBES 251-500	MAXFEE	DEF					NA			N
88387	TISS EXAM MOLECULAR STUDY	PRXOVR	DEF					NA	NA	NA	N
88387	TISS EXAM MOLECULAR STUDY	MAXFEE	DEF					26.72	1/1/2010	12/31/2299	N
88387	TISS EXAM MOLECULAR STUDY	MAXFEE	DEF	TC				5.34	1/1/2010	12/31/2299	N
88387	TISS EXAM MOLECULAR STUDY	MAXFEE	DEF	26				21.38	1/1/2010	12/31/2299	N
88388	TISS EX MOLECUL STUDY ADD-ON	PRXOVR	DEF					NA	NA	NA	N
88388	TISS EX MOLECUL STUDY ADD-ON	MAXFEE	DEF					16.13	1/1/2010	12/31/2299	N
88388	TISS EX MOLECUL STUDY ADD-ON	MAXFEE	DEF	TC				3.23	1/1/2010	12/31/2299	N
88388	TISS EX MOLECUL STUDY ADD-ON	MAXFEE	DEF	26				12.90	1/1/2010	12/31/2299	N

88399	SURGICAL PATHOLOGY PROCEDURE	PRXOVR	DEF					NA	NA	NA	N
88399	SURGICAL PATHOLOGY PROCEDURE	MANUAL	DEF					NA	NA	NA	N
D0120	PERIODIC ORAL EVALUATION	MAXFEE	DEF					17.08	7/1/2008	12/31/2299	S
D0140	LIMIT ORAL EVAL PROBLM FOCUS	MAXFEE	DEF					22.58	7/1/2008	12/31/2299	N
D0150	COMPREHENSVE ORAL EVALUATION	MAXFEE	DEF					26.35	7/1/2008	12/31/2299	S
D0210	INTRAOR COMPLETE FILM SERIES	MAXFEE	DEF					60	7/1/2008	12/31/2299	S
D0220	INTRAORAL PERIAPICAL FIRST	MAXFEE	DEF					5	7/1/2008	12/31/2299	N
D0230	INTRAORAL PERIAPICAL EA ADD	MAXFEE	DEF					5	7/1/2008	12/31/2299	N
D0240	INTRAORAL OCCLUSAL FILM	MAXFEE	DEF					12	7/1/2008	12/31/2299	N
D0250	EXTRAORAL FIRST FILM	MAXFEE	DEF					13.46	7/1/2008	12/31/2299	N
D0270	DENTAL BITEWING SINGLE IMAGE	MAXFEE	DEF					5	7/1/2008	12/31/2299	N
D0272	DENTAL BITEWINGS TWO IMAGES	MAXFEE	DEF					10	7/1/2008	12/31/2299	S
D0273	BITEWINGS - THREE IMAGES	MAXFEE	DEF					14.70	1/1/2007	12/31/2299	S
D0274	BITEWINGS FOUR IMAGES	MAXFEE	DEF					20	7/1/2008	12/31/2299	S
D0321	OTHER TMJ IMAGES BY REPORT	MAXFEE	DEF					51.77	7/1/2008	12/31/2299	N
D0330	PANORAMIC IMAGE	MAXFEE	DEF					46.32	7/1/2008	12/31/2299	S
D0340	CEPHALOMETRIC IMAGE	MAXFEE	DEF					60	7/1/2008	12/31/2299	Y
D0350	ORAL/FACIAL PHOTO IMAGES	MAXFEE	DEF					12.31	7/1/2008	12/31/2299	Y
D0470	DIAGNOSTIC CASTS	MAXFEE	DEF					22.02	7/1/2008	12/31/2299	Y
D0471	DIAGNOSTIC PHOTOGRAPHS	MAXFEE	DEF					NA			Y
D1110	DENTAL PROPHYLAXIS ADULT	MAXFEE	DEF					34.13	7/1/2008	12/31/2299	S
D1120	DENTAL PROPHYLAXIS CHILD	MAXFEE	DEF					20	7/1/2008	12/31/2299	S

D1203	TOPICAL APP FLUORIDE CHILD	MAXFEE	DEF					NA			S
D1208	TOPICAL APP OF FLUORIDE	MAXFEE	DEF					15	1/1/2013	12/31/2299	S
D1351	DENTAL SEALANT PER TOOTH	MAXFEE	DEF					22	7/1/2008	12/31/2299	S
D1510	SPACE MAINTAINER FXD UNILAT	MAXFEE	DEF					113.71	7/1/2008	12/31/2299	N
D1515	FIXED BILAT SPACE MAINTAINER	MAXFEE	DEF					163.28	7/1/2008	12/31/2299	N
D1520	REMOVE UNILAT SPACE MAINTAIN	MAXFEE	DEF					125.08	7/1/2008	12/31/2299	N
D1525	REMOVE BILAT SPACE MAINTAIN	MAXFEE	DEF					133.79	7/1/2008	12/31/2299	N
D2110	AMALGAM ONE SURFACE PRIMARY	MAXFEE	DEF					NA			N
D2120	AMALGAM TWO SURFACES PRIMARY	MAXFEE	DEF					NA			N
D2130	AMALGAM THREE SURFACES PRIMA	MAXFEE	DEF					NA			N
D2140	AMALGAM ONE SURFACE PERMANEN	MAXFEE	DEF					40	7/1/2008	12/31/2299	N
D2150	AMALGAM TWO SURFACES PERMANE	MAXFEE	DEF					54	7/1/2008	12/31/2299	N
D2160	AMALGAM THREE SURFACES PERMA	MAXFEE	DEF					65	7/1/2008	12/31/2299	N
D2161	AMALGAM 4 OR > SURFACES PERM	MAXFEE	DEF					76.54	7/1/2008	12/31/2299	N
D2330	RESIN ONE SURFACE-ANTERIOR	MAXFEE	DEF					51.21	7/1/2008	12/31/2299	N
D2331	RESIN TWO SURFACES-ANTERIOR	MAXFEE	DEF					63.49	7/1/2008	12/31/2299	N
D2332	RESIN THREE SURFACES-ANTERIO	MAXFEE	DEF					76.62	7/1/2008	12/31/2299	N
D2335	RESIN 4/> SURF OR W INCIS AN	MAXFEE	DEF					94.95	7/1/2008	12/31/2299	N

D2391	POST 1 SRFC RESINBASED CMPST	MAXFEE	DEF					51.21	7/1/2008	12/31/2299	N
D2392	POST 2 SRFC RESINBASED CMPST	MAXFEE	DEF					54	7/1/2008	12/31/2299	N
D2393	POST 3 SRFC RESINBASED CMPST	MAXFEE	DEF					65	7/1/2008	12/31/2299	N
D2394	POST >=4SRFC RESINBASE CMPST	MAXFEE	DEF					76.54	7/1/2008	12/31/2299	N
D2752	CROWN PORCELAIN W/ NOBLE MET	MAXFEE	DEF					427.29	7/1/2008	12/31/2299	Y
D2930	PREFAB STNLSS STEEL CRWN PRI	MAXFEE	DEF					101.92	7/1/2008	12/31/2299	N
D2931	PREFAB STNLSS STEEL CROWN PE	MAXFEE	DEF					116.51	7/1/2008	12/31/2299	N
D2933	PREFAB STAINLESS STEEL CROWN	MAXFEE	DEF					153	7/1/2008	12/31/2299	N
D2951	TOOTH PIN RETENTION	MAXFEE	DEF					16.49	7/1/2008	12/31/2299	N
D2952	POST AND CORE CAST + CROWN	MAXFEE	DEF					136.32	7/1/2008	12/31/2299	Y
D3220	THERAPEUTIC PULPOTOMY	MAXFEE	DEF					63.74	7/1/2008	12/31/2299	N
D3310	END THXPY; ANTERIOR TOOTH	MAXFEE	DEF					247.63	1/1/2009	12/31/2299	N
D3320	END THXPY; BICUSPID TOOTH	MAXFEE	DEF					298.10	1/1/2009	12/31/2299	N
D3330	END THXPY; MOLAR	MAXFEE	DEF					379.02	1/1/2009	12/31/2299	N
D3351	APEXIFICATION/RECALC INITIAL	MAXFEE	DEF					60	7/1/2008	12/31/2299	Y
D3352	APEXIFICATION/RECALC INTERIM	MAXFEE	DEF					40	7/1/2008	12/31/2299	Y
D3353	APEXIFICATION/RECALC FINAL	MAXFEE	DEF					40	7/1/2008	12/31/2299	Y
D3410	APICOECT/PERIRAD SURG ANTER	MAXFEE	DEF					178	7/1/2008	12/31/2299	Y
D4210	GINGIVECTOMY/PLASTY 4 OR MOR	MAXFEE	DEF					197.20	7/1/2008	12/31/2299	Y

D5110	DENTURES COMPLETE MAXILLARY	MAXFEE	DEF					400	7/1/2008	12/31/2299	Y
D5120	DENTURES COMPLETE MANDIBLE	MAXFEE	DEF					400	7/1/2008	12/31/2299	Y
D5211	DENTURES MAXILL PART RESIN	MAXFEE	DEF					205	7/1/2008	12/31/2299	Y
D5212	DENTURES MAND PART RESIN	MAXFEE	DEF					205	7/1/2008	12/31/2299	Y
D5213	DENTURES MAXILL PART METAL	MAXFEE	DEF					540.25	7/1/2008	12/31/2299	Y
D5214	DENTURES MANDIBL PART METAL	MAXFEE	DEF					540.25	7/1/2008	12/31/2299	Y
D5510	DENTUR REPR BROKEN COMPL BAS	MAXFEE	DEF					50	7/1/2008	12/31/2299	N
D5520	REPLACE DENTURE TEETH COMPLT	MAXFEE	DEF					40	7/1/2008	12/31/2299	N
D5610	DENTURES REPAIR RESIN BASE	MAXFEE	DEF					50	7/1/2008	12/31/2299	N
D5620	REP PART DENTURE CAST FRAME	MAXFEE	DEF					78	7/1/2008	12/31/2299	N
D5630	REP PARTIAL DENTURE CLASP	MAXFEE	DEF					74	7/1/2008	12/31/2299	N
D5640	REPLACE PART DENTURE TEETH	MAXFEE	DEF					40	7/1/2008	12/31/2299	N
D5650	ADD TOOTH TO PARTIAL DENTURE	MAXFEE	DEF					40	7/1/2008	12/31/2299	N
D5660	ADD CLASP TO PARTIAL DENTURE	MAXFEE	DEF					74	7/1/2008	12/31/2299	N
D5750	DENTURE RELN CMPLT MAX LAB	MAXFEE	DEF					175.51	7/1/2008	12/31/2299	S
D5751	DENTURE RELN CMPLT MAND LAB	MAXFEE	DEF					175.80	7/1/2008	12/31/2299	S
D5760	DENTURE RELN PART MAXIL LAB	MAXFEE	DEF					140	7/1/2008	12/31/2299	S
D5761	DENTURE RELN PART MAND LAB	MAXFEE	DEF					140	7/1/2008	12/31/2299	S

D5899	REMOVABLE PROSTHODONTIC PROC	PADOLR	DEF					NA	NA	NA	Y
D5913	NASAL PROSTHESIS	PADOLR	DEF					NA	NA	NA	Y
D5915	ORBITAL PROSTHESIS	PADOLR	DEF					NA	NA	NA	Y
D5916	OCULAR PROSTHESIS	PADOLR	DEF					NA	NA	NA	Y
D5931	SURGICAL OBTURATOR	PADOLR	DEF					NA	NA	NA	Y
D5932	POSTSURGICAL OBTURATOR	PADOLR	DEF					NA	NA	NA	Y
D5934	MANDIBULAR FLANGE PROSTHESIS	PADOLR	DEF					NA	NA	NA	Y
D5935	MANDIBULAR DENTURE PROSTH	PADOLR	DEF					NA	NA	NA	Y
D5955	PALATAL LIFT PROSTHESIS	PADOLR	DEF					NA	NA	NA	Y
D5999	MAXILLOFACIAL PROSTHESIS	PADOLR	DEF					NA	NA	NA	Y
D6100	REMOVAL OF IMPLANT	MANUAL	DEF					NA	NA	NA	Y
D7110	ORAL SURGERY SINGLE TOOTH	MAXFEE	DEF					NA			N
D7120	EACH ADD TOOTH EXTRACTION	MAXFEE	DEF					NA			N
D7130	TOOTH ROOT REMOVAL	MAXFEE	DEF					NA			N
D7140	EXTRACTION ERUPTED TOOTH/EXR	MAXFEE	DEF					52.45	7/1/2008	12/31/2299	N
D7220	IMPACT TOOTH REMOV SOFT TISS	MAXFEE	DEF					102	7/1/2008	12/31/2299	Y N
D7230	IMPACT TOOTH REMOV PART BONY	MAXFEE	DEF					151.46	7/1/2008	12/31/2299	N
D7240	IMPACT TOOTH REMOV COMP BONY	MAXFEE	DEF					188.80	7/1/2008	12/31/2299	Y
D7241	IMPACT TOOTH REM BONY W/COMP	MAXFEE	DEF					200	7/1/2008	12/31/2299	Y
D7250	TOOTH ROOT REMOVAL	PADOLR	DEF					NA	NA	NA	Y
D7260	ORAL ANTRAL FISTULA CLOSURE	MAXFEE	DEF					0	7/1/1971	12/31/2299	N
D7270	TOOTH REIMPLANTATION	MANUAL	DEF					NA	NA	NA	N

D7280	EXPOSURE IMPACT TOOTH ORTHOD	MAXFEE	DEF					152.30	7/1/2008	12/31/2299	Y
D7285	BIOPSY OF ORAL TISSUE HARD	MAXFEE	DEF					150	7/1/2008	12/31/2299	N
D7286	BIOPSY OF ORAL TISSUE SOFT	MAXFEE	DEF					130	7/1/2008	12/31/2299	N
D7310	ALVEOPLASTY W/ EXTRACTION	MAXFEE	DEF					99.06	7/1/2008	12/31/2299	N
D7320	ALVEOPLASTY W/O EXTRACTION	MAXFEE	DEF					120.64	7/1/2008	12/31/2299	N
D7410	RAD EXC LESION UP TO 1.25 CM	MAXFEE	DEF					0	7/1/1971	12/31/2299	N
D7411	EXCISION BENIGN LESION>1.25C	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7412	EXCISION BENIGN LESION COMPL	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7413	EXCISION MALIG LESION<=1.25C	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7414	EXCISION MALIG LESION>1.25CM	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7415	EXCISION MALIG LES COMPLICAT	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7450	REM ODONTOGEN CYST TO 1.25CM	MANUAL	DEF					NA	NA	NA	N
D7451	REM ODONTOGEN CYST > 1.25 CM	MANUAL	DEF					NA	NA	NA	N
D7460	REM NONODONTO CYST TO 1.25CM	MANUAL	DEF					NA	NA	NA	N
D7461	REM NONODONTO CYST > 1.25 CM	MANUAL	DEF					NA	NA	NA	N
D7465	LESION DESTRUCTION	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7470	REM EXOSTOSIS MAXILLA/MANDIB	PADOLR	DEF					NA	NA	NA	Y
D7471	REM EXOSTOSIS ANY SITE	PADOLR	DEF					NA	NA	NA	Y

D7472	REMOVAL OF TORUS PALATINUS	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7473	REMOVE TORUS MANDIBULARIS	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7485	SURG REDUCT OSSEOUSTUBEROSIT	MAXFEE	DEF					0	1/1/2004	12/31/2299	N
D7510	I&D ABSC INTRAORAL SOFT TISS	MANUAL	DEF					NA	NA	NA	N
D7520	I&D ABSCESS EXTRAORAL	MANUAL	DEF					NA	NA	NA	N
D7610	MAXILLA OPEN REDUCT SIMPLE	MAXFEE	DEF					NA			N
D7620	CLSD REDUCT SIMPL MAXILLA FX	MAXFEE	DEF					NA			N
D7630	OPEN RED SIMPL MANDIBLE FX	MAXFEE	DEF					NA			N
D7640	CLSD RED SIMPL MANDIBLE FX	MAXFEE	DEF					NA			N
D7670	CLOSD RDUCTN SPLINT ALVEOLUS	MAXFEE	DEF					NA			N
D7671	ALVEOLUS OPEN REDUCTION	MANUAL	DEF					NA	NA	NA	N
D7710	MAXILLA OPEN REDUCT COMPOUND	MAXFEE	DEF					NA			N
D7720	CLSD REDUCT COMPD MAXILLA FX	MAXFEE	DEF					NA			N
D7730	OPEN REDUCT COMPD MANDBLE FX	MAXFEE	DEF					NA			N
D7740	CLSD REDUCT COMPD MANDBLE FX	MAXFEE	DEF					NA			N
D7770	OPEN REDUC COMPD ALVEOLUS FX	MAXFEE	DEF					NA			N
D7899	TMJ UNSPECIFIED THERAPY	MAXFEE	DEF					482.50	7/1/2008	12/31/2299	Y
D7960	FRENULECTOMY/FRENECTOMY	MAXFEE	DEF					119.13	7/1/2008	12/31/2299	Y

D7970	EXCISION HYPERPLASTIC TISSUE	PADOLR	DEF					NA	NA	NA	Y
D8080	COMPRE DENTAL TX ADOLESCENT	MAXFEE	DEF					624	7/1/2008	12/31/2299	Y
D8210	ORTHODONTIC REM APPLIANCE TX	MAXFEE	DEF					205	7/1/2008	12/31/2299	Y
D8220	FIXED APPLIANCE THERAPY HABT	MAXFEE	DEF					300	7/1/2008	12/31/2299	Y
D8670	PERIODIC ORTHODONTC TX VISIT	MAXFEE	DEF					261.94	7/1/2008	12/31/2299	Y
D8680	ORTHODONTIC RETENTION	MAXFEE	DEF					205	7/1/2008	12/31/2299	Y
D9220	GENERAL ANESTHESIA	MAXFEE	DEF					95.65	7/1/2008	12/31/2299	N
D9610	DENT THERAPEUTIC DRUG INJECT	MANUAL	DEF					NA	NA	NA	N
D9999	ADJUNCTIVE PROCEDURE	PADOLR	DEF					NA	NA	NA	Y
T1015	CLINIC SERVICE	PRXOVR	DEF					NA	NA	NA	N
T1015	CLINIC SERVICE	UCCENC	UC2					NA	NA	NA	N
Y7255	SURGICAL REMOVAL OF SUPERNUMERARY	MANUAL	DEF					NA	NA	NA	N

EXHIBIT 44

Appendix A

Acquiring management services agreements (MSAs) in September 2006, CSHM contends that it does not own dental centers.[1] Rather, CSHM has insisted it is a mere provider of "management services" such as "billing, accounts receivable, payroll and human resources, purchasing, lease negotiations, legal, compliance, orientation programs, marketing, and taxes."[2] CSHM also asserts that it provides "business, administrative and other 'back office' services" that includes "loans and assistance to the centers for the costs and services needed to develop and open the centers."[3]

Furthermore, the MSAs contractual language goes to great lengths to assert that "owner dentists," and not CSHM, maintain control over the actual practice of dentistry. Labeling CSHM and the "owner dentist" as "provider and purchaser, respectively, of services," "owner dentists" under the MSAs are to always retain "ultimate authority, control and direction" of the dental practice.[4] The MSAs also declare that CSHM "shall not have the authority to manage, direct, perform, supervise or oversee any matters constituting the practice of dentistry," nor "direct or interfere with the independent judgment of the Clinic's dental staff in the performance of their professional duties."[5] Lastly, CSHM is forbidden from "employ[ing], leas[ing], hir[ing], contract[ing] with or supervis[ing], [and] hav[ing] any responsibility . . . with respect to the actions . . . of, any Clinical Staff or personnel who attend, practice, provide clinical, dental or professional services or have privileges at or in the Clinic."[6]

The MSAs also rightly articulate that the practice of dentistry is the sole purview of the "owner dentist":

---

[1] *See* Letter to Senators Baucus and Grassley, from King & Spalding attorney Theodore Hester at 1-2 (Nov. 29, 2011) (Exhibit 5).
[2] Letter to Senators Baucus and Grassley, from King & Spalding attorney Theodore Hester at 1 (Nov. 29, 2011) (Exhibit 5).
[3] Letter to Senators Baucus and Grassley, from King & Spalding attorney Grace Rodriguez at 4 (Dec. 16, 2011).
[4] Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 1 (Oct. 1, 2010) (Exhibit 6).
[5] *Id.* at 2.
[6] *Id.* at 3.

> Practice shall be solely responsible for the employment and *supervision of the Clinic's Clinical Staff*, the *delivery of professional services* to the Clinic's patients, all decisions concerning the *course of care and types of dental services* to be provided to each Clinic patient, and all decisions concerning the drugs, equipment and supplies to be used in treating each Clinic patient. Practice shall also have authority over all non-clinical decisions pertaining to the management of the Business that represent the practice of dentistry, including, without limitation, the *scheduling of the Clinic's patients and staff*, decisions concerning the purchase of equipment, drugs and supplies for the Clinic . . . and decisions concerning repairs and capital improvements.[7]

Despite CSHM's representations and normative contractual language,[8] corporate structure, everyday operations of Small Smiles clinics, and the terms of the CIA tell a drastically different story about the relationship with CSHM.

First, CSHM's "management fee" appears to go beyond that to which an administrative provider would be entitled. Under the terms of MSAs, each month a dental clinic must pay CSHM *the greater of*: (i) $175,000; *or* (ii) 40% of the "Gross Revenues";[9] *or* (iii) **100% of the "Residual."**[10] "Residual" is defined as "the Gross Revenues and income *of any kind derived, directly or indirectly, from the Business* . . . based on the net amount actually collected after taking into account all refunds, allowances, and discounts."[11] Notably, "residual" excludes "owner dentist" or staff compensation and benefits (and other expenses).[12] Therefore, at a minimum for any given month, CSHM is collecting a $175,000 management fee from dental clinics, even if the clinic loses money. However, for banner months CSHM is poised to reap 100% of a clinic's gross revenues and income, minus "owner dentist" and staff salaries and benefits.

---

[7] *Id.* at 6 (emphasis added).
[8] *But see id.* at 9. Despite its de-emphasizing and characterization of CSHM's role, the MSAs cite "the considerable business risk assumed by [CSHM] in providing the items and services that are the subject of this Agreement," and that CSHM "will incur substantial costs and business risks in providing or arranging for the Services."
[9] *See* Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 8 (Oct. 1, 2010) (Exhibit 6). ("Gross Revenues shall mean all fees and charges recorded or booked on an accrual basis each month by or on behalf of Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice or the Clinic, less a reasonable allowance for uncollectable accounts, professional courtesies and discounts.").
[10] *See id.* (emphasis added).
[11] *Id.* at 9 (emphasis added).
[12] *Id.*

Second, despite their title, "owner dentists" have no actual equity in their respective dental practices. Per executed buy-sell agreements, an "owner dentist" may not sell, assign, transfer or bequeath his/her practice without the express consent of Small Smiles Corporation.[13] Moreover, the buy-sell agreements state that should any of the following "Event[s] of Transfer"[14] occur, a Small Smiles representative is entitled to buy all of the "owner dentist's" ownership interests: owner's death; owner's loss of dentistry license; owner's loss of professional liability insurance, and *termination or end of owner's employment with Small Smiles or CSHM.*[15] Per an executed "stock pledge agreement" with CSHM, "owner dentists" may not issue additional shares of capital stock from their clinic without CSHM's prior express written consent which is ultimately at the discretion of CSHM.[16] Stock pledge agreements also state that an "owner dentist" may not amend, alter, terminate or supplement the clinic's Articles of Incorporation, corporate Bylaws, and other vital documents without the prior express written consent of CSHM.[17] Furthermore, despite the MSAs language, "owner dentists" may not determine the clinical schedule or the number of patients to be seen per day.[18] Nor may "owner dentists" hire or fire employees or purchase new clinical equipment without first receiving approval from CSHM.[19]

---

[13] CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] 1 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8); *see also* Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

[14] *See, e.g.,* CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 2-3 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8) (exhaustive list of "Event[s] of Transfer").

[15] *Id.* at 2 (emphasis added).

[16] CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Stock Pledge Agreement with [REDACTED] at 3 (Oct. 1, 2010) (CSHM-00000959) (Exhibit 65).

[17] *Id.*

[18] *See, e.g.,* e-mail from Dr. [REDACTED] to Dr. [REDACTED] (May 19, 2011, 4:57 pm) (Exhibit 9).

[19] *See id.*; *see also* Robinson-Warner Interview (Mar. 7, 2012).

Third, under the terms of the CIA, CSHM must be deeply involved with overseeing the employment and supervision of clinical staff, and interfere with the independent professional judgment of Small Smiles dentists. CSHM is thus required to implement written policies and procedures to ensure delivery of patient services comport with professionally recognized standards of care with respect to "patient safety, appropriate patient assessment and treatment planning . . . appropriate *anesthesia guidelines* for pediatric dental patients, appropriate *behavior guidance* approaches for the pediatric dental patient, including dental team behavior, dentist behavior, communications, *patient assessment*, barriers, and deferred treatment, and advanced behavior guidance techniques for the pediatric dental patient, including *protective stabilization*, *sedation*, *general anesthesia*, and contraindications for each technique."[20] Moreover, CSHM must create an "Internal Audit Program" tasked with "performing internal quality audits and reviews[21] and enforce a "Code of Conduct" that articulates, among other issues, the consequences for non-complying dentists.[22] While the aims of the CIA are admirable, CSHM, a self-proclaimed provider of "management services", should arguably not be involved in the implementation of policies and procedures which are so inextricably tied to a dentist's exercise of independent professional judgment.

We believe that the operative facts speak for themselves. "Owner dentists" have wrongly ceded control of their dental practices in form and substance, while corporate providers of "management services" take full advantage of such concessions. The Committees have attached an informative survey of state laws relating to the corporate practice of dentistry.[23] Unless and until states enforce their existing laws against various manifestations of corporate dentistry, our most vulnerable citizens will continue to receive substandard care of questionable medical necessity, while the American taxpayer is ultimately left to foot the bill.

---

[20] Corporate Integrity Agreement Between the Office of Inspector Gen. of the Dep't of Health & Human Serv. and Forba Holdings, LLC, at 12-13 (Jan. 14, 2010) (Exhibit 3) (emphasis added).
[21] *Id.* at 10.
[22] *Id.* at 11-12.
[23] *See generally* JIM MORIARTY & MARTIN J. SIEGEL, SURVEY OF STATE LAWS GOVERNING THE CORPORATE PRACTICE OF DENTISTRY (2012) (Exhibit 44).

EXHIBIT 45

THE ROAD TO THE SUPER BOWL

January

There will be 3 Conferences and 9 Divisions with 9 Divisional Coaches

Western Conference	**Division Coaches**
Western Division One	[redacted] (Denver, Aurora, Tulsa, OKC1, Topeka, OKC2, Omaha)
Western Division Two	[redacted] (Colorado Springs, Alb 1, Phoenix, Tucson, KCK, Reno)
Western Division Three	[redacted] (Pueblo, Santa Fe, Thornton, Wichita, Boise, Alb 2)

Central Conference	**Division Coaches**
Central Division One	[redacted] (Rochester, Lawrence, Mattapan, Cinci, Ft.Wayne, Toledo)
Central Division Two	[redacted] (Gary, Indy 2, Syracuse, Roselawn, Lynn)
Central Division Three	[redacted] (Indy 1, Springfield, Columbus, Albany, Worcester, Dayton)

Eastern Conference	**Division Coaches**
Eastern Division One	[redacted] (Atlanta, Augusta, Richmond, Myrtle Beach, Baltimore)
Eastern Division Two	[redacted] (Columbia, Florence, Savannah, Roanoke)
Eastern Division Three	[redacted] (Greenville, Charleston, Macon, Spartanburg, Washington DC)

What's the goal?

The ROAD TO THE SUPER BOWL is designed to improve clinic team work and create positive working environments, while delivering outstanding patient care, improving children's health and self esteem and rewarding those who best deliver on our stated goals and Mission Statement.

What are the rules?

Each clinic will earn points each week for achieving their goals in the following categories…

Average Broken Appointment Rate	=	3 points (field goal)
Average # of Patients per Day	=	6 points (touch down)
Average $ Production per Patient per Day	=	3 points (field goal)
Average Daily Production	=	6 points (touch down)

EXTRA POINTS:

- When a clinic achieves 3 of 4 weekly goals they will be awarded 1 point ('extra point')
- When a clinic achieves 4 of 4 weekly goals they will be awarded 2 points ('two point conversion')

FORBA 0230059
CONFIDENTIAL

"GRASS ROOTS" BONUS POINTS:
Your clinic can earn bonus points for Dental Screening, Oral Hygiene Presentations and Site Visits.
3 points (field goal) for every **site visit**
3 points (field goal) for every **dental screening**
3 points (field goal) for every **oral hygiene presentation**

Examples:

Agencies, Events, Locations, Organizations, Facilities, etc.	Site Visits	Dental Screening	Oral Hygiene Presentations
Head Start		X	X
Schools	X	X	X
Health Fairs		X	X
Foster Care Meetings		X	X
Churches	X	X	X
Day Care Facilities	X	X	X
Social Services Department	X		
Government Agencies	X		
Dental Practices	X		
Medical Practices	X		

NOTE: See Grass Roots instructions (attached) for reporting completed events to earn points.

Points will be awarded to each clinic at the end of each week and points will accumulate for the month to determine **6 Divisional Champions, 2 Conference Champions** and **1 Super Bowl Champion** at the end of the month.

Who is eligible for this contest?
Everyone!!!

What do we win?
Divisional Champions – Will receive a **2007 Division Champion Trophy** and
ALL EMPLOYEES in clinic will win **$250.00**
Conference Champions – Will receive a **2007 Conference Champion Trophy** and
ALL EMPLOYEES in that clinic will win **$500.00**
Super Bowl Champions - Will receive a **2007 Super Bowl Champion Trophy** and
ALL EMPLOYEES in that clinic will win **$1,000.00**

***Note:** clinics must have at least 30 points total for the month to win.*

How will we know how we're doing on The Road to the Super Bowl?
We will take care of all that! [redacted] will provide everyone with weekly Super Bowl updates every Monday. All you need to do is focus on the game and WIN!!!

Good Luck and have FUN!!!

FORBA 0230060
CONFIDENTIAL

THE ROAD TO THE SUPER BOWL

Instructions for Reporting Grass Roots Events

In order to provide the high-quality care to children and youth who need it most, we need to be letting our communities know what our mission is through effective grass roots marketing. During the Road to the Super Bowl, we would like to reward and encourage you for doing what we hope you are already doing on a consistent basis.

If you complete an event during the month of January that falls into the Grass Roots categories for the Road to the Super Bowl, please send me an email so that I can give you credit for the proper number of Bonus Points. Please include the following information in your message:

- Event category
- Location of event
- Name and phone number of a contact person (I will follow up with the contact person to see how the event went)

Definitions of Qualifying Events – *if you have any questions about whether a specific event would qualify, please email me.*

Site Visit: a visit to your clinic/practice by an agency representative (Head Start, school nurse, Social Services Department, dental or medical practices, etc.) for the purpose of them seeing the facility and the way that you treat your patients so that they will be encouraged to refer patients to you.

Dental Screening: going to another location to do a dental screening on children or young adults, giving them information about your clinic/practice, and encouraging them to come visit you for an exam and cleaning.

Oral Hygiene Presentation: going to another location to do an oral hygiene presentation (health fairs, schools, etc.) and giving out information about your clinic/practice.

Please let me know if you have any questions.

Thank you,

[redacted]

FORBA 0230061
CONFIDENTIAL

Divisional Coaches Conference Call Minutes
12/27/06

Please call your leadership teams (Lead Dentist, Office Manager, and Lead Dental Assistant) in your division on Friday to give them their goals, get them excited about the contest (!!!!), and answer any questions they might have. Please be sure that they understand how they can earn points, extra points, and bonus points. *Remind them that every employee in the clinic is eligible to be a part of the contest and win!* **Whatever they win will be above and beyond their salaries and regular bonuses.**

The BA rate percentage goal was calculated by taking the clinic's average BA rate for 2006 through November and subtracting 2% points. If the clinic wasn't open for the whole year, we took the average of just the months that they were open. The BA rate was calculated by taking the broken appointments and reschedules and dividing them by the total original appointments (number of patients seen, broken appointments, and reschedules). All of the other numbers for their goals are the same numbers as their monthly budget for January. These budget numbers were derived from looking at past trends and from communication at the budget meetings.

[redacted] will update the tracking sheets and send them to the divisional coaches weekly (the clinics will never see the goals for any of the other clinics). [redacted] will also track the grass roots events and points. She will ask the Office Managers to copy their divisional coaches and SVP's of Operations when they email her about their grass roots events.

Divisional coaches should email their clinics at least once a week with an update on where they stand in the contest. This update would most likely consist of a generic email to the clinics in their division that would summarize the points that each clinic has earned. These emails should be sent to the entire clinic leadership teams. *Please also copy* [redacted] *on all communication emails so that he can see the number of updates going out to the teams.*

[redacted] will send you a report every Friday that tracks trends in the clinics. You can gain valuable information from the reports and will be able to use this information in conversations with your clinics. Contact the clinics in your team at least every other day. The contest by itself produces no results; it merely provides a vehicle for communication with the clinics. Have as much phone interaction as possible with all the members of the leadership team in the clinic to ensure that there is effective communication and that every member of the team knows how to motivate and encourage their area of influence in the clinic. The more you can communicate, the better, because it shows them that we care.

Important points to remember:

- Be positive and enthusiastic – let clinics know that the goals *are* attainable and that they are *all* eligible to win
- Communication is the key – contact your clinics often and keep them updated on where they stand
- Encourage the leadership team to get everyone in the clinic involved

FORBA 0230062
CONFIDENTIAL

FORBA

THE ROAD TO THE SUPER BOWL

To: Road to the Super Bowl Teams
From: [redacted]
Cc: Divisional Coaches
Re: Road to the Super Bowl Recognition

Road to the Super Bowl Teams,

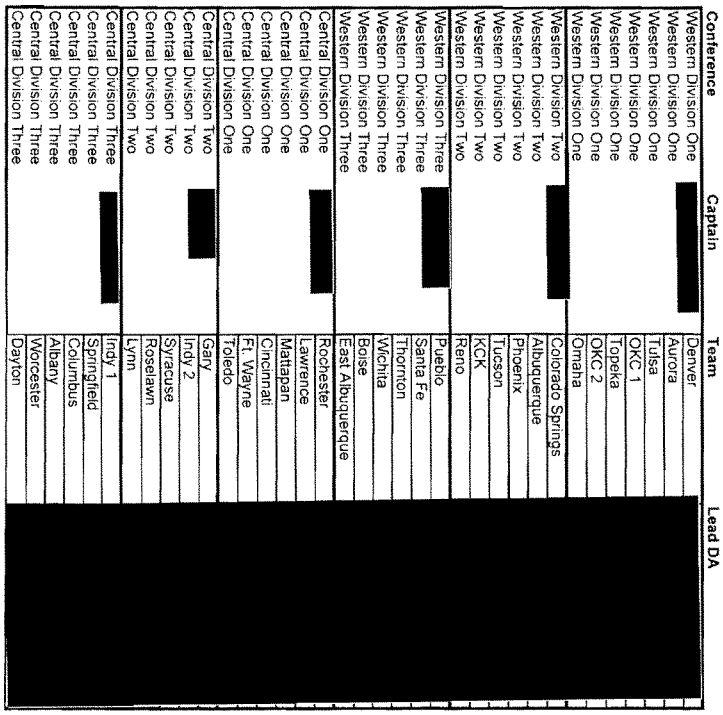
We want to express our appreciation for all of your hard work and team efforts during the month of January for the Road to the Super Bowl. We have heard many positive reports about how you have used this as an opportunity to foster team spirit and that through this your employees have gained a renewed passion for their work. Even though the Road to the Super Bowl has been completed, we hope that all of you will continue to think of creative ways to reach out to your communities to let them know that you are here to serve the underserved children in their midst.

Although we only have a limited number of prizes to give out, we know that all of you worked hard to achieve your goals, so all of you are winners in our eyes. Stay focused on your goals and the mission of providing quality dental service in a timely manner to low-income children to enhance their health and self-esteem. Thanks again for the extra efforts that you have put into this.

Sincerely,

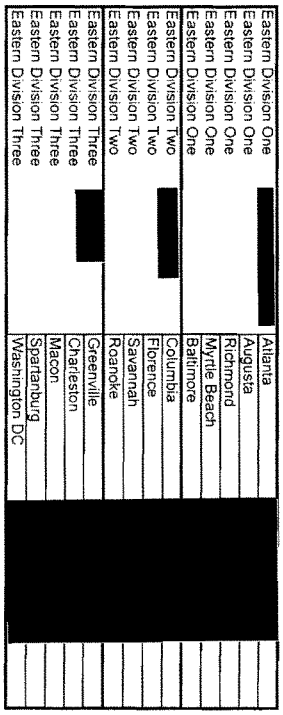
[redacted]

FORBA 0230063
CONFIDENTIAL



Conference	Captain	Team	Lead DA
Western Division One	[redacted]	Denver	[redacted]
Western Division One		Aurora	
Western Division One		Tulsa	
Western Division One		OKC 1	
Western Division One		Topeka	
Western Division One		OKC 2	
Western Division One		Omaha	
Western Division Two	[redacted]	Colorado Springs	
Western Division Two		Albuquerque	
Western Division Two		Phoenix	
Western Division Two		Tucson	
Western Division Two		KCK	
Western Division Two		Reno	
Western Division Three	[redacted]	Pueblo	
Western Division Three		Santa Fe	
Western Division Three		Thornton	
Western Division Three		Wichita	
Western Division Three		Boise	
Western Division Three		East Albuquerque	
Central Division One	[redacted]	Rochester	
Central Division One		Lawrence	
Central Division One		Mattapan	
Central Division One		Cincinnati	
Central Division One		Ft. Wayne	
Central Division One		Toledo	
Central Division Two	[redacted]	Gary	
Central Division Two		Indy 2	
Central Division Two		Syracuse	
Central Division Two		Roselawn	
Central Division Two		Lynn	
Central Division Three	[redacted]	Indy 1	
Central Division Three		Springfield	
Central Division Three		Columbus	
Central Division Three		Albany	
Central Division Three		Worcester	
Central Division Three		Dayton	

FORBA 0230064
CONFIDENTIAL



FORBA 0230065
CONFIDENTIAL

EXHIBIT 46

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the
Inspector General

[redacted], J.D.
Compliance Officer
Church Street Health
Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Clinic Report
Desk Audit
Small Smiles Dental Center of Worcester, LLC

Deliverable #1-14

January 4, 2011

Executive Summary

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), a Tennessee corporation (formerly FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Center of Worcester, LLC (Clinic), 290 Park Avenue, Worcester, Massachusetts, 01609.

Overall Summary of Critical Findings and Observations

[redacted] preformed re-review of 25 records previously reviewed by CSHM as part of their internal audit program. The purpose of the desk audit conducted by [redacted] was to test the effectiveness of CSHM in monitoring its Clinics and ensuring appropriate quality of care. The following highlights the critical findings from the Monitor's review of 25 records that CSHM audited during the third quarter of 2010.

Each of the five dentists received a lower score under the Monitor's review compared to the CSHM audit, with three dentists failing. The overall Clinic score assessed by the Monitor was also was lower than the CSHM audit score.

The Monitor determined that two records (patients #004 and #011) did not have sufficient documentation to support the medical necessity for the treatment provided. In addition, the Monitor determined that two records (patients #006 and #025) did not have proper consent for the procedures rendered. The CSHM audit addressed the finding in patient #025 and requested the Clinic make the appropriate refund.

HIPAA forms are not completed or completed incorrectly and the CSHM auditors are not including this in their findings.

The CSHM auditors are not making findings related to the Tooth Charts being completed incorrectly. Specifically, the Clinic is not documenting existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms.

CSHM auditors are auditing forms that are outside the audit date range or relate to another dentist/provider who is not the subject of the audit.

The *Guidelines for Chart Audit Scoring* specifies that additional guidance will be supplied to determine when a medical alert or per-med sticker should be affixed to the Tooth Chart. Such guidance has yet to be supplied, therefore, the CSHM auditors should not be making any "no" findings at this time.

The Monitor noted that the CSHM auditors periodically use an asterisk in addition to a "yes" or "no" response. This practice results in the testing attribute not being included in the overall score. The *Guidelines for Chart Audit Scoring* does not specify when an asterisk is appropriate.

Overall Summary of Recommendations

Set forth below are the recommendations contained in the report:

- Ensure staff members provide all requested materials that meet quality standards and can be reviewed, including diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are verifying that HIPAA forms are completed correctly by the parent/guardian.
- Ensure Health History forms are correctly completed with explanations to all "yes" answers.
- Ensure staff members clearly and accurately document existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart.
- Ensure staff members are correctly completing all sections of the Hygiene Procedures form, the Treatment Plan, and the Op Sheet.
- Ensure staff members are verifying that consent has been received for all diagnosed treatment and that additional written consent is received prior to performing any modifications in the original Treatment Plan.
- Provide additional training to CHSM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas where there were Monitor findings but no corresponding CHSM findings.
- Ensure CSHM auditors are correctly using the *Guidelines for Chart Audit Scoring* when determining how to respond to the question related to whether a medical alert or per-med sticker should be affixed to the Tooth Chart.
- Provide written guidance about the proper use of the asterisk and the effect on the overall score.
- Ensure that forms audited by CSHM are within the audit date range and pertain to the selected provider/dentist and include operative procedures in order to obtain the most accurate quality assessment of the provider/dentist.
- Determine the reason that the Monitor could not validate CSHM's findings related to the unsigned *Local Anesthesia and Nitrous Oxide Consent Forms* dated June 23 and 28, 2010, for patient #010.
- Provide color copies of Tooth Charts to allow for accurate review of documentation during chart audits conducted by CSHM and the Monitor.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), a Tennessee corporation (formerly FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Center of Worcester, LLC (Clinic), 290 Park Avenue, Worcester, Massachusetts, 01609.

Implementation

The OIG approved a desk audit to be performed on Small Smiles Dental Center of Worcester, LLC. The Monitor mailed a notice announcing the desk audit to the Clinic and to CSHM's Compliance Officer on October 29, 2010, requesting records from the Clinic and the findings from the chart audit from CSHM, including the audit tool, the instructions and training provided, names of reviewers and their credentials, review notes, calculations used to determine results, any Corrective Action Plans (CAPs) and rationale for imposing them. The Monitor received the documentation from the Clinic and CSHM on November 8, 2010. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the third quarter of 2010
  - E-mail to the Clinic with results for the third quarter audit
  - Third quarter audit spreadsheet
- Twenty-five charts from the Clinic that were the basis for the chart audit
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by Shawn Massey, RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - Chart audit
    - Guidelines for chart audit scoring
    - Methodology for calculating individual dentist chart audit scores

- Crosswalk-concordance of audit tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinic Guidelines

CSHM's initial request to the Center for charts was July 12, 2010. The charts were provided on July 20, 2010. The chart audit was completed by July 29, 2010. The chart audit was conducted by a dental hygienist with a current license. CSHM indicated that the findings revealed that the Clinic and all dentists passed the audit and therefore there was no need to impose a CAP.

Scope of Desk Audit

The scope of this desk audit is to review the chart audit conducted by CSHM during the third quarter of 2010 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 6 of the 25 visit records reviewed.

Review of CSHM Chart Audit

Twenty-five records were reviewed, five for each dentist, following the *Clinical Guidelines and Quality Assurance Protocol* (QAP) metrics as outlined in the *Quality Assurance Protocols and Guidelines for Dental Centers for whom FORBA provides Management Services*. The Monitor reviewed the same documents and X-rays when possible and used CSHM's chart audit tool in order to conduct the desk audit.

The following comparison table shows the Clinic and individual dentist scoring differences between the Monitor and CSHM.

	Monitor Score	CSHM Score
Clinic Audit Score	**91%**	**98%**
[redacted]	92%	100%
[redacted]	98%	100%
[redacted]	88%	98%
[redacted]	87%	100%
[redacted]	89%	97%

The following is a summary of the findings pertaining to the records reviewed for each dentist. The question number in each table corresponds to the question in the chart audit tool. The findings reported by CSHM are taken verbatim from the e-mail responding to the Clinic with the chart audit results. If there were no findings by CSHM, the table was left blank. The Monitor completed the chart audit and then compared the findings to the findings reported by CSHM. After the comparison of the chart audit results, additional findings were made by the Monitor and are also included in the following tables.

[redacted]

Patient #001		
Question	Monitor's Findings	CSHM's Findings
#15	The Health History form had no explanation for the "yes" answer given for allergies.	Nice job
#38	The documentation of sealants on the Hygiene Procedures form was recorded incorrectly. The teeth that were "opened" and sealed during the restorative procedure and listed on the Operative Procedures form (Op Sheet) were added to the Hygiene Procedures form by the dentist. Therefore, teeth #3, 5, and 14 were listed on the Hygiene Procedures form and the Op Sheet. The record appears to have had correct documentation of the sealants placed during the hygiene procedure, prior to the dentist's modification.	

Patient #002		
Question	Monitor's Findings	CSHM's Findings
#10	The *Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian* (Health Insurance Portability and Accountability Act, or HIPAA form) was incomplete. Only the Acknowledgement of Receipt of Notice of Privacy Practices was signed.	
#18-24 and #27-38	Both the Hygiene Procedures form and the Tooth Chart were dated October 9, 2009, and outside of the audit date range. According to the *Guidelines for Chart Audit Scoring*, "n/a" is used when the requested material is outside of the audit date range. The Monitor recorded "n/a" in	

	the sections for the Tooth Chart and Hygiene Procedures Form due to these guidelines; however, the guidelines prevent the reporting of findings related to no documentation of the patient's current oral conditions at the time of service. The Hygiene Procedures form that was scored by CSHM's auditor was not only outside of the audit date range, but also completed by a different dentist. CSHM's auditor scored both the Tooth Chart and Hygiene Procedures form but failed to note that the upper odontogram of the Tooth Chart was missing documentation regarding trauma to teeth #7-10. Had this omission been noted by the auditor, the score would have been impacted.	
#53	Patient reported to the Clinic for emergency treatment of teeth #7-10. No Limited Oral Exam or Emergency was noted on the Op Sheet.	
#60	The most recent Tooth Chart, dated October 9, 2009, did not record the condition of teeth #7-10 or the provided treatment. Therefore, the Treatment Plan and the Op Sheet did not match the Tooth Chart. A new tooth chart was not completed on the date of service.	O-Sheet-(5/28/2010) surfaces and procedures match the TX-Plan. Do not match the tooth chart. These teeth are not documented on a tooth chart for TX. If this was an emergency why was an LOE chart or a recall exam done?
#68	X-rays were not labeled right and left.	

Patient #003		
Question	Monitor's Findings	CSHM's Findings
#21	The Tooth Chart did not document decay on the mesial (M) of tooth #L.	Nice job
#27-38	The Hygiene Procedures form dated May 3, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	

Patient #004		
Question	Monitor's Findings	CSHM's Findings
#60	The lower odontogram on the Tooth Chart does not document the extraction of the root tip of tooth #I.	Nice job
#7, #72	The Op Sheet states a digital picture was taken of the root tip of tooth #I; however, the picture was not sent with the requested materials and the root tip was not visible on the radiograph. Therefore, the Monitor was unable to verify medical necessity or correct billing and coding for the extraction of tooth #I.	

Patient #005		
Question	Monitor's Findings	CSHM's Findings
#10	The HIPAA form was incomplete. Only the Acknowledgement of Receipt of Notice of Privacy Practices was signed.	Nice job
#21	The upper odontogram of the Tooth Chart does not document decay on tooth #10, the distal (D) and lingual (L) of tooth #9, and the mesial (M) and lingual (L) of tooth #11.	
#27-38	The Hygiene Procedures form dated April 9, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#68	X-rays were not labeled right and left.	
#7, #71 and #73	No account summary was sent with the requested materials; therefore, the Monitor was unable to verify accurate billing and whether the services were billed under the correct provider.	

[redacted] Small Smiles Dental Center of Worcester, LLC

[redacted]

Patient #006		
Question	Monitor's Findings	CSHM's Findings
#27-38	The Hygiene Procedures form dated May 3, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	No comments
#43	The Treatment Plan did not list any tooth surfaces for teeth #K and #L. The treatment description for tooth #L on the Treatment Plan only listed "poss pulp" and did not include a stainless steel crown (SSC); therefore, there was no consent for the SSC performed on tooth #L.	
#60	The lower odontogram of the Tooth Chart did not record the pulpotomy performed on tooth #L.	

Patient #007		
Question	Monitor's Findings	CSHM's Findings
	No findings	Nice job

Patient #008		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form.	Nice job
#27-38	The Hygiene Procedures form dated June 22, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#59	The Op Sheet documents that treatment time was longer than one hour without explaining why.	
#71	The surfaces billed for tooth #8 were listed as "DFLD" on the Account History Report instead of "MFLD" as documented on the Op Sheet.	

Patient #009		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form.	
#27-38	The Hygiene Procedures form dated June 14, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#60	The occlusal buccal (OB) tooth surfaces listed on the Op Sheet for tooth #K do not match the mesial occlusal buccal (MOB) surfaces documented on the Tooth Chart and the Treatment Plan. The lower odontogram on the Tooth Chart did not document the pulpotomy performed on tooth #K.	
#65	The Monitor did not report this finding because it involved documentation on a form that did not apply to this dentist and was not audited.	X-rays-(6/14/2010)-Clinician taking the x-ray film not documented.

Patient #010		
Question	Monitor's Findings	CSHM's Findings
#15	Questions on the Health History form were not completed regarding an explanation for the "yes" answers given for asthma and medications.	Health-HX-(6/23/2010) HX – questions answered "yes" need supporting explanations in the "if you answered 'Yes' to any of the above, please explain:" section
#19	The Tooth Chart did not have a medical alert sticker; however, according to the Guidelines for Chart Audit Scoring, "'No' is not being given at this time because it has not been determined what medical conditions require an alert sticker. [This is being reviewed by [redacted] and [redacted].]" The guidelines further instruct the auditor to use "N/A when a medical condition is noted on the health history but a sticker is not placed on tooth chart."	Tooth-Chart-(6/23/2010) No visible health sticker for documented health condition.

[redacted] Small Smiles Dental Center of Worcester, LLC

#27-38	The Hygiene Procedures form dated June 23, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#46	The Monitor did not find CSHM's finding regarding the Local Anesthesia and Nitrous Oxide Consent Form. The Monitor reviewed two forms, dated June 23 and 28, 2010, and both forms, were signed by a witness and dated respectively. This leads the Monitor to question whether the signature and date were added after CSHM performed the chart audit.	Local Anesthesia and Nitrous Oxide Consent Form-(6/23/2010)-Witness did not sign the form.
#60	The lower odontogram on the Tooth Chart did not document the pulpotomy performed on tooth #I.	
#68	X-rays were not labeled right and left.	
#71	The Account History Report showed billing on June 23, 2010, for a Limited Oral Exam by this provider as well as a Periodic Oral Exam by another provider. According to the Monitor's pediatric dentist, there is no justification to bill for two exams on the same date of service.	

[redacted]

Patient #011		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form.	Nice job
#27-38	The Hygiene Procedures form dated June 03, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#41	The Monitor's pediatric dentist reviewed the X-rays and found insufficient evidence to support the	

	medical necessity for the pulpotomy performed on tooth #K. The overlap between tooth #H and #I make it difficult to determine the radiographic evidence for the pulpotomy on tooth #I. The radiograph shows a peculiar resorptive lesion at the distal cemento-enamel junction of tooth #I that was not diagnosed.	
#45	The Crown Options section of the Treatment Plan had "n/a" in the SSC box and was not initialed by the parent.	
#68	X-rays were not labeled right and left.	

Patient #012		
Question	Monitor's Findings	CSHM's Findings
#14	CSHM's finding was recorded on the audit tool for question #14, but applies to question #15.	Health-HX – questions answered "yes" need supporting explanations in the "if you answered 'Yes' to any of the above, please explain:" section.
#15	The Health History form question regarding an explanation for the "yes" answer given for asthma was not completed.	
#21	The upper odontogram on the Tooth Chart did not document decay on tooth #H.	
#27-38	The Hygiene Procedures form dated March 12, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#46	The Local Anesthesia and Nitrous Oxide Consent form did not include the date by the parent's signature.	Local Anesthesia and Nitrous Oxide Consent Form-(5/11/2010) Parent did not date form.

Patient #013		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA authorization form.	

#20	Upon review of the X-rays, the Monitor noticed the existence of a mesiodens on the maxillary occlusal radiograph and there was no documentation of this finding in the patient's record.	
#21	The upper odontogram on the Tooth Chart did not document decay on tooth #H.	
#27-38	The Hygiene Procedures form dated June 25, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#58	The Op Sheet's Stabilization form did not include documentation for the outcome of stabilization.	OP-Sheet-Stabilization form-(6/28/2010)-outcome of stabilization not properly documented.

Patient #014		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA authorization form.	
#21	The upper odontogram on the Tooth Chart did not document decay on tooth #M.	
#27-38	The Hygiene Procedures form dated May 3, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#60	The tooth surfaces (OB) listed for tooth #K on the Treatment Plan do not match the surfaces (MODBL)[1] listed on the Op Sheet. The lower odontogram on the Tooth Chart did document the treatment to the distal, facial, and lingual (DFL) of tooth #M.	OP-Sheet-(6/11/2010)-surfaces and diagnosis on op-sheet properly documented? Yes. Match tooth-chart and TX-plan? No. TX plan has no surfaces of decay properly documented. Surfaces that are involved with decay should be indicated in three places: (1) on the top odontogram of the Tooth Chart, (2) on the TX Plan, and (3) on the Op Sheet. Please be sure to mark

[1] Mesial occlusal distal buccal lingual

		surfaces in all three places.

Patient #015		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form.	No comments
#27-38	The Hygiene Procedures form dated May 10, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#65	The Hygiene Procedures form did not document the person who took the radiographs.	

[redacted]

Patient #016		
Question	Monitor's Findings	CSHM's Findings
#32	X-rays were not taken during the June 29, 2010, hygiene appointment, and there was no documentation explaining why on the Hygiene Procedures form.	
#65	The Monitor recorded "n/a" in the audit tool for this question since no x-rays were taken on the date of service being audited.	X-rays-(6/29/2010)-clinician taking x-ray film not documented.

Patient #017		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form. CSHM recorded "n/a" on the audit tool spreadsheet for question #10.	Nice job
#18	A Caries Risk Assessment was not documented on Tooth Chart dated June 1, 2010.	
#27-38	The Hygiene Procedures form dated June 1, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not	

	audit the form.	

Patient #018		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form. CSHM recorded "n/a" on the audit tool spreadsheet for question #10.	Nice job
#21	The upper odontogram on the Tooth Chart dated April 19, 2010, did not document the buccal (B) caries on teeth #30 and #31.	

Patient #019		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form. CSHM recorded "n/a" on the audit tool spreadsheet for question #10.	
#15	The Health History form dated June 25, 2010, did not have explanations for "yes" answers to allergies and anemia.	
#27-38	The Hygiene Procedures form dated June 25, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	Hygiene Page (6/25/2010)-Chief complaint not documented.
#54	The Nitrous Oxide section was not completed on the June 30, 2010, Op Sheet. Neither the "Y" nor the "N" was circled, and there was no line marked through the box.	

Patient #020		
Question	Monitor's Findings	CSHM's Findings
#20	The Tooth Chart dated January 12, 2010, did not document existing conditions and restorations on the upper odontogram.	No comments
#21	The upper odontogram of the Tooth Chart did not document decay on tooth #S.	

#27-38	The Hygiene Procedures form dated January 12, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	
#60	The Treatment Plan did not list the tooth surfaces for tooth #S.	
#63	The Op Sheet did not document a diagnosis, such as Carious Pulp Exposure (CPE), to support the medical necessity for the pulpotomy performed on tooth #S.	
#68	X-rays dated January 12, 2010, and July 14, 2010, were duplicated and labeled incorrectly.	

[redacted]

Patient #021		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form. CSHM recorded "n/a" on the audit tool spreadsheet for question #10.	
#15	No explanation was documented for the "yes" answers to asthma and allergies on the May 6, 2010, Health History form.	Health HX Page- HX – questions answered "yes" need supporting explanations in the "if you answered 'Yes' to any of the above, please explain:" section
#19	The Tooth Chart did not have a medical alert sticker; however, according to the Guidelines for Chart Audit Scoring, "'No' is not being given at this time because it has not been determined what medical conditions require an alert sticker. [This is being reviewed by [redacted] and [redacted].]" The guidelines further instruct the auditor to use "N/A when a medical condition is noted on the health history but a sticker is not placed on tooth chart."	Tooth Chart- NO visible sticker for medical conditions/medical allergies.
#28	The occlusion section on the	

	Hygiene Procedures form was not completed.	
#67 and #68	September 11, 2009, X-rays and a May 6, 2010, Panoramic X-ray were diagnostic, correctly duplicated, and labeled. CSHM's audit tool shows that the answer "*no" was given for question #67 regarding the quality of the radiographs. When an asterisk is used before an answer, the answer is not counted in the total responses; therefore, the Monitor and CSHM have a different number of total responses for this patient.	X-rays (9/1/2009) & (5/6/2010). Bite wings were sent labeled backwards.* Pan was too light and not clear. Please mount x-ray film and label correctly
	The lower odontogram on the Tooth Chart documents sealants on additional teeth and does not match the Treatment Plan or the sealants listed on the Hygiene Procedures form. Since this procedure was recorded on the Hygiene form, the Monitor was unable to determine where to score this finding in CSHM's audit tool.	

Patient #022		
Question	Monitor's Findings	CSHM's Findings
#27-38	The Hygiene Procedures form dated May 10, 2010, which was audited by CSHM, was completed by a different dentist; therefore, the Monitor did not audit the form.	Hygiene Page-(5/10/2010)-Signatures and initial box do not match. Two (2) sets of initials three (3) signatures documented.
#65	The clinician who took the May 10, 2010 radiographs was not documented on the Hygiene Procedures form.	X-rays-(5/10/2010) clinician taking x-ray film not documented.

Patient #023		
Question	Monitor's Findings	CSHM's Findings
#31	No hygiene services were performed; therefore, an "n/a" was given by the Monitor for question #31. According to the January 8, 2010, Hygiene	No comments

	Procedure form, the father reported the patient had a "prophy and fluoride treatment on October 14, 2009, somewhere else." CSHM's audit recorded a "yes" for question #31 indicating that proper prophylactic measures and fluoride were noted correctly.	

Patient #024		
Question	Monitor's Findings	CSHM's Findings
#10	The parent/guardian did not complete the HIPAA form.	No comments
#15	The heart murmur question had no answer on the Health History form.	
#21	The upper odontogram of the Tooth Chart did not document decay on teeth #3, #18, and #31.	

Patient #025		
Question	Monitor's Findings	CSHM's Findings
#21	The upper odontogram of the Tooth Chart did not show documentation of decay for tooth #K.	
#27-38	A different dentist completed the Hygiene Procedures form dated June 2, 2010, which was audited by CSHM; therefore, the Monitor did not audit the form.	
#43	The treatment plan did not include pulpotomies in the treatment descriptions for teeth #K and #L. CSHM reported this finding in the e-mail to the Clinic, but did not score it in the audit tool.	
#56	The Op Sheet did not properly document the reason for stabilization.	OP-Sheet-(6/3/2010)-Reason for stabilization not properly documented. Reasons for Behavior Management need to be documented in the notes section of the corresponding Op or Hyg sheet. Specific behavior ("pt thrashing arms", etc) instead of general

		behavior ("patient uncooperative") should be documented as to why the patient needed Protective Stabilization.
#58	The stabilization verification portion of the Consent for Protective Stabilization form dated June 3, 2010, was completed incorrectly. Proper placement was not checked during the 0-15 minute period and there was no documentation of open airway, peripheral circulation or proper placement during the 16-30 minute time period.	
#59	The Monitor was able to see and verify that the operatory time recorded at the bottom of the Op Sheet was less than one hour.	Time in OP-Can't verify time start and end due to poor duplication.
#60	The lower odontogram of the Tooth Chart did not document the pulpotomies performed on teeth #K and #L. In response to CSHM's finding, the Clinic filed a Void Request form with MassHealth on August 9, 2010, for the pulpotomies performed to teeth #K and #L.	Were procedures and diagnosis on op sheet properly documented yes, do they match tooth chart and TX plan? No. Teeth #s K and L were tx-planned for crowns only. There is no documentation for pulps. The fees for the pulps will have to be refunded.
#61	The June 3, 2010, Op Sheet did not have an answer circled for whether a written prescription was given.	
#71	The Account History Report shows a correction was made for the billing of pulpotomies for teeth #K and #L.	Billing-(6/3/2010)-The billing is incorrect. Pulps on teeth #s K and L are not treatment planned. Fees must be returned.

Set forth below is an overall summary of the findings related to the Monitor's re-review of CSHM's audit of the Clinic:

- The Monitor determined that two records (patients #004, and #011) did not have sufficient documentation to support the medical necessity for treatment that was provided. In addition, the Monitor determined that two records (patients #006 and #025) did not have proper consent for the procedures rendered. The CSHM audit addressed the finding related to patient #025 and requested the Clinic make the appropriate refund.

- The Monitor determined that 13 records did not have completed *Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian* (Health Insurance Portability and Accountability Act, or HIPAA) forms. The CSHM audit did not have this finding in the 13 records. In addition, CSHM's audit tool showed "n/a" was entered for four of the thirteen records that the Monitor found to have incomplete HIPAA forms. *The Guidelines for Chart Audit Scoring* states that "yes" is given "when name, address, and telephone number in sections A & B are completely documented and form is signed and dated." The guidelines further state that a "no" is used "when the above is not completed correctly." The HIPAA forms that were found to be incomplete by the Monitor were signed by a witness, but did not have sections A or B completed.
- The Monitor determined that six records contained Health History forms that were completed incorrectly. The CSHM audit found only three of the records were completed incorrectly. Areas that were completed incorrectly included missing answers pertaining to health history questions or follow-up questions pertaining to an illness.
- The Monitor determined, with respect to the Tooth Chart, one record did not have the initial dental evaluation completed; two records did not have existing conditions and/or restorations properly documented on the upper odontogram of the Tooth Chart; and nine records did not show documentation of decay on the upper odontogram of the Tooth Chart. The CSHM audit did not report any of these findings in the audit tool's Tooth Chart section. More significantly, the findings related to the upper odontogram of the Tooth Chart were not scored on questions #20 and #21 of the audit tool spreadsheet, which are considered by CSHM as: *Quality Assurance Protocol (QAP) and Quality Score Items*, and directly affect the dentist's overall chart audit score.
- The Monitor determined that three records did not have correctly completed Hygiene Procedure forms. The CSHM audit had two findings related to Hygiene Procedure forms; however, those forms were completed by another dentist and did not apply to the dentist being audited. CSHM's audit included the review of 17 Hygiene Procedure forms completed by another dentist.
- The Monitor determined that treatment plan procedures were documented incorrectly in the records of Patients #006 and #025. In addition, the record for patient #011 had "n/a" instead of a parent's signature in the boxes designated for crown options. CSHM's only reported findings in the treatment plan section were related to the consent form for local anesthesia and nitrous oxide. The Monitor confirmed only one of the two findings by CSHM.
- The Monitor determined, with respect to the Operative Procedures form (Op Sheet), a Limited Oral Exam or Emergency Exam was not documented in patient #002's record. The documented operatory time in one record was not less than one hour and there was no explanation why in the notes. In addition, eight records had procedures, surfaces, and/or diagnosis on the Op Sheet that did not match the Tooth Chart and/or the Treatment Plan and two records had

incomplete documentation for protective stabilization. The CSHM audit tool only matched four out of the sixteen "no" answers given by the Monitor in the Op Sheet section. CSHM was unable to verify the length of time on the Op Sheet in one record due to the quality of the copied document.

- The Monitor determined, with respect to X-rays, three records did not identify the clinician who took the X-rays and five records included X-rays that were not labeled right and left.
- A billing error occurred pertaining to Patient #008's record. The surfaces billed for tooth #8 were listed as "DFLD" on the Account History Report instead of "MFLD" as documented on the Op Sheet.
- The records for patients #004 and #005 did not include all requested materials; therefore, the Monitor was unable to verify correct billing for the services provided.

Recommendations

- Ensure staff members provide all requested materials that meet quality standards and can be reviewed, including diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are verifying that HIPAA forms are completed correctly by the parent/guardian.
- Ensure Health History forms are correctly completed with explanations to all "yes" answers.
- Ensure staff members clearly and accurately document existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart.
- Ensure staff members are correctly completing all sections of the Hygiene Procedures form, the Treatment Plan, and the Op Sheet.
- Ensure staff members are verifying that consent has been received for all diagnosed treatment and that additional written consent is received prior to performing any modifications in the original Treatment Plan.
- Provide additional training to CHSM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas where there were Monitor findings but no corresponding CHSM findings.
- Ensure CSHM auditors are correctly using the *Guidelines for Chart Audit Scoring* when determining how to respond to the question related to whether a medical alert or per-med sticker should be affixed to the Tooth Chart.
- Provide written guidance about the proper use of the asterisk and the effect on the overall score.
- Ensure that forms audited by CSHM are within the audit date range and pertain to the selected provider/dentist and include operative procedures in order to obtain the most accurate quality assessment of the provider/dentist.

- Determine the reason that the Monitor could not validate CSHM's findings related to the unsigned *Local Anesthesia and Nitrous Oxide Consent Forms* dated June 23 and 28, 2010, for patient #010.
- Provide color copies of Tooth Charts to allow for accurate review of documentation during chart audits conducted by CSHM and the Monitor.

EXHIBIT 47

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted] J.D.
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Children's Dental Clinic of Thornton, PC

Deliverable #1-16

February 4, 2011

Executive Summary

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (formerly FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Children's Dental Clinic of Thornton, PC (Clinic), 550 E. Thornton Parkway, Suite 240A, Thornton, Colorado, 80229.

Overall Summary of Critical Findings and Observations

[redacted] preformed a review of 20 records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of 20 records that CSHM audited during the third quarter of 2010.

All four dentists received a lower score under the Monitor's review compared to the CSHM audit, with one dentist failing and two other dentists receiving an automatic failure due to inadequate documentation of medical necessity. The Monitor's overall Clinic score was a failing score of 87 percent.

The Monitor determined that four records (patients #003, #004, #015, and #017) did not have sufficient documentation to support the medical necessity for the treatment provided and recommends that the fees for those services be refunded. In addition, the Monitor verified the billing error found by CSHM related to the X-ray taken on July 1, 2010, for patient #002 and found an additional billing error when reviewing patient #014's record.

All 20 records reviewed by the Monitor were missing portions of the *Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian* (Health Insurance Portability and Accountability Act, or HIPAA form) or the entire HIPAA form was not provided. The CSHM auditor did not include this in the findings.

CSHM's auditor did not record any findings related to the Tooth Chart being completed incorrectly, despite instances where the Clinic did not document existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms. The Tooth Chart is critical when assessing the documentation of medical necessity, yet an auditor is unable to accurately determine correct charting and documentation of decay, which is charted in red, when reviewing a black-and-white copy.

The CSHM auditor examined forms that related to another dentist/provider who was not the subject of the audit.

The *Guidelines for Chart Audit Scoring* (*Guidelines)* specifies that additional guidance will be supplied to determine when a medical alert or pre-med sticker should be affixed to the Tooth Chart. Such guidance has yet to be supplied; however, CSHM's auditor recorded a "no" response for two records, which is against *Guidelines'* instructions.

The Monitor noted that CSHM auditors periodically use an asterisk, in addition to a "yes" or "no" response. The asterisk results in the testing attribute being excluded from the overall score. The *Guidelines* do not specify when an asterisk is appropriate.

Overall Summary of Recommendations

Set forth below are the recommendations contained in the report:

- Ensure staff members provide all requested materials that meet quality standards and can be reviewed, including all pages of the HIPAA form and diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are trained to take radiographs that meet diagnostic standards.
- Ensure staff members are verifying that HIPAA forms are completed correctly by the parent/guardian.
- Ensure Health History forms are completed correctly with explanations to all "yes" answers.
- Ensure staff members clearly and accurately document existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart.
- Ensure staff members are correctly completing all sections of the Hygiene Procedures form, the Treatment Plan, the Stabilization form, and the Op Sheet.
- Revise and provide clarification in the *Guidelines* to ensure that they relate to updated forms that have been incorporated into the patient record.
- Expand the criteria used in the audit tool to determine medical necessity to include the review of procedures that may be required for reasons other than decay.
- Provide additional training to CHSM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas where there were Monitor findings but no corresponding CHSM findings.
- Provide written guidance indicating rationale and proper use of the asterisk when scoring questions on the CSHM audit tool.
- Ensure that forms audited by CSHM pertain to the selected provider/dentist and include operative procedures in order to obtain the most accurate quality assessment of the provider/dentist. To the extent that such records should be

audited even though they relate to another dentist, then the *Guidelines* should be clarified to reflect this approach and the results of the chart audit communicated in a manner that allows for the provider who created the record to receive the relevant feedback.

- Provide color copies of Tooth Charts to allow for accurate review of documentation during chart audits conducted by CSHM and the Monitor.
- Create a mechanism to ensure that the documentation reviewed is related to the dentist being audited.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (formerly FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Children's Dental Clinic of Thornton, PC (Clinic), 550 E. Thornton Parkway, Suite 240A, Thornton, Colorado, 80229.

Implementation

The OIG approved a desk audit for Children's Dental Clinic of Thornton, PC. On November 30, 2010, the Monitor notified the Clinic and CSHM's Compliance Officer via mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs) and rationale for imposing them. The Monitor received the documentation from the Clinic and CSHM on December 7, 2010. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the third quarter of 2010
  - E-mail to the Clinic with results for the third-quarter audit
  - Third-quarter audit spreadsheet
- Thumb drive containing scanned records and X-rays from the 20 charts that were the basis for the CSHM third-quarter chart audit
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*

- *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*

CSHM initially requested the Clinic's charts on August 2, 2010. The Clinic provided the charts on August 9, 2010. The chart audit was completed on August 24, 2010 by a licensed dental hygienist. CSHM indicated the Clinic and all dentists passed the audit and, therefore, no CAP was needed.

Scope of Desk Audit

The scope of this desk audit is to review the chart audit conducted by CSHM during the third quarter of 2010 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 8 of the 20 visit records reviewed.

Review of CSHM Chart Audit

Twenty records were reviewed, five for each dentist, following the *Clinical Guidelines and Quality Assurance Protocol* (QAP) metrics as outlined in the *Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services*. The Monitor evaluated the same documents and X-rays reviewed by CSHM, and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor and CSHM's scoring differences for the Clinic and dentists. All four dentists scored lower under the Monitor's review compared to the CSHM audit, with one dentist failing and two other dentists ([redacted] and [redacted] receiving an automatic failure due to inadequate documentation of medical necessity. According to *The Methodology for Calculating Individual Dentist Chart Audit Scores*, "failure to adequately document medical necessity will result in automatic failure of the audit." The Monitor's overall Clinic score was a failing score of 87 percent.

	Monitor Score	CSHM Score
Clinic Audit Score	**87%**	**97%**
[redacted]	68%	94%
[redacted]	96%	100%
[redacted]	93%	100%
[redacted]	96%	100%

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After

completing the chart audit, additional findings were identified. These findings are also included below.

[redacted]

Patient #001		
Question	Monitor's Findings	CSHM's Findings
#7	The *Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian* (Health Insurance Portability and Accountability Act, or HIPAA form) was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#19	Although the patient's Health History reported asthma and there was no medical alert sticker on the Tooth Chart, the Monitor recorded "n/a" for this question in the audit tool, in accordance with the instruction in the *Guidelines*.	Tooth Chart - A medical sticker should be attached for Asthma/Breathing Problems.
#26-38	The Hygiene Procedures form dated July 22, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	HYG- Oral Hygiene Instructions marked but nothing pertaining to oral hygiene instructions documented.
#56	"N" was circled for Behavior Management on the Operative Procedures form (Op Sheet) when the Account History Report, Op Sheet notes, and Protective Stabilization form document the use of protective stabilization.	
#58	Oxygen saturation and heart rate were not documented on the Protective Stabilization form	OP-7/22/2010: O/2 Sat HR for time increment 0-15 was documented "visually checked". Please explain what that means? A number should be documented in this section.
#68	X-rays were not labeled right or left.	

Patient #002		
Question	Monitor's Findings	CSHM's Findings
#7	The last page of the HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#15	The Health History did not have a "yes" or "no" response for the question related to HIV/AIDS.	
#20	The fracture of tooth #9 was not recorded on the upper odontogram of the Tooth Chart.	
#26-38	The Hygiene Procedures form dated July 1, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#46	The Local Anesthesia and Nitrous Oxide Consent Form was not signed by the parent.	TX Plan- 7/1/2010: Local Anesthesia and Nitrous Oxide Consent Form not signed by Patient or Guardian.
#59	The operatory time was longer than one hour without a documented explanation in the Op Sheet notes.	
#60	The tooth surfaces listed on the Op Sheet and Treatment Plan do not match the tooth surfaces recorded on the lower odontogram of the Tooth Chart. The composite filling recorded on the Tooth Chart does not include the mesial surface.	
#65	The post-operative periapical X-ray of #9 taken on July 22, 2010, was not recorded on the Op Sheet, and there was no documentation on the duplicate X-ray or in the record regarding who took the X-ray.	
#68	X-rays were not labeled right or left.	X-Rays-7/1/2010 & 7/22/2010-label is upside down from the X-Rays. (Or X-Rays are mounted upside down). X-Rays not labeled L-R.
#71	The Hygiene Procedures form dated	BILLING- Periapical x-ray of #9 not

	July 1, 2010, was completed for a limited oral exam. A periapical X-ray of tooth #9 was documented on the hygiene form but not charged, according to the Account History Report. The Monitor agrees with the billing error reported by CSHM regarding the X-ray taken on July 1, 2010. The Monitor did report the finding related to the X-ray taken on July 22, 2010, in question #65. Since the Op Sheet did not document the X-ray and there was no charge for the X-ray on the Account History Report, the Monitor found no billing issue for the X-ray taken on July 22, 2010.	documented on the account history but was documented on the hygiene sheet 7/1/2010. Periapical x-ray dated 7/22/2010 not documented on the operative sheet 7/22/2010.

Patient #003		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#15	Health History did not have an explanation for "yes" responses to Asthma and Allergies.	HX- An explanation is needed for Asthma/Breathing Problems and Allergies in the "if you answered "yes" to any of the above, please explain:" section.
#19	Although the patient's Health History reported asthma and an allergy to codeine and there was no medical alert sticker on the Tooth Chart, the Monitor recorded "n/a" for this question in the audit tool in accordance with the *Guidelines*.	Tooth Chart -6/8/2010: A medical sticker should be affixed for Asthma/Breathing Problems, Allergies and Codeine allergy.
#20	The existing restoration on tooth #30 was not recorded on the upper odontogram of the Tooth Chart.	
#21	There was no documentation of decay on the mesial of #2, the mesial or distal of #3 and the distal of #4 on	

	the upper odontogram of the Tooth Chart.	
#23	The Monitor was unable to see the diagnosed interproximal caries due to overlapping contacts of teeth #2, #3, and #4 on the June 8, 2010, radiographs. The Monitor's pediatric dentist did not find adequate documentation to support the medical necessity for the treatment provided to teeth #2, #3, and #4 on July 21, 2010.	
#26-38	The Hygiene Procedures form dated June 8, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#41	The X-rays were non-diagnostic; therefore, the Monitor recorded "can't verify" for this question on the audit tool, as instructed in the *Guidelines*.	
#60	The Treatment Plan dated June 8, 2010, recorded the mesial and occlusal (MO) surfaces for tooth #4. The updated treatment plan dated July 21, 2010, recorded the distal (D) surface only for tooth #4. According to the Account History Report and the Op Sheet, tooth #4 received a (D) restoration and there was no rationale given for restoring only the distal surface. There was also no note or modification to address the treatment planned (MO) restoration for tooth #4.	
#67	June 8, 2010, mandibular anterior periapical and right side bite-wing X-rays were non-diagnostic.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

Patient #004		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	No Comments
#21	The Monitor was provided a black-and-white copy of the Tooth Chart and unable to distinguish between the charting of an existing restoration and caries on tooth #J.	
#23	The Monitor's pediatric dentist was unable to determine the medical necessity for the pulpotomies performed on teeth #I and #J due to non-diagnostic radiographs and inadequate documentation.	
#30	There was no documentation of a chief complaint on the Hygiene Procedures form.	
#41	The Monitor recorded "can't verify" due to non-diagnostic X-rays.	
#67	Scanned X-rays are non-diagnostic due to overlapping contacts and poor contrast.	
#69	There was no documentation of a defective restoration or Prior Service Acknowledgement (PRSA) for tooth #J on the Op Sheet and the left bite-wing X-ray shows an existing restoration on #J. There was no documentation on the Tooth Chart, Treatment Plan, or Op Sheet to indicate who placed the filling or whether the pulpotomy and stainless steel crown (SSC) performed on #J was necessary due to recurrent caries or a defective restoration. The Op Sheet showed "n/a" recorded for the PRSA of tooth #J.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

[redacted] Children's Dental Clinic of Thornton, PC

Patient #005		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#15	The Health History form did not document a "yes" or "no" answer for the question asking if the patient is taking any medications.	
#49-63	Another dentist completed the Op Sheet dated July 20, 2010; therefore, this dentist did not have an Op Sheet to audit. CSHM's audit tool shows that this form was reviewed and scored for this dentist.	
#67	The scanned radiographs dated July 20, 2010, were non-diagnostic.	X-Rays-7/20/2010: Radiographs unclear. It appears possibly the rollers on the developer need to be cleaned.

[redacted]

Patient #006		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	No Comments
#49-63	Another dentist completed the Op Sheet dated July 2, 2010; therefore, this dentist did not have an Op Sheet to audit.	

Patient #007		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor;	No Comments

	therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#26-38	The Hygiene Procedures form dated June 21, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#60	The Monitor was unable to determine if the treatment performed was charted on the lower odontogram of the Tooth Chart due to the black-and-white copy provided. Regardless, the lower odontogram documented a composite filling when the Op Sheet and the Account History Report recorded an amalgam filling for the occlusal (O) and (B) of tooth #30.	

Patient #008		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form provided to the Monitor did not include the entire form and was an older version dated August 23, 2005.	
#9,10	The Monitor recorded "n/a" on the audit tool since "no" was given for question #7. CSHM's audit tool recorded "yes" for questions #7, #9, and #10, indicating that all forms were present and completed correctly; however, CSHM did report a finding. The Notice of Privacy Practices was not included in the documents sent to the Monitor.	***Please have the parent/guardian document an updated Notice of Privacy Practices. The form included was an older form.
#36	The dentist's signature was missing on the Hygiene Procedure form.	HYG-7/2/2010: 2 sets of initials in the initials box and 1 signature. The Dentist's Signature was not documented.
#49-63	Another dentist completed the Op Sheet dated July 2, 2010; therefore, this dentist did not have an Op Sheet to audit.	

#68	The periapical X-ray dated July 2, 2010, was not labeled right or left.	

Patient #009		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#45	The boxes for single appointment, local anesthesia, and nitrous oxide were highlighted. The Monitor was unable to see the parent's initials on the scanned image provided by CSHM. As a result, "can't verify" was recorded on the audit tool.	
#49-63	Another dentist completed the Op Sheet dated July 2, 2010; therefore, this dentist did not have an Op Sheet to audit.	
#67	The Monitor agrees with CSHM's findings related to teeth #3 and #30 on the bite-wing X-ray; however, ""yes" was used by CSHM's auditor and "no" was recorded by the Monitor on the audit tool because treatment was diagnosed for tooth #30 by the audited dentist. The right side bite-wing X-ray was non-diagnostic and should have been re-taken.	*X-Rays 7/2/2010: #3 & #30 areas on the radiograph are not completely clear. It appears that another radiograph might have been overlapping when developing.

Patient #010		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	No Comments
#45	The boxes for single appointment, local anesthesia, and nitrous oxide were highlighted. The Monitor was	

	unable to see the parent's initials on the scanned image provided by CSHM. As a result, "can't verify" was recorded on the audit tool.	
#49-63	The Op Sheet dated July 2, 2010, was completed by another dentist; therefore, this dentist did not have an Op Sheet to audit.	

[redacted]

Patient #011		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	No Comments
#49-63	This patient had only preventive procedures completed; therefore, this dentist did not have an Op Sheet to audit.	

Patient #012		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#37	The Monitor agrees with CSHM's finding related to the notes section of the Hygiene Procedures form.	HYG-7/19/2010: Initials or diagonal line not documented after the last entry in the notes.
#49-63	This patient had only preventive procedures completed; therefore, this dentist did not have an Op Sheet to audit.	

Patient #013		
Question	Monitor's Findings	CSHM's Findings
#7	The *Authorization for Disclosure of Protected Health Information* portion	

	of the HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#24	The Monitor did not report this finding. The *Guidelines* do not address the need for auxiliary staff signatures for this question. The answer "yes" is given "when the dentist signature is documented."	Tooth Chart-7/12/2010: Signature not documented for Asst/Hyg.
#49-63	This patient had only preventive procedures completed; therefore, the dentist did not have an Op Sheet to audit.	

Patient #014		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	No Comments
#18	The Tooth Chart was dated with the incorrect date of service.	
#26-38	The Hygiene Procedures form dated May 11, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#41	The Monitor was unable to verify if the Treatment Plan reflected the diagnostic findings of the X-rays due to non-diagnostic radiographs.	
#65	There was no documentation of who took the X-rays on the Hygiene form and the duplicate X-rays did not include the initials of the person who exposed the radiographs.	
#67	The occlusal and left bite-wing radiographs were too dark and non-diagnostic. The right bite-wing was cone cut and had overlapping	

	contacts.	
#71	The Account History Report billed an occlusal filling for tooth #A when the dental record shows that only the lingual pit was restored.	

Patient #015		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#20	Existing pulpotomies were not recorded on the upper odontogram of the Tooth Chart.	
#26-38	The Hygiene Procedures form dated June 18, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	HYG-6/18/2010: Notes should begin on the top line of the note section. Initials or diagonal line not documented after the entry in the notes.
#60	The filling provided to tooth #19 on July 16, 2010, was not documented on the lower odontogram of the Tooth Chart.	OP-7/16/2010: Tooth Chart-6/18/2010: Completed treatment documented on the operative sheet not charted for #19 on the bottom odontogram of the tooth chart.
#69	The Op Sheet documented a missing filling and recurrent caries on the buccal of tooth #19. The Monitor was unable to verify the existence or history of a previous filling on the X-rays or documents provided for this audit.	
CSHM audit tool does not have a place to record this finding	The 2008 panoramic X-ray and the 2009 X-rays show evidence of existing space maintainers for teeth #B and #L, which had been extracted. The June 18, 2010, X-rays show both space maintainers to be missing, and there appeared to be inadequate space for the succeeding teeth. The Monitor's pediatric dentist found no documentation on the Tooth Chart or Op Sheet explaining	

	the rationale for replacing space maintainers in areas where this treatment had previously failed. Therefore, there was no medical necessity for replacing the space maintainer for tooth #B. There was also undiagnosed caries on the distal of #S and the mesial of #T. The interproximal caries on teeth #S and #T can be seen on the 2009 as well as the 2010 bite-wing radiographs.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

[redacted]

Patient #016		
Question	Monitor's Findings	CSHM's Findings
#7	The *Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian* portion of the HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#21	The Monitor was unable to determine the areas marked as decay on the upper odontogram of the Tooth Chart.	
#26-38	The Hygiene Procedures form dated July 2, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#62,63	The Monitor agrees with CSHM's findings related to the signatures and notes sections on the Op Sheet.	OP-7/23/2010: 3 sets of initials in the initials box and 2 signatures. Initials or diagonal line not documented after the last entry in the notes.

Patient #017		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	No Comments
#20, 21	The Monitor was unable to verify correct documentation of existing restorations and decay on the upper odontogram of the Tooth Chart. It is difficult to determine the difference between existing restorations and decay on a black-and-white copy.	
#23	There was no evidence of distal decay on the maxillary occlusal X-ray to support the medical necessity for the filling performed to the distal of tooth #G. The upper odontogram of the Tooth Chart recorded mesial decay on tooth #G; however, the Treatment Plan and Op Sheet both recorded the distal surface. The occlusal radiograph shows mesial caries and no caries on the distal of tooth #G.	
#26-38	The Hygiene Procedures form dated June 16, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#60	The tooth surface recorded on the Treatment Plan and the Op Sheet for tooth #G does not match the surface documented on the upper odontogram of the Tooth Chart.	
#71	Since the documentation indicates that the filling was performed on the wrong surface of tooth #G, the fee for the procedure billed for tooth #G should be refunded.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

Patient #018		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#9	The Monitor agrees with CSHM's finding.	Notice of Privacy Practices- 7/2/2010: Parent/guardian did not document signature on the correct line.
#20, 21	The Monitor was unable to verify correct documentation of existing restoration and decay on the upper odontogram of the Tooth Chart due to the quality of the scanned document. It is difficult to determine the difference between existing restorations and decay on a black-and-white copy.	
#26-38	The Hygiene Procedures form dated July 2, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	HYG- 7/2/2010: Initials or diagonal line not documented after the last entry in the notes.
#53	The Op Sheet did not have the "Y" circled to indicate that the consent was signed and in the chart.	
#60	Due to the poor quality of the black-and-white scanned Tooth Chart, the Monitor was unable to determine if the surfaces and diagnosis on the Op Sheet matched the Tooth Chart.	
#69	Due to the poor quality of the black-and-white scanned Tooth Chart, the Monitor was unable to determine if defective restorations were treatment planned to be properly restored.	

Patient #019		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	
#15	The Health History did not have an answer for the question asking if the patient had any dental concerns.	HX-7/19/2010: Section "Does the patient have any dental problems/concerns at this time? Please explain:" not documented. If this does not pertain an N/A can be documented.
#20, 21	The Monitor was unable to verify correct documentation of existing restoration and decay on the upper odontogram of the Tooth Chart due to the quality of the scanned document. It is difficult to determine the difference between existing restorations and decay on a black-and-white copy.	
#26-38	The Hygiene Procedures form dated July 19, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	
#60	Due to the quality of the black-and - white scanned Tooth Chart, the Monitor was unable to determine if the surfaces and diagnosis on the Op Sheet matched the Tooth Chart.	
#68	X-rays were duplicated and labeled incorrectly.	

Patient #020		
Question	Monitor's Findings	CSHM's Findings
#7	The HIPAA form was not included in the materials provided to the Monitor; therefore, the Monitor was unable to determine if the HIPAA form was completed correctly.	

#15	The Health History did not have an answer for the question asking if the patient was taking any medications.	
#26-38	The Hygiene Procedures form dated July 14, 2010, which was audited by CSHM, was completed by a different dentist; therefore, it was not audited by the Monitor.	HYG- 7/14/2010: Initials or diagonal line not documented after the last entry in the notes.

The Monitor had the following additional findings:

- Most of the reviewed records included documentation by the dentist to support the medical necessity of the treatment provided; however, some of the dentist's notes were illegible and difficult for the Monitor to interpret.
- The overall quality of the radiographs provided to the Monitor was poor. Many of the bite-wing X-rays had overlapping contacts, cone-cuts, and/or processing errors. Several of the panoramic radiographs were non-diagnostic. The labels on the scanned panoramic X-rays were also dark and difficult to read, with several that appeared to have a label on top of another label.

Below is a summary of the Monitor's findings of CSHM's audit of the Clinic:

- There continues to be significant scoring differences between the Monitor and CSHM's audit, especially related to questions that affect the dentist's quality score.
- The Monitor determined that four records (patients #003, #004, #015, and #017) did not have sufficient documentation to support the medical necessity for treatment that was provided; therefore, the fees for those services should be refunded.
- The Monitor found a billing error in the record for patients #002 and #014. The CSHM audit only recorded the billing error for patient #002.
- All 20 records reviewed by the Monitor were missing portions of the HIPAA form or the entire HIPAA form was not provided; therefore, the Monitor recorded a "no" for question #7 indicating that all requested materials were not received. Conversely, the CSHM auditor marked "yes" for this question in every record. This meant that all records were present. The CSHM auditor then marked "n/a" for question #10 in 16 of the 20 records. This question asked whether the HIPPA authorization form was property completed and signed. The audit finding of "n/a" would only be appropriate if the HIPAA form was not provided and therefore the answer to question #7 would be "no."
- The Monitor determined that five records contained Health History forms that were completed incorrectly. The CSHM audit found only two of the records were completed incorrectly. Areas that were completed incorrectly included missing answers pertaining to health history questions or follow-up questions pertaining to an illness.

- The Monitor determined, with respect to the Tooth Chart, one record's form was dated with the incorrect date; three records did not have existing conditions and/or restorations properly documented on the upper odontogram of the Tooth Chart; and one record did not show documentation of decay on the upper odontogram of the Tooth Chart. The Monitor also used "can't verify" for the scoring related to documentation of decay in five records and documentation of existing conditions and restorations in three records. An auditor is unable to accurately determine correct charting and documentation of decay, which is charted in red, when reviewing a black-and-white copy. The CSHM audit did not report any of these findings in the audit tool's Tooth Chart section.
- The Monitor determined that two records did not have correctly completed Hygiene Procedure forms. The CSHM audit had six findings related to Hygiene Procedure forms; however, four of those forms were completed by another dentist and did not apply to the dentist being audited. CSHM's audit included the review of 11 Hygiene Procedure forms completed by another dentist.
- The Monitor determined, with respect to the Op Sheet, one record did not have the "Y" circled to indicate that the consent was signed and in the chart. In the record of patient #001, "Y" was not circled for behavior management and the heart rate and oxygen saturation was not recorded. The documented operatory time in one record was not less than one hour and there was no explanation why in the notes. In addition, five records had procedures, surfaces, and/or diagnosis on the Op Sheet that did not match the Tooth Chart and/or the Treatment Plan. The CSHM audit tool only matched four out of the eleven "no" answers given by the Monitor in the Op Sheet section. CSHM's audit included review of one Op Sheet completed by another dentist.
- The Monitor determined, with respect to X-rays, five records were found to have non-diagnostic X-rays, two records did not identify the clinician who took the X-rays and four records included X-rays that were not labeled correctly.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 20 visit records:

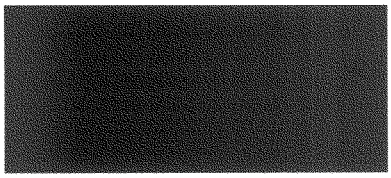
- Ensure staff members provide all requested materials that meet quality standards and can be reviewed, including all pages of the HIPAA form and diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are trained to take radiographs that meet diagnostic standards.
- Ensure staff members are verifying that HIPAA forms are completed correctly by the parent/guardian.
- Ensure Health History forms are completed correctly with explanations to all "yes" answers.

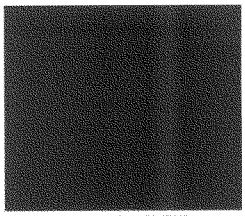
- Ensure staff members clearly and accurately document existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart.
- Ensure staff members are correctly completing all sections of the Hygiene Procedures form, the Treatment Plan, the Stabilization form, and the Op Sheet.

The following recommendations are related to CHSM's chart audit process and the *Guidelines*:

- Revise and provide clarification in the *Guidelines* to ensure that they relate to updated forms that have been incorporated into the patient record.
- Expand the criteria used in the audit tool to determine medical necessity to include the review of procedures that may be required for reasons other than decay.
- Provide additional training to CHSM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas where there were Monitor findings but no corresponding CHSM findings.
- Provide written guidance indicating rationale and proper use of the asterisk when scoring questions on the CSHM audit tool.
- Ensure that forms audited by CSHM pertain to the selected provider/dentist and include operative procedures in order to obtain the most accurate quality assessment of the provider/dentist. To the extent that such records should be audited even though they relate to another dentist, then the *Guidelines* should be clarified to reflect this approach and the results of the chart audit communicated in a manner that allows for the provider who created the record to receive the relevant feedback.
- Provide color copies of Tooth Charts to allow for accurate review of documentation during chart audits conducted by CSHM and the Monitor.
- Create a mechanism to ensure that the documentation reviewed is related to the dentist being audited.

EXHIBIT 48





To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted] J.D.
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Small Smiles Dental Centers of Santa Fe, PC

Deliverable #1-18

March 7, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Santa Fe, PC, 2008 St. Michaels Drive #B, Santa Fe, NM, 87505.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 20 records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of 20 records that CSHM audited during the third quarter of 2010.

All four dentists received a lower score under the Monitor's review compared to the CSHM audit, with two dentists failing and one other dentist receiving an automatic failure due to inadequate documentation of medical necessity. The Monitor gave the Clinic an overall failing score of 86 percent.

The Monitor determined that two records (patients #001 and #016) did not have sufficient documentation to support the medical necessity for the treatment provided and recommends that fees for those services be refunded. Three additional records (patients #007, #011, and #012) did not provide written consent for the pulpotomies performed during treatment. Treatment performed without written consent is considered an adverse event, according to the *Parent Notification and Adverse Events* policy.

Nine of the twenty records reviewed did not provide adequate documentation to support the medical necessity for the exposure of occlusal X-rays that were taken on the audited date of service.

CSHM's auditor recorded only one finding related to the upper odontogram of the Tooth Chart being completed incorrectly, despite multiple instances where the Clinic did not document existing conditions, restorations, or decayed surfaces on the upper odontogram. These results may be due to the use of black-and-white copies of the Tooth Charts during the CSHM chart audit. The Tooth Chart is critical when assessing the documentation of medical necessity, yet an auditor is unable to accurately determine correct charting and documentation of decay, which is charted in red, when reviewing a black-and-white copy. The Monitor was provided with color copies of Tooth Charts for this audit and found it essential to determine the accuracy of documentation.

The Monitor noted that CSHM auditors periodically use an asterisk, in addition to a "yes" or "no" response. The asterisk results in the testing attribute being excluded from the overall score. The *Revised Guidelines for Chart Audit Scoring (Guidelines)* does not specify when an asterisk is appropriate.

Overall Summary of Recommendations

Set forth below are the Monitor's recommendations:

- Ensure staff members provide all requested materials that are of a quality that allows review, including the "Acknowledgement of Receipt of Notice of Privacy Practices" (Acknowledgment) and "Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian" (Authorization) forms and diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are trained to take radiographs that meet diagnostic standards.
- Ensure that radiographs are prescribed in accordance with the *ADA/FDA Guide to Patient Selection for Dental Radiographs*.
- Establish a procedure that documents when a parent/guardian has refused to complete the Authorization forms.
- Ensure Health History forms are completed correctly with explanations to all "yes" answers.
- Provide written guidance to Clinics in regards to which health conditions indicate the need to affix a medical alert or premedication sticker to the Tooth Chart.
- Ensure staff members clearly and accurately document, in the correct ink color, existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart.
- Ensure staff members are correctly completing all sections of the Hygiene Procedures (Hygiene) form, Treatment Plan, Consent for Protective Stabilization Form, and the Operative Procedures Form (Op Sheet).
- Ensure billing errors are corrected and procedures that fail to have documentation of medical necessity are refunded.
- Ensure that consent is obtained for all treatment.
- Ensure that when consent is not given for a procedure an adverse event is reported and appropriate refunds are provided.
- Provide an explanation of why complete exams are being billed after a periodic exam.

The following recommendations are related to CHSM's chart audit process and the *Guidelines*:

- Provide clarification and direction in the *Guidelines* to assist auditors in determining when a medical alert or premedication sticker is required to be affixed to the Tooth Chart.
- Provide additional training to CHSM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas where there were Monitor findings but no corresponding CHSM findings.

- Ensure that all Op Sheets audited by CSHM pertain to the selected provider/dentist.
- Ensure that all findings are accurate and clearly stated when communicating audit results with Clinics.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Santa Fe, PC, 2008 St. Michaels Drive #B, Santa Fe, NM, 87505.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of Santa Fe. On December 27, 2010, the Monitor notified the Clinic and CSHM's Compliance Officer via mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from the Clinic and CSHM on January 5, 2010. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the third quarter of 2010
  - E-mail to the Clinic with results for the third-quarter audit
  - Third-quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Revised Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*
    - *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*

CSHM initially requested the Clinic's charts on July 19, 2010. The Clinic provided the charts on July 23, 2010. The chart audit was completed on August 26, 2010, by a licensed dental hygienist. CSHM indicated the Clinic and all dentists passed the audit; therefore, no CAP was required, according to the *Chart Audit Policy*.

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the third quarter of 2010 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 10 of the 20 visit records reviewed.

Review of CSHM Chart Audit

Twenty records were reviewed, five for each dentist, following the *Clinical Guidelines and Quality Assurance Protocol* (QAP) metrics as outlined in the *Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services*. The Monitor evaluated the same documents and X-rays reviewed by CSHM, and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor and CSHM's scoring differences for the Clinic and dentists. All four dentists scored lower under the Monitor's review compared to the CSHM audit, with two dentists failing and one other dentist (Dr. [redacted]) receiving an automatic failure due to inadequate documentation of medical necessity. According to *The Methodology for Calculating Individual Dentist Chart Audit Scores*, "failure to adequately document medical necessity will result in automatic failure of the audit." The Clinic score was 86 percent, which is failing.

	Monitor Score	CSHM Score
[redacted]	90%	100%
	90%	97%
	86%	95%
	87%	100%
Clinic Total Audit Score	**86%**	**96%**

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified. These findings are also included below.

[redacted] Small Smiles Dental Centers of Santa Fe, PC

[redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The upper odontogram of the Tooth Chart did not document the existing condition of tooth #8 and the root canal therapy was documented incorrectly. The photograph of tooth #9, dated April 21, 2010, shows a white area on the attached gingiva of the facial of tooth #9 with no documentation of such finding on the Tooth Chart.	No comments
#23	Mesial-lingual decay was documented on the upper odontogram of the Tooth Chart for tooth #9; however, there was no evidence of decay on the X-rays dated April 13, 2010. Furthermore, there was no documentation on the Tooth Chart or the Operative Procedures forms (Op Sheets) dated April 21, 2010, and May 18, 2010, indicating the medical necessity for the crown placed on tooth #9. According to the *Guidelines*, inadequate documentation of medical necessity results in automatic failure of the Chart Audit for the audited dentist.	
#34	There was no indication for the medical necessity for the mandibular occlusal X-ray taken on April 13, 2010.	
#41	The digital photograph, X-rays, and documentation in the dental record do not provide adequate documentation of the medical necessity for the Treatment Plan and the treatment provided to tooth #9.	
#42	The date recorded on the Treatment Plan was incorrect.	
#43	The Treatment Plan, dated February	

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
	22, 2010, listed pulpectomy/root canal therapy/crown as the planned procedures for tooth #9. The Account History billed for a mesial-incisal-lingual filling on February 23, 2010, which is not included on the Treatment Plan form. The Account History then billed for a crown on tooth #9 on May 18, 2010.	
#60	There was no documentation of the procedures performed or the medical necessity for the treatment provided to tooth #8 or #9 on the Op Sheets dated April 21, 2010, and May 18, 2010.	
#69	Due to poor documentation in the dental record, the Monitor was unable to determine the answer to the audit question: "Were defective restorations treatment planned to be properly restored?" The Account History Report documents payment was received on March 3, 2010, for a three-surface filling on tooth #9; however, the April 13, 2010, Tooth Chart does not document an existing, defective, or missing filling. The Hygiene Procedures (Hygiene) form or Op Sheets also fail to have documentation about this filling.	
#71	Neither the April 21, 2010, nor the May 18, 2010, Op Sheets document the codes that were billed on May 18, 2010, on the Account History Report. In addition, the Account History Report documents that payments were received for a composite filling for tooth #9 on March 3, 2010, and the crown on tooth #9 on May 26, 2010.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#63	There were no initials following the written summary of appointment on the Op Sheet.	OP-6/23/2010: Initials or diagonal line not documented after the last entry in the notes.
#71	The behavior management code was not recorded on the Account History Report.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	Consent for Protective Stabilization Form to document time, vitals, and outcome was not sent with requested materials.	
#15	The Health History form had no answer regarding history of prosthetic joints, plates, or pins.	HX-4/1/2010: Prosthetic Joints, Plates or Pins not documented "Yes" or "No".
#19	Unable to verify need for medical alert sticker due to incomplete Health History form.	Tooth Chart-4/1/2010: Can't Verify if a medical sticker is needed because "Prosthetic Joints, Plates or Pins were not marked "Yes" or "No" on the patient health history.
#73	It appears that CSHM's findings have been corrected. The Monitor noticed the incorrect provider was recorded on the Account History Report for preventive services rendered on April 1, 2010. The provider was listed as AV; however, the Hygiene form, Treatment Plan, Tooth Chart, and Health History forms record [redacted] as the provider.	BILLING-4/1/2010: Documented on the hygiene sheet that x-rays were not able to be taken due to patient's behavior. 2 Periapical x-rays were documented on the account history for 4/1/2010 but were not taken or included. 2 digital photos were included dated 4/8/2010 but no documented on the account history or operative sheet dated 4/8/2010.
No Question to address this finding	According to the patient's record, it appears that X-rays were attempted but unable to be obtained due to poor cooperation. CSHM did not score this finding on the Audit Tool.	***HYG-4/1/2010: Documented next to initials and signature "x-rays" but documented that no x-rays were taken.
No Question to address	The CSHM Audit Tool does not have a question to address this finding; therefore, it was not scored and did not affect the Clinic's audit score.	***OP-4/8/2010: 2 digital photos were dated 4/8/2010 but were not documented on the operative sheet 4/8/2010.

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
this finding	The Monitor did not have this finding. The Op Sheet dated April 8, 2010, showed a check mark beside 00350 Diagnosis Photos. If this was added after CSHM's audit, it should be dated and initialed.	

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#36	The Hygiene form is missing a signature. There are three sets of initials at the top of the form but only two signatures at the bottom of the form.	HYG-5/26/2010: 3 sets of initials in the initials box and 2 signatures.
#53	The "Y" was circled indicating that X-rays were reviewed; however, X-rays were not taken on this patient.	
#59	The Monitor reviewed the Op Sheet and the start time was legible. It appeared the anesthetic was started at 4:05 p.m. with treatment ending at 4:45 p.m.	OP-6/1/2010: Can't Verify if time in OP less than one hour because the anesthetic started time was not legible.
#60	The filling provided for tooth #A and the pulpotomies for teeth #B, C, I, and H were not documented in black on the lower odontogram of the Tooth Chart.	Pulpotomies that have been completed should be documented with a "p" above the tooth on the Tooth Chart. A "p" was not charted above #B, #I, #H, & #C on the bottom odontogram. Pulpotomies for these teeth were documented on the operative sheet.
#71	Digital photographs were taken but were not documented on the Account History Report, Hygiene form, or Op Sheet.	

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The patient's father wrote his name, instead of the patient's name, in section A of the "Authorization of Persons to Consent for Treatment in	No Comments.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
	the Absence of Parent/Guardian" form (Authorization form). The remaining portion of the form was left incomplete.	
#65	The clinician who took the bitewing X-ray was not identified on the duplicate X-ray or Op Sheet.	
#68	The record indicated that a bitewing X-ray was taken of tooth #I; however, the duplicate bitewing X-ray was not labeled right or left and appears to have been flipped.	
#71	The Account History Report records one periapical X-ray at no charge but does not document the bitewing X-ray or the digital photographs that were recorded on the June 16, 2010, Op Sheet.	

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The "Acknowledgement of Receipt of Notice of Privacy Practices" form (Acknowledgement form) and the Authorization form were not sent with the requested materials.	
#9	The Monitor was unable to review this document because it was not sent with the requested materials. CSHM's auditor recorded "*yes" to score this question. The *Guidelines* do not include or define the use of the asterisk. Furthermore, this response decreases the total number of responses generated in the audit tool.	*Privacy Practices- 4/20/2010: Errors were corrected without proper error notation.
#15	The question regarding dental problems/concerns on the Health History form was not answered.	HX: 4/28/2010: No documentation for section "Does the patient have any dental problems/concerns at

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
		this time? Please explain:"
#18	The details regarding "habits" were not completed on the initial dental evaluation section of the Tooth Chart.	Tooth Chart- 4/28/2010: No documentation in Habits section for the Initial Dental Evaluation.
#20	Crowns for teeth #D, #E, #F, and #G were documented in red on the upper odontogram of the Tooth Chart. Treatment-planned procedures should be documented on the lower odontogram.	#D, #E, #F & #G are charted as crowns on the top odontogram but are treatment planned for crowns. Planned treatment should be charted on the bottom odontogram.
#34	There was no indication for the medical necessity for the mandibular occlusal X-ray taken on April 28, 2010 or the additional maxillary occlusal X-ray taken on June 16, 2010.	
#35	The Hygiene form did not have adequate documentation about oral hygiene instructions. The notes state: "Instruct patient to brush and floss two times a day for two minutes." Based on the patient's age (age 4), oral hygiene instructions should be demonstrated and reviewed with the patient and parent.	
#60	The distal surface is recorded for tooth #D on the Op Sheet and Treatment Plan; however, the X-ray and the upper odontogram of the Tooth Chart shows mesial decay.	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#9	The Acknowledgement form was completed incorrectly. The father did not enter his name on the first line or sign the document. CSHM's auditor entered "*yes" to this question.	*Privacy Practices- Parent/Guardian did not sign on the correct line.
#20	Existing fillings on teeth #A, #I, and #J were not recorded on the upper	Tooth Chart- 5/20/2010: Can't Verify if all existing conditions and

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
	odontogram of the Tooth Chart.	restorations were properly documented because x-rays were not included. Only a digital photo of the mandibular arch was included.
#21	The surfaces recorded for teeth #A, #H, and #J on the Treatment Plan and Op Sheet do not match the surfaces documented on the upper odontogram of the Tooth Chart. The Tooth Chart included additional surfaces of decay on the lingual surface of #A and the distal of #H and #J.	
#28	The Oral Hygiene and Soft Tissue Evaluation was not completed on the Hygiene form.	
#34	There was no indication for the medical necessity for the mandibular occlusal X-ray taken on May 20, 2010.	
#35	The Hygiene form did not have adequate documentation of oral hygiene instructions. The notes state: "X-plained why he needs to brush twice everyday." Based on the patient's age (age 5), oral hygiene instructions should be demonstrated and reviewed with the patient and parent.	
#43	The Treatment Plan did not include pulpotomies for teeth #A, #I, and #J in the description column for planned procedures; therefore, there was no written consent for the pulpotomies performed to those teeth.	
#50	Date on the Op Sheet was recorded as "6/10/91."	OP-6/10/2010: Date of visit was documented on the operative sheet as 6/10/91.
#60	The pulpotomies performed on teeth #A, #I, and #J were not recorded in black on the lower odontogram and the completed filling on tooth #B that	Pulpotomies that have been completed should be documented with a "p" above the tooth on the Tooth Chart. A "p" was not charted

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
	was documented in black on the lower odontogram did not include the occlusal surface. Therefore, the surfaces and procedures documented on the Op Sheet did not match the Treatment Plan or the Tooth Chart.	above #A, #I & #J on the bottom odontogram of the tooth chart.
#65	The Hygiene form and X-rays did not identify the Clinician who took the X-rays.	X-Rays- Clinician taking x-rays not noted/identified.
#68	The duplicate X-rays provided to the Monitor were labeled correctly.	5/20/2010: X-rays not labeled L-R.
#71	The Monitor did not have this finding; however, the Account History Report and Op Sheet does record a lingual filling for tooth #H.	BILLING- 6/10/2010: Lingual resin for #A documented on the account history but was not documented on the operative sheet. (This procedure was not done.)

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#34	There was no indication for the medical necessity for the occlusal X-rays taken on June 23, 2010.	
#68	No findings. The duplicate X-rays provided to the Monitor were dated June 23, 3010, and labeled correctly.	X-Rays-5/20/2010: X-Rays not labeled L-R.

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#19	The Tooth Chart, dated May 26, 2010, did not have a red medical alert sticker affixed to the top of the form. The patient's Health History documents disabilities/special needs and speech/hearing problems. The response from CSHM for this patient was "No Comments" on the e-mail to the Clinic; however, the audit tool shows that the auditor scored this question as "no" and the e-mail to the	No Comments.

[redacted] Small Smiles Dental Centers of Santa Fe, PC

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
	Clinic records the finding under a different patient.	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The question regarding dental problems/concerns was left blank on the Health History form.	
#19	CSHM auditor reported this finding for the wrong patient in the e-mail to the Clinic. This comment belongs to Patient #09	Tooth Chart- 5/26/2010: A medical sticker should be affixed for Speech/Hearing Problems and Disabilities/Special Needs.
#20	The upper odontogram of the Tooth Chart recorded tooth #L as present and restored with a Stainless Steel Crown (SSC). Tooth #21 was also marked as present. The X-ray, dated March 5, 2010, shows tooth #L is missing with #21 erupted in its place.	

[redacted]

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The parent completed section C but did not complete Sections A and B of the Authorization form pertaining to consent of treatment.	
#15	No "yes" or "no" responses were given for autism or heart-related questions on the Health History form. Answers were not provided for the questions about other health and dental problems or concerns.	
#19	The Tooth Chart did not have a red medical alert sticker affixed to the top of the form, and the Health History form recorded a history of asthma.	Tooth Chart-5/27/2010: A medical sticker should be affixed for Asthma/Breathing Problems.
#43	The description line on the Treatment Plan did not include pulpotomy for tooth #S; therefore, there was no	

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
	consent for the pulpotomy performed to tooth #S.	
#54	There was no indication of behavior response in the Nitrous Oxide section of the Op Sheet.	OP-5/27/2010: Nitrous Oxide: Behavior Response not documented.
#56	According to the Account History Report and Op Sheet notes, the patient was stabilized using a papoose during treatment; however, "N" was circled for behavior management on the Op Sheet.	
#60	The Op Sheet and Account History show a pulpotomy was performed to tooth #S; however, the lower odontogram of the Tooth Chart and the Treatment Plan do not show documentation of this procedure.	Pulpotomies that have been completed should be documented with a "p" above the tooth on the Tooth Chart. A "p" was not charted above #S on the bottom odontogram of the tooth chart.
#65	The Hygiene form and X-rays did not identify the Clinician who took the X-rays.	X-Rays-5/27/2010: Clinician taking X-Rays not noted/identified.

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The parent did not complete Section B of the Authorization form pertaining to consent for treatment.	
#15	The question regarding dental problems/concerns was left blank on the Health History form.	
#28	The Soft Tissue Evaluation was not completed on the Hygiene form.	
#43	The description line on the Tooth Chart did not include pulpotomy for teeth #A and #T; therefore, there was no consent for the pulpotomies performed on teeth #A and #T.	
#60	The Op Sheet and Account History record pulpotomies were performed on teeth #A and #T; however, the lower odontogram of the Tooth Chart and Treatment Plan do not show	OP-7/8/2010: Pulpotomies that have been completed should be documented with a "p" above the tooth on the Tooth Chart. A "p" was not charted above #A & #T on the

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
	documentation of this procedure.	bottom odontogram of the tooth chart.
#65	The Hygiene form and X-rays did not identify the Clinician who took the X-rays.	X-Rays- 6/7/2010: Clinician taking X-Rays not noted/identified.

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The Authorization form did not list the relationship to the patient of two individuals listed as authorized to consent for treatment on behalf of the patient; however, this is not addressed in the *Guidelines* and was not scored as a "no" on the Audit Tool by either the Monitor or CSHM.	*HIPAA-1/5/2010: Please document relationship to the patient for all authorized to consent on behalf of the patient.
#21	The upper odontogram of the Tooth Chart did not document the decay on the distal of tooth #S, and there was no documentation regarding the mesial of tooth #T.	
#34	There was no indication for the medical necessity for the occlusal X-rays taken on July 6, 2010.	
#54	The Nitrous Oxide section on the Op Sheet was not completed correctly. No information was documented for behavior indication and response or initial and working concentrations of Nitrous Oxide and Oxygen. The pre- and post-blood pressure and respiration lines were left blank, and there were no notes regarding condition upon discharge.	OP-7/7/2010: Nitrous Oxide: Behavior Indication, Working and Initial Concentration and Behavior Response not documented. Vital Signs: Condition upon discharge and complications not documented.
#56	According to the Op Sheet notes and the Consent for Protective Stabilization Form, behavior management was used during the appointment; however, "N" was circled for behavior management on the Op Sheet.	

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#71	Behavior management was not documented on the Account History Report.	

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The periapical X-ray, taken according to the Op Sheet dated July 8, 2010, was not sent with the requested material.	
#9	The Monitor requests CSHM's policy regarding corrections made by parents when completing documents. It appeared to the Monitor that this error was made and corrected by the parent since the parent is responsible for completing the Acknowledgement form. Neither the Monitor nor did CSHM's auditor score this as a finding on the audit tool.	*Privacy Practices: Error was corrected without proper error notation.
#15	The Health History form did not record the type of medication the patient was taking for seasonal allergies.	
#19	A medical alert sticker was not placed on the Tooth Chart for seasonal allergies. The criteria for which health conditions require a medical alert sticker have not been defined by CSHM in the *Patient Care Manual* or audit reference tools.	HX-7/8/2010: A medical sticker should be affixed for seasonal allergies.
#20	The existing filling on tooth #J and all existing crowns were charted in red instead of black on the upper odontogram of the Tooth Chart.	
#22	The Monitor was unable to verify if tooth #J had significant root resorption and was properly restored, because the periapical X-ray taken, as indicated on the Op Sheet, was not sent with the requested	

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
	materials.	
#65	The Hygiene form and X-rays did not identify the Clinician who took the X-rays.	OP-7/8/2010: Clinician taking x-rays not noted/identified.
#71 and #73	The billing issues reported by CSHM appear to have been corrected; however, the Account History Report records the pulpotomy and SSC provided for tooth #J twice, once with the provider listed as "AV" and the other with the provider listed as "DE". The Op Sheet records the provider as Dr. [redacted].	BILLING- Services for hygiene and operative procedures 7/8/2010 were not documented on the account history. Procedures not billed: #J Stainless Steel Crown Primary-02930. Pulpotomy #J – 03220. Periodic Exam, Prophy-child, Fluoride, Oral Hygiene Instruction, 2 Bitewings, 2 Periapical x-rays.
The Op Sheet audited by CSHM was completed by another dentist, [redacted], and should not have been audited for this dentist.		

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The Authorization form was not completed correctly.	
#15	The question regarding dental problems/concerns was left blank on the Health History form.	
#34	There was no indication for the medical necessity for the occlusal X-rays taken on March 25, 2010.	

[redacted]

Patient #016		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The Authorization form was not completed correctly. The mother did not correctly state the relationship to the patient and signed the revocation portion of the form.	No Comments
#15	The question regarding dental problems/concerns was left blank on the Health History form.	
#22	The Monitor's pediatric dentist reviewed the record and determined there was inadequate documentation	

Patient #016		
Question	**Monitor's Findings**	**CSHM's Findings**
	to support the medical necessity to extract tooth #N, which had very little root resorption. Caries were documented on the facial surface of the upper odontogram, but crowding was listed as the diagnosis on the Op Sheet for the extraction of #N, #O, and #P. Crowding was not evident on the X-rays for tooth #N. The Monitor was also unable to see evidence of decay on tooth #N; however, there was evidence of decay on tooth #Q, which may suggest the X-rays were not properly copied.	
#53	The Op Sheet did not have "Y" circled to confirm whether the Treatment Plan was reviewed.	
#68	X-rays may have been labeled incorrectly. When viewing the X-rays, it appears that #Q has caries instead of #N.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

Patient #017		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	Authorization form completed with revocation signed.	
#20	Existing SSC was not documented on tooth #I.	
#21	All surfaces were colored red for teeth #A, #I, and #K. Tooth #I has a SSC; therefore, coronal decay is not evident on the X-ray.	
#36	An auxiliary staff member's signature was missing on the bottom of the Hygiene form dated April 6, 2010. CSHM's finding referred to the incorrect date of service.	HYG-4/16/10:3 sets of initials in the initials box and 2 signatures.

Patient #018		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The question regarding dental problems/concerns was left blank on the Health History form.	
#34	There was no indication for the medical necessity for the occlusal X-rays taken on April 7, 2010.	
#41	Question #41 was left blank on the CSHM Chart Audit Tool. The CSHM finding to the right was reported under the wrong patient's name on the e-mail to the Clinic as this patient did not have treatment performed on tooth #I.	Visual, Tactile and Radiographic means was documented for decay #I. 2 BWXS and 2 Periapicals were documented as being taken on the hygiene sheet 3/16/2010 but were not included. Please include any x-rays that were taken and involve teeth that pertain to the audit.
#65	No documentation on the Hygiene form or X-rays indicated the clinician who took the X-rays dated April 7, 2010.	

Patient #019		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The question regarding dental problems/concerns was left blank on the Health History form.	
#20	Existing fillings on teeth #A, #B, and #K were not documented on the upper odontogram of the Tooth Chart.	
#34	There was no indication for the medical necessity for the occlusal X-rays taken on March 16, 2010.	
#41	The Monitor cannot verify the medical necessity for the pulpotomy performed to tooth #I due to the quality of the X-rays provided.	
#43	The Treatment Plan description recorded "fill/pc" for tooth #I and did not include consent for the pulpotomy performed on tooth #I.	
#60	The Treatment Plan did not include the pulpotomy procedure, which was	

Patient #019		
Question	**Monitor's Findings**	**CSHM's Findings**
	documented on the Op Sheet and lower odontogram of the Tooth Chart.	
#62	The number of signatures at the bottom of the Op Sheet did not match the number of initials in the initial box.	
#65	The clinician who took the X-rays was identified on the Hygiene form dated March 16, 2010, in the initials box and by the clinician's signature at the bottom of the form. The CSHM auditor's finding was not supported by the documentation provided to the Monitor.	X-Rays-4/7/2010: Clinician taking x-rays not noted/identified.
#67	The duplicate X-rays provided to the Monitor were non-diagnostic.	

Patient #020		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The question regarding dental problems/concerns was left blank on the Health History form.	
#18	CSHM's finding appears to be an incomplete sentence; therefore, this finding is unclear.	Tooth chart-3/31/2010: A complete exam was documented for 3/31/2010 on the hygiene procedure sheet but a tooth chart with an Initial Dental Evaluation
#34	There was no indication for the medical necessity for the occlusal X-rays taken on March 31, 2010.	

The Monitor had the following observations:

- If the Authorization form is not required to be completed by the parent or guardian, then it is difficult for an auditor to determine whether the document is missing or the patient has refused to complete the form.
- The abbreviation "PC" was used on the upper and lower odontograms of the Tooth Chart. The Monitor was unable to determine the meaning of the undefined abbreviation.
- Treatment-planned services were documented on the upper and lower odontogram of the Tooth Chart. According to the *Patient Care Manual*, the upper odontogram should only be used to document existing conditions in black and

decay in red, while the lower odontogram should show in red the least invasive treatment options from the treatment plan.

- Question #18 applies to the Tooth Chart and asks if the initial dental evaluation was completed and dated. The revised *Guidelines* instruct the auditor to score this question as "n/a" and states that "this section is now located on the hygiene sheet." Several records reviewed during this audit, however, contained older forms where this question still applied; therefore, the Monitor answered "yes" or "no" when applicable. Upon review of the CSHM Chart Audit Tool, it was noted that CSHM's auditor answered this question in the same manner as the Monitor.
- The *Guidelines* supplied for this audit were revised and included tracked changes; however, some questions relate to newer forms making it difficult for the Monitor to apply these Guidelines to the older forms that were the subject of this audit.
- In general, the reviewed records poorly documented diagnosis and medical necessity on the Op Sheet and Tooth Chart. For example, crowding (CR) was recorded as the diagnosis for the extraction of multiple teeth, instead of multi-surface caries (MSC) and/or non-restorable (NR). There were also instances where decay was not visible on the X-ray but caries found by visual/tactile means were documented in the Op Sheet notes; however, the documentation did not record which teeth had caries by visual/tactile means. There was no documentation of such findings on the Tooth Chart.
- The Hygiene forms reviewed did not show proper documentation of the chief complaint. Instead of recording "none" or "n/a," a line was drawn in the space designated for recording the chief complaint. In addition, the Monitor noted that in the record related to patient #001, the chief complaint was written in Spanish. This creates a risk that a non-Spanish speaking provider will not be able to interpret the information. The documentation related to oral hygiene instructions included statements such as: "Patient was told to brush two times a day and to start flossing." Documentation of oral hygiene instructions should include the demonstration of brushing, flossing, and discussion of other oral health prevention methods. Oral hygiene instructions should also include the parent or guardian, especially when the child is dependent on the parent to maintain good oral health. Nine of the Hygiene forms were not completed by the dentist being audited. Even though the scoring of the hygiene form does not affect the dentist's audit score and is used to determine the overall Clinic score, the findings related to that document are reported by CSHM auditors under the audited dentist's name. The communication of those findings should be reported in a manner that would allow the dentist who incorrectly completed the form to receive that feedback.
- The asterisk was used when scoring several items in the Chart Audit Tool. None of the reference tools used for training the auditors document instructions for use of an asterisk in the Chart Audit Tool. The use of an asterisk with a response is not identified as an accepted response in the audit tool; therefore, it affects the total number of responses calculated.

Below is a summary of the Monitor's findings of CSHM's audit of the Clinic:

- There continues to be significant scoring differences between the Monitor and CSHM's audit, especially related to questions that affect the dentist's quality score.
- The Monitor determined that two records (patients #001 and #016) did not have sufficient documentation to support the medical necessity for treatment that was provided.
- Three additional records (patients #007, #011, and #012) did not provide written consent for the pulpotomies performed during treatment. Treatment performed without written consent is considered an adverse event, according to *Parent Notifications and Adverse Events, Appendix A, List of Adverse Events and Medical Errors.*
- Occlusal X-rays were recorded and billed as periapical X-rays on the Hygiene form and Account History Report. It appears the Clinic may be taking occlusal X-rays each time that X-rays are exposed, which is not in accordance with the *ADA/FDA Guide to Patient Selection for Dental Radiographs*. Nine of the twenty records reviewed (patients #001, #006, #007, #008, #013, #015, #018, #019, and #020) did not provide adequate documentation to support the medical necessity for the exposure of occlusal X-rays that were taken on the audited date of service.
- The Monitor noted that complete oral exams were billed in seven records (patients #001, #004, #008, #015, #018, #019, and #020) when the previous six-month hygiene visit recorded the billing of periodic exams.
- The Monitor found the following billing errors:
  - The Account History Report for patients #002 and #013 did not record behavior management.
  - The Account History Report did not document the X-rays or digital photographs that were taken on June 16, 2010.
  - The Account History Report for patient #014 recorded the services for tooth #J twice: once with "AV" recorded as the provider and again with "DE" listed as the provider.
- Three of the records provided to the Monitor did not include all of the requested materials.
- Several records were missing the Acknowledgement form or Authorization form. Of the forms that were sent with the requested materials, the Monitor found one record where the Acknowledgement form was completed incorrectly and six records where the Authorization forms were not completed correctly.
- The Monitor determined that ten records contained Health History forms that were completed incorrectly. The CSHM audit found only two of the records were completed incorrectly. Areas that were completed incorrectly included missing answers pertaining to health history questions, follow-up questions pertaining to an illness, and/or the question regarding dental problems/concerns.
- The Monitor determined, with respect to the Tooth Chart, seven records did not have existing conditions and/or restorations properly documented on the upper

odontogram of the Tooth Chart, and three records did not show documentation of decay on the upper odontogram of the Tooth Chart. The CSHM audit reported only one finding in the audit tool's Tooth Chart section and it was associated with the charting of existing conditions and restorations.

- The Monitor determined that nine records did not have correctly completed Hygiene forms. The CSHM audit had two findings related to Hygiene forms.
- The Monitor determined, with respect to the Op Sheet, one record indicated that X-rays had been reviewed when no X-rays were taken and another was dated incorrectly. Furthermore, one record did not have the "Y" circled for behavior management and did not have the Nitrous Oxide section completed. Another record did not have the notes section completed correctly. In addition, eight records had procedures, surfaces, and/or diagnosis on the Op Sheet that did not match the lower odontogram of the Tooth Chart and/or the Treatment Plan. The CSHM audit tool only matched 10 out of the 16 "no" answers given by the Monitor in the Op Sheet section. CSHM's audit included review of one Op Sheet completed by another dentist.
- The Monitor determined, with respect to X-rays, one record was found to have non-diagnostic X-rays, six records did not identify the clinician who took the X-rays, and two records included X-rays that were not labeled correctly.
- CSHM's audit results e-mailed to the Clinic appeared to report several findings under the wrong patient's name. Additionally, there was a finding that was unclearly stated for patient #020.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 20 visit records:

- Ensure staff members provide all requested materials that are of a quality that allows review, including the Acknowledgment and Authorization forms and diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are trained to take radiographs that meet diagnostic standards.
- Ensure that radiographs are prescribed in accordance with the *ADA/FDA Guide to Patient Selection for Dental Radiographs*.
- Establish a procedure that documents when a parent/guardian has refused to complete the Authorization forms.
- Ensure Health History forms are completed correctly with explanations to all "yes" answers.
- Provide written guidance to Clinics in regards to which health conditions indicate the need to affix a medical alert or premedication sticker to the Tooth Chart.
- Ensure staff members clearly and accurately document, in the correct ink color, existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart.

- Ensure staff members are correctly completing all sections of the Hygiene form, Treatment Plan, Consent for Protective Stabilization Form, and the Op Sheet.
- Ensure billing errors are corrected and procedures that fail to have documentation of medical necessity are refunded.
- Ensure that consent is obtained for all treatment.
- Ensure that when consent is not given for a procedure an adverse event is reported and appropriate refunds are provided.
- Provide an explanation of why complete exams are being billed after a periodic exam.

The following recommendations are related to CHSM's chart audit process and the *Guidelines*:

- Provide clarification and direction in the *Guidelines* to assist auditors in determining when a medical alert or premedication sticker is required to be affixed to the Tooth Chart.
- Provide additional training to CHSM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas where there were Monitor findings but no corresponding CHSM findings.
- Ensure that all Op Sheets audited by CSHM pertain to the selected provider/dentist.
- Ensure that all findings are accurate and clearly stated when communicating audit results with Clinics.

EXHIBIT 49

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted], J.D.
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Small Smiles of East Albuquerque, PC
Albuquerque, New Mexico

Deliverable #1-22

April 8, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles of East Albuquerque, PC, (d/b/a) Small Smiles Dental Centers of Albuquerque (Clinic), 201 San Pedro SE, Suite B-2, Albuquerque, New Mexico, 87108.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 20 records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of 20 records that CSHM audited during the fourth quarter of 2010.

All four dentists received a lower score under the Monitor's review compared to the CSHM audit, with two dentists failing. The Monitor gave the Clinic an overall failing score of 88 percent.

The Monitor determined that three records (patients #002, #017, and #019) did not have sufficient documentation to support the medical necessity for the treatment provided and recommends that fees for those services be refunded. For patient #019, there is a notation that digital photographs were taken; however, they were not supplied to the Monitor. One additional record (patient #016) did not provide written consent for the stainless steel crown (SSC) performed on tooth #O. Treatment performed without written consent is considered an adverse event, according to the *Parent Notification and Adverse Events* policy.

The Monitor had the following findings related to billing on the Account History Report: patients #001, #014, #017, #018, and #019 show billing for non-diagnostic X-rays; patient #016 shows the billing of a SSC on tooth #I when there was no documented consent for the treatment of that tooth; patient #019 shows three periapical X-rays were billed on October 13, 2010, when the Operating Room (O.R.) Procedure form notes state they were non-diagnostic and taken at no charge.

Overall Summary of Recommendations

Set forth below are the Monitor's recommendations.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.

- Ensure that staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are trained to take radiographs that meet diagnostic standards and that there is no billing for non-diagnostic X-rays.
- Ensure that radiographs are prescribed in accordance with the *ADA/FDA Guide to Patient Selection for Dental Radiographs* and that the interpretation of X-rays is clearly documented in the patient's record.
- Establish a procedure that documents when a parent/guardian has refused to complete the Authorization forms.
- Ensure Health History forms are completed by a parent or person authorized to consent for treatment and completed correctly with explanations to all "yes" answers.
- Ensure staff members clearly and accurately document, in the correct ink color, existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members provide clear documentation regarding the medical necessity for each procedure performed when there is no evidence of decay visible on X-rays.
- Ensure staff members are correctly completing all sections of the Hygiene form, Treatment Plan, Consent for Protective Stabilization Form, and the Operative Procedures form (Op Sheet).
- Ensure billing errors are corrected and procedures that fail to have documentation of medical necessity are refunded.
- Ensure that consent is obtained for all treatment.
- Ensure that when consent is not given for a procedure an adverse event is reported and appropriate refunds are provided.
- Ensure that any form requiring a witness to the parent's signature is signed by the witness after obtaining the parent or guardian's signature.
- Ensure that staff members do not modify any documents in preparation for a chart audit.

The following recommendation is related to CSHM's chart audit process and the *Guidelines*:

- Provide additional training to CSHM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas, especially with respect to question #23, where there were Monitor findings but no corresponding CSHM findings.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles of East Albuquerque, PC, (d/b/a) Small Smiles Dental Centers of Albuquerque (Clinic), 201 San Pedro SE, Suite B-2, Albuquerque, New Mexico, 87108.

Implementation

The OIG approved a desk audit for Small Smiles of East Albuquerque, PC. On January 28, 2011, the Monitor notified the Clinic and CSHM's Compliance Officer via mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from the Clinic and CSHM on February 8, 2011. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the fourth quarter of 2010
  - E-mail to the Clinic with results for the fourth-quarter audit
  - Fourth-quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Revised Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*
    - *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*

CSHM initially requested the Clinic's charts on November 1, 2010. The Clinic provided the charts on November 5, 2010. The chart audit was completed on November 18, 2010, by a licensed dental hygienist. CSHM indicated the Clinic and all dentists passed the audit; therefore, no CAP was required, according to the *Chart Audit Policy*.

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the fourth quarter of 2010 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 13 of the 20 visit records reviewed.

Review of CSHM Chart Audit

Twenty records were reviewed, five for each dentist, following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services. The Monitor evaluated the records provided by the Clinic and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor and CSHM's scoring differences for the Clinic and dentists. All four dentists scored lower under the Monitor's review compared to the CSHM audit, with two dentists failing. The two dentists who received failing scores also had automatic failures of the chart audit due to inadequate documentation of medical necessity. The Clinic score was 88 percent, which is a failing score.

	Monitor Score	CSHM Score
[redacted]	80%	91%
[redacted]	94%	100%
[redacted]	96%	98%
[redacted]	71%	97%
Clinic Total Audit Score	**88%**	**96%**

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified. These findings are also included below.

[redacted] Small Smiles of East Albuquerque, PC

[redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The Health History form dated July 12, 2010, was signed by the patient's sister, who did not have authorization to give consent for the treatment that was rendered on July 12, 2010.	
#20	Existing restorations for teeth #R and #T were not recorded on the upper odontogram of the Tooth Chart.	
#21	The upper odontogram of the Tooth Chart documented mesial decay, which was evident on the X-ray; however, the Operative Procedures form (Op Sheet) and the Treatment Plan listed the distal surface, instead of the mesial. This documentation error did not impact the billing since the tooth was restored with a stainless steel crown (SSC).	
#37	There were no initials or diagonal line recorded after the last entry in the Hygiene notes.	HYG-7/12/2010: Initials or diagonal line not documented after the last entry in the notes.
#63	There were no initials or diagonal line recorded after the last entry in the Op Sheet notes.	OP-7/28/2010: Initials or diagonal line not documented after the last entry in the notes.
#67	Non-diagnostic panoramic X-ray.	
#71	The Monitor found the Account History Report was corrected and showed the extraction code 7140; however, the Montior did not review the July 12, 2010, Op Sheet because it did not relate to the dentist being audited. The Account History Report showed billing for the non-diagnostic panoramic X-ray.	BILLING: #F was documented on the account history as code 7111 but was documented on the operative sheet as code 7140.

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The existing restorations on teeth #A, #K, #S, and #T were not recorded on the upper odontogram of the Tooth Chart. There is a radiopacity visible on the bitewing X-ray between teeth #A and #B in the area of the crestal bone. There is a radiolucent area visible at the trifurcation of tooth #B. Neither of these radiographic findings were noted, nor was a periapical X-ray taken to further explore the condition of tooth #B.	No Comments
#23	Decay was not evident on the X-rays for tooth #C. There was no further documentation of caries detection by visual, tactile means recorded on the Tooth Chart or the Op Sheet. Therefore, there was inadequate documentation of medical necessity for the pulpotomy and SSC provided to tooth #C.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	"Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian" (Authorization form) was not sent with the requested materials.	
#15	There was no explanation given on the Health History form related to the patient's asthma/breathing problems.	HX-9/30/2010: An explanation is needed for Asthma/Breathing Problems in the "IF you answered "yes" to any of the above, please

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
		explain:" section.
#20	The existing crowns on teeth #E and #F were not recorded on the upper odontogram of the Tooth Chart.	
#54	The nitrous oxide section was completed on the Op Sheet and then marked through, initialed, and dated as an error; however, neither the "Y" nor the "N" was circled, thus making it difficult for the Monitor to determine whether nitrous oxide had or had not been administered.	OP-10/4/2010: Nitrous Oxide: Documentation not correct. Y or N was not documented but Behavior Indication, N2O%, Flush, Behavior Response & Vital Signs were documented and an error notation was documented.
#59	The treatment start time was recorded as 8:23 with the end of treatment as 8:28. Therefore, the total time recorded to perform five pulpotomies and SSC was five minutes. The time recorded for stabilization was 8:23 to 8:27. Either this was an error in documentation of time or it indicates an unlikely or insufficient length of time to perform the amount of treatment documented.	

Patient #004		
Question	Monitor's Findings	CSHM's Findings
#7	The Authorization form was not sent with the requested materials.	
#14	While the Monitor confirmed that no phone number or Social Security number was recorded at the top of the form, a phone number was found at the bottom of the Health History form. Therefore, the Monitor did not have this finding.	HX-8/12/2010: Phone number or Social Security Number not provided.
#58	The stabilization verification time has the 16 to 30 minute interval checked when the start and stop time	OP-8/19/2010: Stabilization Verification: Time increments 16-30 documented but time in Protective

[redacted] Small Smiles of East Albuquerque, PC

Patient #004		
Question	Monitor's Findings	CSHM's Findings
	recorded for stabilization totaled only 12 minutes.	Stabilization was 10:22-10:34 which is 12 minutes therefore, time increment 16-30 should not have been documented.
#68	X-rays were not labeled right or left.	

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
	The Monitor had no findings related to this record.	No Comments.

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The Monitor did not score this finding as "no" in the audit tool because it is not addressed in the *Guidelines*. The Monitor was unable to determine if the correction was made by the parent/guardian or a staff member.	HX-5/18/2010: Parent/Guardian date was corrected without proper error notation.
#34	There was no medical necessity or interpretation documented for the anterior periapical X-rays taken on May 18, 2010, or the periapical X-rays taken of tooth #19 on May 18, 2010, and August 19, 2010.	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Monitor was only provided with the "Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian" portion of the Authorization form.	No Comments
#21	The upper odontogram of the Tooth Chart does not document the interproximal decay that is evident on the X-ray on the mesial of tooth #D	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
	and the distal of tooth #E. Caries is only documented on the lingual surface of both teeth.	
#60	Only the lingual surface is documented for teeth #D and #E on the Op Sheet and Tooth Chart when the Treatment Plan lists the mesial, lingual for tooth #D, and the distal, lingual for tooth #E. Therefore, the tooth surfaces recorded on the Op Sheet and the Tooth Chart do not match the Treatment Plan.	

Patient #008		
Question	Monitor's Findings	CSHM's Findings
#7	The Authorization form was not sent with the requested materials	
#14	The patient's address was incomplete on the Health History form with no record of city, state, or ZIP code.	
#15	The Health History form was not dated correctly by the guardian. The date read "Aug 13" with no year recorded.	
#21	The Tooth Chart, Op Sheet, and Treatment Plan document distal, lingual caries on tooth #C. Upon review of the X-rays, the Monitor's pediatric dentist found significant mesial decay and no distal decay on tooth #C; therefore, the documentation of decay in the patient's record was incorrect. The findings on the X-ray, however, support the medical necessity for the SSC that was performed on tooth #C.	

Patient #008		
Question	Monitor's Findings	CSHM's Findings
#36	There are two staff initials on the Hygiene form but only one signature at the bottom of the form.	
#46	The Local Anesthesia and Nitrous Oxide Consent Form was signed by the dentist and a witness; however, there was no parent's signature.	TX Plan-8/13/2010: Local Anesthesia and Nitrous Oxide Consent Form not signed by the Parent/Guardian.
#53	The Op Sheet recorded "yes" for "consent signed and in chart"; however, the Local Anesthesia and Nitrous Oxide Consent Form was not signed by the parent.	

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#36	There are two staff initials on the Hygiene form but only one signature at the bottom of the form.	No Comments.

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Authorization form was not sent with the requested materials.	
#36	There were three initials in the staff box at the top of the Hygiene form but only two signatures at the bottom of the form.	
#37	There were no initials or diagonal line recorded after the last entry in the Hygiene notes.	HYG-8/16/2010: Initials or diagonal line not documented after the last entry in the notes.
#68	The bitewing X-ray of the left side was flipped, causing the duplicated X-rays to appear as two right side bitewing X-rays.	

[redacted]

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#36	The initials "DW" were recorded in the staff initials box at the top of the Hygiene form, but do not match the signature and initials "AZ" at the bottom of the page.	No Comments
#62	The initials "DW" were recorded in the staff initials box at the top of the Op Sheet, but do not match the signature and initials "AZ" at the bottom of the page.	

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Authorization form was not sent with the requested materials.	No Comments

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	The Authorization form did not document a witness name or signature.	
#21	The Monitor was unable to determine if tooth #C or #H had decay recorded on the upper odontogram of the Tooth Chart due to the poor quality of the black-and-white copy.	
#60	The Monitor was unable to verify if the tooth surfaces recorded on the Op Sheet and Treatment Plan matched the surfaces documented on the Tooth Chart due to the poor quality of the Tooth Chart copy sent with the requested materials.	
#63	A diagonal line was used after the last entry in the notes section; however, it was not recorded directly after the last entry. Instead, it was	OP-8/6/2010: Initials or diagonal line should go immediately after the last entry in the notes. Diagonal line was documented but on the next line

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
	located in the middle of the notes section.	after the last entry in the notes.

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The Monitor did not report CSHM's finding because it appeared as if the parent was the person who marked through the writing on the Health History form. Furthermore, no clear guidelines exist to address the issue of corrections made to forms by parents.	HX-6/7/2010: Error correction made without proper error notation in the question section below Patient Health History.
#59	The anesthetic start time was not documented correctly on the Op Sheet.	OP-8/10/2010: Anesthetic Started time documented as 9:4.
#61	Post operative instructions were not documented as written or oral on the OP Sheet.	
#67	The mandibular and maxillary occlusal X-rays dated June 6, 2010, were non-diagnostic due to poor contrast.	
#71	The Account History Report shows billing for the June 6, 2010, occlusal X-rays, which were non-diagnostic.	
No question number to address this finding	A correction was made to the June 7, 2010, Hygiene form in which two bitewing X-rays were marked through and "diagnostic photos" were added. The correction was made on November 2, 2010, the day after the CSHM Chart Audit Request e-mail was sent.	

[redacted] Small Smiles of East Albuquerque, PC

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#36	The initials "DW" were recorded in the staff initials box at the top of the Hygiene form, but do not match the signature and initials "AZ" at the bottom of the page.	
#45	The parent did not initial the appointment options box.	

[redacted]

Patient #016		
Question	**Monitor's Findings**	**CSHM's Findings**
#28	The caries risk assessment section was not completed on the Hygiene form.	
#44	The Treatment Plans dated August 16, 2010, and October 13, 2010, did not document consent for the treatment that was performed on tooth #O. Therefore, there was no consent for the SSC performed on tooth #O.	
#45	There were no initials or n/a recorded in the white crown(s) option box on the October 13, 2010, Treatment Plan.	
#60	The Treatment Plan did not include tooth #O; therefore, the O.R. Procedures form and the lower odontogram of the Tooth Chart did not match the Treatment Plan.	
#63	Blank lines were left between entries in the notes section of the O.R. Procedures form.	OP-10/13/2010: Initials or diagonal line not documented after last entry in the notes. Also, do not leave blank lines in between lines of notes.
#68	X-rays dated August 16, 2010, were not labeled right or left.	

Patient #016		
Question	**Monitor's Findings**	**CSHM's Findings**
#71	The Account History Report shows billing of an SSC for tooth #O when consent was not obtained for the treatment of that tooth.	

Patient #017		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Authorization form was not sent with the requested materials.	
#20	The Monitor was unable to verify if existing conditions were properly documented due to non-diagnostic X-rays.	
#21	According to the *Guidelines*, "no" is scored on the audit tool when "X-rays are not diagnostic and written documentation is not provided." Not only were X-rays non-diagnostic, but digital photographs were not taken and there was no documentation of caries detection by visual, tactile means.	
#23	The Monitor's pediatric dentist reviewed the X-rays and found that there was inadequate documentation to support the medical necessity for the SSC placed on teeth #A, #J, #K, #L, and #T due to non-diagnostic X-rays, no digital photographs, and no documentation of caries detection by visual, tactile means. CSHM's audit tool did not have an answer for this question.	
#32	The CSHM auditor scored a "no" for this question on the audit tool but did not include the finding in the e-mail to the Clinic. The question asks: "If no X-rays were taken, is reason documented?" Upon review of the	

Patient #017		
Question	**Monitor's Findings**	**CSHM's Findings**
	record, the Monitor found documentation of the reason for not taking X-rays on the Hygiene form; therefore, the Monitor entered "yes" for this question.	
#33	This question asks: "If no X-rays were taken, were digital pictures taken?" Upon review of the record, the Monitor found that neither X-rays nor digital photographs were taken.	
#47	The Treatment Plan had a line through the date of the dentist's signature. The date was changed from August 5, 2010, when the Treatment Plan was formulated, to October 20, 2010, the day the treatment was rendered. The change was not initialed or dated.	TX Plan-8/5/2010: Proper error correction was not made for the date documented by the Dentist. The treatment plan date is to correspond with the operative sheet date. If any changes are made then a new treatment plan should be documented. The date was changed by the Dentist from 8/5/2010 to 10/20/2010.
#62	The Monitor did not have a finding related to the initials and signatures on the O.R. Procedures form dated October 20, 2010. There were three initials in the box and three signatures at the bottom of the form.	Three sets of initials and 4 signatures.
#63	The last entry in the notes section of the O.R. Procedures form was not followed by initials or a diagonal line.	OP-10/20/2010: Initials or diagonal line not documented after the last entry in the notes.
#65	There was no documentation on the O.R. Procedures form or on the X-rays indicating the clinician who took the X-rays.	
#67	The X-rays dated October 20, 2010, were of poor quality and non-diagnostic.	
#71	The Account History Report shows billing for two bitewing X-rays and four periapical X-rays, all of which	

Patient #017		
Question	**Monitor's Findings**	**CSHM's Findings**
	were non-diagnostic.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity.		

Patient #018		
Question	**Monitor's Findings**	**CSHM's Findings**
#45	The appointment options and local anesthesia and nitrous oxide/oxygen sections on the October 20, 2010, form were not completed correctly. An "X" was marked beside the one appointment box and the local anesthesia box; however, both boxes were left blank.	TX Plan-10/20/2010: TX Plan – At least one of the option boxes should be either initialed or marked n/a in the appointment options and crown options (and both the local anesthesia and the nitrous need to be either initialed or marked n/a). Local Anesthesia not documented with initials or n/a.
#46	The Monitor did observe that the Local Anesthesia and Nitrous Oxide Consent form dated October 20, 2010, was signed by the dentist and the witness with only a date entered next to the parent's signature line. Local anesthesia and nitrous oxide, however, were not administered because the patient was treated in the O.R.; therefore, consent was not required.	Local Anesthesia and Nitrous Oxide Consent Form not signed by the parent/guardian.
#63	The last entry in the notes section of the O.R. Procedures form was not followed by initials or a diagonal line.	OP- 10/20/2010: Initials or diagonal line not documented after the last entry in the notes.
#65	Clinician who took X-rays was not documented on the O.R. Procedures form or the X-rays.	
#67	The posterior X-rays dated October 20, 2010, were of poor quality and generally non-diagnostic.	
#68	The maxillary anterior X-ray dated October 20, 2010, appears to be flipped and was not duplicated	

Patient #018		
Question	**Monitor's Findings**	**CSHM's Findings**
	correctly.	
#71	The Account History Report shows billing for two bitewing X-rays and four periapical X-rays, all of which were non-diagnostic.	BILLING-Digital Photos documented on the hygiene sheet 9/9/2010 not documented on the account history for 9/9/2010.

Patient #019		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The "Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian" portion of the Authorization form was not included in the requested materials.	
#14	The Health History form did not document whether the patient was male or female.	HX-9/15/2010: Gender not documented.
#21	The upper odontogram of the Tooth Chart recorded only mesial decay on tooth #L. The Monitor's pediatric dentist reviewed the X-rays and found distal decay on tooth #L. Mesial decay could not be determined due to the poor quality of the X-rays.	
#23	The Monitor's pediatric dentist found the X-rays for teeth #A, #J, #K, #S, and #T were non-diagnostic and there was no documentation of caries detection by visual, tactile means; therefore, there was inadequate documentation to support the medical necessity for the treatment provided to teeth #A, #J, #K, #S, and #T. The Hygiene form documents that three digital photos were taken; however, they were not sent with the requested materials.	
#24	The Monitor did not have this finding.	Tooth Chart-9/15/2010:ASST/HYG

Patient #019		
Question	**Monitor's Findings**	**CSHM's Findings**
	The Tooth Chart dated September 15, 2010, had a signature on the line designated for "Asst/Hyg Signature" with no indication that the signature was added at a later date.	signature not documented
#37	There were no initials or diagonal line recorded after the last entry in the Hygiene notes.	HYG-9/15/2010: Initials or diagonal line not documented after the last entry in the notes.
#63	There were no initials or diagonal line recorded after the last entry in the notes on the O.R. Procedures form.	OP-10/13/2010: Notes should begin on the top line. Initials or diagonal line not documented after the last entry in the notes.
#65	There was no documentation on the O.R. Procedures form or the X-rays indicating the clinician who took the X-rays dated October 13, 2010.	
#67	The X-rays dated October 13, 2010, were of poor quality and generally non-diagnostic.	
#68	The X-rays dated September 15, 2010, were not labeled right or left.	
#71	The Hygiene form recorded three digital photos were taken; however, there was no entry for digital photos on the Account History Report. The O.R. Procedures form documents that three periapical X-rays were taken, but the notes section states: "PA's taken but did not expose to be diagnostic so no charge". The Account History Report shows that the three periapical X-rays were billed.	
Automatic failure of the chart audit due to inadequate documentation of medical necessity; however, the Monitor notes that the digital photographs mentioned in the record were not supplied.		

Patient #020		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The existing crown on tooth #I was not documented on the upper odontogram of the Tooth Chart. Upon review of the X-rays, the Monitor's pediatric dentist found a radiolucency in the trifurcation of tooth #I, which was not documented or addressed in the Treatment Plan.	Tooth Chart-8/9/2010: An existing crown visible on the radiograph for #I was not documented on the tooth chart.
#63	The entire notes section on the Op Sheet was used, leaving no blank lines; however, there were no initials following the last entry.	OP-8/26/2010: Initials or diagonal line not documented after the last entry in the notes.
#68	The X-rays sent to the Monitor were labeled correctly.	X-Rays- 8/19/2010: X-Rays not labeled L-R.

The Monitor had the following observations:

- Six of the reviewed records contained blank Authorization forms. When the Authorization form is blank, the *Guidelines* instruct the auditor to score as "n/a" on the audit tool since, according to CSHM, this form is not required to be completed by the parent or guardian. A blank form, however, makes it difficult for an auditor to determine whether the document was ever provided to the parent or guardian since there is no documentation that they refused to complete the form.
- The documentation for sealants consisted of a circle drawn on the occlusal surface instead of an "S," which is instructed in the *Patient Care Manual*.

Below is a summary of the Monitor's findings of CSHM's audit of the Clinic:

- There continues to be significant scoring differences between the Monitor and CSHM's audit, especially to questions that affect the dentist's quality score.
- The Monitor determined that three records (patients #002, #017, and #019) did not have sufficient documentation to support the medical necessity for treatment that was provided. The Monitor notes, however, that for patient #019, the record reflects digital photographs were taken but they were not supplied for the audit.
- One additional record (patient #016) did not provide written consent for the SSC performed on tooth #O. Treatment performed without written consent is considered an adverse event, according to *Parent Notifications and Adverse Events, Appendix A, List of Adverse Events and Medical Errors.*
- The Monitor found the following billing errors:
  - The Account History Report for patients #001, #014, #017, #018, and #019 shows billing for non-diagnostic X-rays.

- The Account History Report for patient #016 shows the billing of an SSC on tooth #I when there was no documented consent for the treatment of that tooth.
- The Account History Report for patient #019 did not record the three digital photos taken at the hygiene appointment and shows that three periapical X-rays were billed on October 13, 2010, when the O.R. Procedure form notes state that they were non-diagnostic and taken at no charge.

- Eight of the records provided to the Monitor did not include all of the requested materials. The records were either missing the entire Authorization form or a portion of the form.
- The Monitor determined that four records contained Health History forms that were completed incorrectly. The CSHM audit found five records with incorrectly completed Health History forms. Of the five CSHM health history related findings, the Monitor only agreed with two of the findings (patients #003 and #019). Two records that CSHM did not report health history related findings were for patient #001, whose Health History form was completed and signed by the patient's sibling who was not authorized to give consent for treatment. Patient #008's address was incomplete and the parent's signature date did not include the year.
- The Monitor determined, with respect to the Tooth Chart, four records did not have existing conditions and/or restorations properly documented on the upper odontogram of the Tooth Chart, and five records did not show documentation of decay on the upper odontogram of the Tooth Chart. The CSHM audit reported only two findings in the audit tool's Tooth Chart section and they were associated with the charting of existing conditions and restorations in one record and a missing signature in another record.
- Question #23 addresses whether appropriate documentation of medical necessity was recorded in the patient's record when decay is not visible on the X-rays. According to the Guidelines, a "no" answer to this question results in an automatic failure of the chart audit for the dentist being audited. Nineteen records on the CSHM audit tool show "n/a" was entered for question #23; the remaining record did not have an entry and was left blank. The Monitor scored question #23 as either "yes" or "no" for 10 of the 20 records; 3 of the 10 were scored as "no" due to inadequate documentation of medical necessity.
- The Monitor determined that ten records did not have correctly completed Hygiene forms. The CSHM audit had four findings related to Hygiene forms.
- The Monitor determined there were eight records with one or more documentation errors on the Op Sheet. These involved documentation associated with local anesthesia or nitrous oxide, time in the operatory, stabilization, confirmation of consent, signatures, complications or post operative instructions, and the proper documentation of procedures, surfaces, and diagnosis. The CSHM audit tool recorded 12 "no" answers and only matched 10 out of the 16 "no" answers given by the Monitor in the Op Sheet section.
- The Monitor determined, with respect to X-rays, one record (patient #006) did not document the medical necessity or interpretation of the X-rays that were taken.

Five records were found to have non-diagnostic X-rays, while three records did not identify the clinician who took the X-rays. Five records also included X-rays that were not labeled correctly.

- The record for patient #014 showed a correction was made to the June 7, 2010, Hygiene form on November 2, 2010, the day after the CSHM Chart Audit Request e-mail was sent.
- The Monitor was unable to determine proper documentation on the Tooth Chart for patient #013 due to the quality of the Tooth Chart copy sent with the requested materials.
- Several documents, in which CSHM's auditor reported missing information, appeared as if they were changed or corrected without properly initialing and dating the modification.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 20 visit records:

- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.
- Ensure that staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are trained to take radiographs that meet diagnostic standards and that there is no billing for non-diagnostic X-rays.
- Ensure that radiographs are prescribed in accordance with the *ADA/FDA Guide to Patient Selection for Dental Radiographs* and that the interpretation of X-rays is clearly documented in the patient's record.
- Establish a procedure that documents when a parent/guardian has refused to complete the Authorization forms.
- Ensure Health History forms are completed by a parent or person authorized to consent for treatment and completed correctly with explanations to all "yes" answers.
- Ensure staff members clearly and accurately document, in the correct ink color, existing conditions, restorations, decayed surfaces, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members provide clear documentation regarding the medical necessity for each procedure performed when there is no evidence of decay visible on X-rays.
- Ensure staff members are correctly completing all sections of the Hygiene form, Treatment Plan, Consent for Protective Stabilization Form, and the Op Sheet.
- Ensure billing errors are corrected and procedures that fail to have documentation of medical necessity are refunded.
- Ensure that consent is obtained for all treatment.

- Ensure that when consent is not given for a procedure an adverse event is reported and appropriate refunds are provided.
- Ensure that any form requiring a witness to the parent's signature is signed by the witness after obtaining the parent or guardian's signature.
- Ensure that staff members do not modify any documents in preparation for a chart audit.

The following recommendation is related to CSHM's chart audit process and the *Guidelines*:

- Provide additional training to CSHM auditors to ensure that the testing attributes are being properly scored, with emphasis in those areas, especially with respect to question #23, where there were Monitor findings but no corresponding CSHM findings.

EXHIBIT 50

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Small Smiles Dental Centers of Myrtle Beach
Myrtle Beach, South Carolina

Deliverable #1-25

May 9, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Myrtle Beach (Clinic), 1317 N. Kings Highway, Suite 106, Myrtle Beach, SC 29577.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 15 records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings and observations from the Monitor's review of 15 records that CSHM audited during the fourth quarter of 2010.

All three dentists received a lower score under the Monitor's review compared to the CSHM audit, with one dentist failing. The Monitor's overall Clinic score of 90 percent was also lower than CSHM's overall Clinic score of 96 percent.

The CSHM Chart Audit Tool does not have a question to assess whether the decision to provide operative treatment without local anesthesia was appropriate. There were no comments in the CSHM chart audit results to the Clinic regarding the operative procedures performed on two patients without the documentation of the administration of local anesthesia.

The Monitor was unable to find a question in CSHM's Chart Audit Tool to report when there was no documentation provided in the patient's record to support the modification of the Treatment Plan or the choice of restoration(s) provided on the audited date of service. The Monitor reported this finding for patients #001, #007, #008, and #010; however, the Monitor understands that the new testing attributes in the revised Chart Audit Tool will allow for the assessment of these findings.

CSHM did not report any findings related to the Tooth Chart. All 11 of the Monitor's findings related to the Tooth Chart were for *Quality Assurance Protocol* (QAP) and Quality Score Items.

The September 15, 2010, Treatment Plan for patient #010 did not document a planned procedure for tooth #B; therefore, there was no consent obtained for the multiple-surface filling that was performed on tooth #B.

The Monitor had the following findings pertaining to treatment rendered by one of the audited dentists. Since the majority of these findings were not addressed in the Guidelines and, therefore, not captured in the Chart Audit Tool, the audited dentist received a passing chart audit score. These findings were not identified or addressed by CSHM.

- Two records (patients #007 and #010) showed five-surface fillings were performed instead of the stainless steel crowns (SSCs) that were treatment planned. In addition, there was no documentation in the patient's records to support the rationale or show parental consent was obtained for the change in treatment. Furthermore, the record for patient #010 showed that decay was left untreated to watch in a child with rampant decay.
- One record (Patient #008) showed that teeth with existing two-surface fillings and extensive decay were re-treated with multiple-surface fillings rather than SSCs and no justification was documented to support the rationale for the choice in treatment.
- Three records reviewed for this dentist had significant findings pertaining to local anesthesia. Two records (patients #007 and #008) showed no evidence that local anesthesia was administered for operative procedures that involved extensive treatment due to rampant decay. The remaining record (patient #010) did not show evidence that the Dose Calculated for Patient's Weight (DCPW) was calculated and according to the patient's weight, the local anesthesia dose that was documented exceeded the maximum dose allowed.

According to the Monitor's pediatric dentist's review of the X-ray, patient #014 had extensive decay on tooth #S that appears to extend into the pulp chamber and a furcation radiolucency. Tooth #S appears on the X-ray to be abscessed and non-restorable. If the X-ray was in conflict with the visual appearance of the tooth during clinical examination, and the clinical appearance of the tooth was used to justify the treatment decision, the discrepancy should have been noted in the dentist's notes or on the Tooth Chart. The patient's record did not show documentation of this finding or the rationale for restoring a tooth that appears to be non-restorable on the X-ray. This finding was not addressed in the CSHM chart audit.

While we note that this observation is outside of the scope of the audit, the Monitor observed residual cement or restorative material between teeth #I and #J on the March 8, 2010, and September 9, 2010, bite-wing X-rays of patient #008. There was no documentation in the patient's record to show this was identified and/or removed.

Overall Summary of Recommendations

Set forth below are the Monitor's recommendations:

The following recommendations are based on the Monitor's findings from the review of the 20 visit records:

- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.
- Ensure that staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure that consent is obtained when a change is made in restoration materials.
- Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members are trained and monitored in the proper completion of the Health History, Hygiene Procedure form, Operative Procedures form (Op Sheet), and Treatment Plan.
- Ensure that further assessment is provided by the Chief Dental Officer to determine trends and training needs in this Clinic related to procedures involving multiple-surface fillings on primary molars and operative treatment provided without the use of local anesthesia.
- Ensure that patients are receiving local anesthesia when necessary.
- Ensure that staff members are using the available tools to determine the DCPW and monitor to ensure that the maximum dose of local anesthesia is not exceeded.
- Determine why a mesial occlusal (MO) composite was billed for patient #006 when the dentist indicated that there was only a distal occlusal (DO) filling performed.

The following recommendations are related to CSHM's chart audit process and the *Guidelines for Chart Audit Scoring* (*Guidelines*):

- Further discussion is needed between the Monitor and CSHM regarding the *Clarification of Guidelines for Chart Audit Scoring*.
- Ensure that QAP and Quality Score Items are identified by CSHM's auditor and modifications are made to capture all unaddressed findings in the Chart Audit Tool.
- Add a testing attribute in the chart audit tool to assess whether local anesthesia was used when procedures performed would typically require it.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Myrtle Beach (Clinic), 1317 N. Kings Highway, Suite 106, Myrtle Beach, SC 29557.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of Myrtle Beach. On February 18, 2011, the Monitor notified the Clinic and CSHM's Compliance Officer by mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, and any Corrective Action Plans (CAPs) including rationale for imposing them. The Monitor received the documentation from the Clinic and CSHM on February 28, 2011; however, the package was damaged and was returned to CSHM to determine the completeness of the response. CSHM returned the materials on March 10, 2011, and the due date was amended to May 9, 2011. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the fourth quarter of 2010
  - E-mail to the Clinic with results for the fourth-quarter audit
  - Fourth-quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- *Clarification of Guidelines for Chart Audit Scoring*
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Guidelines for Chart Audit Scoring (Guidelines)*

- *Methodology for Calculating Individual Dentist Chart Audit Scores*
- *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*

CSHM initially requested the Clinic's charts on December 7, 2010. The Clinic provided the charts on December 13, 2010. The chart audit was completed on December 22, 2010, by a licensed dental hygienist. CSHM indicated the Clinic and all dentists passed the audit; therefore, no CAP was required, according to the *Chart Audit Policy*.

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the fourth quarter of 2010 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 5 of the 15 visit records reviewed.

Review of CSHM Chart Audit

Fifteen records were reviewed, five for each dentist, following the *Clinical Guidelines and Quality Assurance Protocol* (QAP) metrics as outlined in the *Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services*. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentists. All three dentists scored lower under the Monitor's review compared to the CSHM audit, with one dentist failing. The Monitor's overall Clinic score of 90 percent was also lower than CSHM's overall Clinic score of 96 percent.

	Monitor Score	CSHM Score
[redacted]	87%	92%
[redacted]	91%	97%
[redacted]	90%	97%
Clinic Total Audit Score	**90%**	**96%**

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified. These findings are also included below.

[redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#21	The Operative Procedures form (Op Sheet) documents a distal occlusal buccal (DOB) filling was performed on tooth #S; however, the upper odontogram of the Tooth Chart did not document buccal decay for tooth #S.	
#54	Initial concentration of nitrous oxide was not documented on the Op Sheet.	
#68	X-rays dated October 11, 2010, were not labeled right or left.	X-rays-(10/11/2010) Bite wing x-ray film are not properly labeled L-R.
#71	X-rays dated October, 11, 2010, were not recorded on the Account History Report.	
There is no question on the current CSHM Audit Tool to address this issue.	No explanation was given in the Op Sheet notes regarding the rationale for providing three-surface fillings on teeth #B and #S as opposed to SSCs. The Monitor recognizes that this has been addressed by Dr. [redacted] Chief Dental Officer (CDO), in the November 1, 2010, *Intracoronal Restorations Documentation Policy* and will be captured in the revised Chart Audit Tool.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#59	The start and stop time recorded at the bottom of the Op Sheet was not fully visible. The Monitor agrees with CSHM's auditor in that this finding was not an issue of excessive treatment time but a communication to the Clinic regarding their responsibility in providing a complete and accurate duplication of the patient's record for review. This question was scored as "yes" by both CSHM and the Monitor.	Operative sheet-(10/29/2010) Note: please make sure that time in operative is clearly visible when duplicating the operative sheet for audit review. Do not cut the bottom of the sheet off.

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#68	X-rays dated October 7, 2010, were not labeled right or left.	X-rays-(10/7/2010) Bite wing x-ray film are not properly labeled L-R.

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#54	Initial concentration of nitrous oxide was not documented on the Op Sheet dated November 11, 2010.	Operative sheet-(11/11/2010) Under the Nitrous oxide section of the operative sheet. The initial concentration was not properly documented. The initial concentration section as well as the working concentration sections must be properly documented.
#68	Duplicate X-rays received by the Monitor were not dated correctly or labeled right or left. Two sets of bitewing X-rays were received, one dated August 22, 2008, and the other with two dates, August 22, 2008, and October 13, 2010.	X-rays-(10/13/2010) Bite wing x-ray film are not properly labeled L-R.

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#54	Initial concentration of nitrous oxide was not documented on the Op Sheet dated October 20, 2010.	Operative sheet-(10/20/2010) Under the Nitrous oxide section of the operative sheet. The initial concentration was not properly documented. The initial concentration section as well as the working concentration sections must be properly documented.
#68	X-rays dated October 14, 2010, were not labeled right or left.	X-rays-(10/13/2010) Bite wing x-ray film are not properly labeled L-R.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#54	Initial concentration of nitrous oxide was not documented on the Op Sheet dated October 15, 2010.	Operative sheet-(10/15/2010) Under the Nitrous oxide section of the operative sheet. The initial concentration was not properly documented. The initial concentration section as well as the

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
		working concentration sections must be properly documented.
#68	X-rays dated October 8, 2010, were not labeled right or left.	X-rays-(10/8/2010) Bite wing film are not properly labeled L-R.

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#20 and #21	The Monitor was sent a black-and-white copy of the Tooth Chart and was unable to verify if existing conditions and decay were properly documented on the upper odontogram of the Tooth Chart.	
#60	The Treatment Plan for tooth #5 initially documented a mesial occlusal distal (MOD) filling but was changed on the date of service, October 8, 2010, to a "(DO) fill only per [redacted]" Despite the note on the Treatment Plan, the October 8, 2010, Op Sheet and the Account History Report recorded a mesial occlusal (MO) composite and a distal occlusal (DO) amalgam were performed on tooth #5. If two separate restorations were performed on tooth #5, there was no documentation to support the rationale for performing and billing two restorations instead of one, especially when the Treatment Plan was changed to reflect that only a DO filling was needed.	
#68	X-rays dated September 10, 2010, were not labeled right or left.	X-rays-(9/10/2010) Bitewing x-ray film are not properly labeled L-R.

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement of Receipt of Notice of Privacy Practices	Consents and acknowledgements (10/4/2010) the acknowledgements

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
	(Acknowledgement form) and the Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment (Authorization form), dated August 31, 2010, were included in the requested materials; however, a different patient name was listed on the forms, possibly the patient's sibling. Therefore, the Acknowledgement and Authorization forms that pertain to this patient were not received with the requested materials.	notice of privacy practice signed and dated by the parent/guardian is not included with the materials requested.
#60	The procedures recorded for teeth #B and #S on the October 7, 2010, Op Sheet do not match the Treatment Plan. The Treatment Plan shows a stainless steel crown (SSC) and possible pulpotomy for tooth #B and pulpotomy and SSC for tooth #S; however, the Op Sheet documents five-surface fillings were performed on teeth #B and #S. According to the *Clarification of Guidelines for Chart Audit Scoring*, this finding should have been identified since there was no consent for the change in restorative materials and procedures that were performed on teeth #B and #S.	Operative -sheet (10/7/2010) Surfaces and procedures on the operative sheet do not match the treatment plan form. Tooth #S was treatment planned for a stainless steel crown and a pulptomy however a five (5) surface Mesial Distal Occulusal Buccal Lingual composite restoration was done instead.
#68	X-rays dated October 4, 2010, were not labeled right or left.	X-rays-(10/4/2010) Bitewing x-ray film are not properly labeled L-R.
There is no question on the current CSHM Audit Tool to address	No explanation was given in the Op Sheet notes regarding the change in the Treatment Plan or the rationale for providing five-surface fillings on teeth #B and #S as opposed to SSCs. The Monitor recognizes that this has been addressed by [redacted], CDO, in the November 1, 2010, *Intracoronal Restorations*	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
this issue.	*Documentation Policy* and will be captured in the revised Chart Audit Tool.	
There is no question on the current CSHM Audit Tool to address this issue.	There was no documentation of use of local anesthesia on the October 7, 2010, Op Sheet for the treatment performed on teeth #A, #B, #S, #T, and #30. There was documentation of the use of nitrous oxide. Teeth #B and #S had the potential of carious pulp exposures and were treatment planned for SSCs with possible pulpotomies. According to the Monitor's pediatric dentist, teeth #B and #S had radiographically demonstrable large carious lesions that extended more than half way through the dentin. It would be unreasonable to expect to be able to remove decay and restore these teeth without the use of local anesthesia.	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Monitor only received the last page of the Authorization form and did not receive the entire document with the requested materials.	
#20	The Monitor's pediatric dentist noted on the X-rays dated September 9, 2010, a furcation radiolucency indicative of failure of the pulpotomy on tooth #S. The existing pulpotomy on tooth #S and this radiographically demonstrable finding were not noted on the upper odontogram of the Tooth Chart.	
#21	The Monitor's pediatric dentist noted radiographically demonstrable decay on the distal of tooth #T, which was not recorded on the upper	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
	odontogram of the Tooth Chart.	
#53	The Op Sheet did not have "Y" or "N" circled to indicate "consents signed and in chart."	
#68	X-rays dated March 8, 2010, and September 9, 2010, were not labeled right or left.	Xrays-(9/9/2010) Bite wing xray film are not properly labeled L-R.
There is no question on the current CSHM Audit Tool to address this issue.	Teeth #L and #T were re-treated due to recurrent decay around the existing two-surface fillings. Tooth #L received another (DO) filling and tooth #T received a (MOD) filling. There was no documentation of the rationale to restore teeth #L and #T with multiple-surface fillings instead of SSCs. The Monitor recognizes that this has been addressed by [redacted] CDO, in the November 1, 2010, *Intracoronal Restorations Documentation Policy* and will be captured in the revised Chart Audit Tool.	
There is no question on the current CSHM Audit Tool to address this issue.	There was no documentation of use of local anesthesia on the September 9, 2010, Op Sheet for the multiple-surface fillings performed on teeth #L and #T. The X-ray reveals significant decay on the mesial of tooth #T that could have resulted in a carious pulp exposure. According to the Monitor's pediatric dentist, teeth #L and #T had large carious lesions that extended more than half way through the dentin. It would be unreasonable to expect to be able to remove decay and restore these teeth without the use of local anesthesia.	

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#20 and #21	The Monitor was sent a black-and-white copy of the Tooth Chart and was unable to verify if existing conditions and decay were properly documented on the upper odontogram of the Tooth Chart.	
#61	The section on the Op Sheet to indicate whether there were complications or no complications was not completed.	
#68	X-rays dated April 20, 2010, and October 21, 2010, were not labeled right or left.	X-rays-(10/29/2010) Bite wing x-ray film are not properly labeled L-R.

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The Health History did not have an explanation for the "yes" answer given for Attention Deficit Hyperactivity Disorder (ADHD).	Health X page-(9/15/2010)-questions answered "yes" need supporting explanations in the "if you answered 'Yes' to any of the above, please explain:" section
#20	The existing restoration on tooth #R was not documented on the upper odontogram of the Tooth Chart. The Tooth Chart also did not record the radiograhically demonstrable ectopic eruption of tooth #3.	
#28	The patient's oral hygiene and occlusion were not documented on the Hygiene Procedures form.	
#43	There was no procedure(s) listed for tooth #B on the Treatment Plan dated September 15, 2010. Therefore, there was no consent obtained for the multiple-surface filling that was performed on tooth #B. The note to watch the diagnosed mesial and distal decay "watch (MD)" of tooth #A was added to the Treatment Plan without being	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
	initialed or dated.	
#54	Initial concentration of nitrous oxide was not documented on the Op Sheet. The Op Sheet used on September 23, 2010, did not include a space for the Dose Calculated for Patient's Weight (DCPW) and the Local Anesthetic Calculation Worksheet was not provided. The Op Sheet records 2 carpules of 4% Septocaine were administered and the maximum calculated dose for this child's weight was 1.76 carpules.	Operative -sheet (9/23/2010) Under the Nitrous oxide section of the operative sheet. The initial concentration was not properly documented. The initial concentration section as well as the working concentration sections must be properly documented.
#60	The surfaces and procedures on the Op Sheet do not match the Treatment Plan. Tooth #A was treatment planned for a pulpotomy and SSC; however, an occlusal, lingual composite was performed instead. Tooth #B did not have a procedure recorded on the Treatment Plan; however, the Op Sheet documents a four-surface composite restoration was performed. According to the Clarification of Guidelines for Chart Audit Scoring, this finding should have been identified since there was no consent for the change in restorative materials or the procedures that were performed on teeth #A and #B.	
#68	X-rays dated April 27, 2009, and September 15, 2010, were not labeled right or left.	X-rays-(9/15/2010) Bite wing x-ray film are not properly labeled L-R.
There is no question on the current CSHM Audit	The Monitor's pediatric dentist reviewed this record and found teeth #B and #C were restored with large multiple-surface fillings instead of SSCs with no justification for choice of restoration. According to the notes on the Op Sheet, tooth #A was not	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
Tool to address this issue.	treated as planned with a pulpotomy and SSC and received an occlusal-lingual filling instead because the dentist was "unable to access #A distal without damaging mesial of tooth #3 which is wedged into distal root structure of #A – will watch". Therefore mesial and distal decay on tooth #A, which were "diagnosed radiographically and via visual-tactile detection" according to the Tooth Chart, were left untreated to "watch" in a child with rampant decay.	

[redacted]

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#60	The pulpotomies performed on teeth #B, #S, and #T were not documented on the lower odontogram of the Tooth Chart. The Monitor disagrees with CSHM's auditor's findings that surfaces are properly documented on the Op Sheet. The Monitor found that all tooth surfaces, mesial, occlusal, distal, buccal, and lingual (MODBL), were recorded on the Op Sheet for teeth #B, #S, and #T and do not match the Treatment Plan surfaces shown as (MOD) for tooth #B, (DO) for tooth #S, and (O) for tooth #T.	Operative sheet (9/8/2010) surfaces and procedures are properly documented on the operative sheet however the operative sheet does not match the tooth chart because teeth #s B, S, and T are not properly documented with the "P" for pulp on the bottom of the dental odontogram
#68	X-rays dated October 28, 2008, and August 20, 2010, were not labeled right or left.	X-rays-(8/30/2010) Bite wing x-ray film are not properly labeled L-R.

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
#43	Tooth surfaces diagnosed with decay for teeth #S and #T were not included on the Treatment Plan.	
#54	Initial concentration of nitrous oxide	Operative sheet (9/15/2010) Under

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
	was not documented on the Op Sheet. The Monitor also noticed that the location for local anesthetic was recorded for the left side when treatment was performed on the right side.	the Nitrous oxide section of the operative sheet. The initial concentration was not properly documented. The initial concentration section as well as the working concentration sections must be properly documented.
#60	Tooth surfaces diagnosed with decay were not recorded for teeth #S and #T on the Op Sheet.	
#68	X-rays dated August 10, 2009, and August 22, 2010, were not labeled right or left. The X-rays dated August 22, 2010, were dated with the wrong date. There were no X-rays dated August 27, 2010, provided to the Monitor.	X-rays-(8/27/2010) Bite wing x-ray film are not properly labeled L-R.

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#60	The diagnosis of carious pulp exposure (CPE) to support the medical necessity for the pulpotomies performed on teeth #S and #T was not documented on the November 18, 2010, Op Sheet. In addition, all tooth surfaces (MODBL) were recorded on the Op Sheet for teeth #S and #T and do not match the Treatment Plan surfaces shown as (DO) for tooth #S and (MO) for tooth #T.	
#68	X-rays dated November 8, 2010, were not labeled right or left.	X-rays-(11/8/2010) Bite wing x-ray film are not properly labeled L-R.

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The upper odontogram of the Tooth Chart does not reflect the radiographically demonstrable findings for tooth #S. The Monitor's pediatric dentist reviewed the X-ray	

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
	dated October 26, 2010, and noted furcation radiolucency for tooth #S.	
#21	All tooth surfaces recorded on the Op Sheet were not documented on the upper odontogram of the Tooth Chart. The Op Sheet shows all surfaces MODBL for teeth #S and #T are diseased, whereas the Tooth Chart only documents decay on the occlusal surface of teeth #S and #T.	
#43	Tooth surfaces diagnosed with decay were not included for teeth #S and #T on the Treatment Plan.	
#60	The diagnosis of CPE for the pulpotomies performed on teeth #S and #T was not documented on the November 16, 2010, Op Sheet.	
#68	X-rays dated October 26, 2010, were not labeled right or left.	X-rays-(10/26/2010) Bite wing x-ray film are not properly labeled L-R.
There is no question on the current CSHM Audit Tool to address this issue.	According to the Monitor's pediatric dentist's review of the X-rays dated October 26, 2010, tooth #S had extensive decay that appears to extend into the pulp chamber and a furcation radiolucency. Tooth #S appears on the X-ray to be abscessed and non-restorable. The patient's record did not show documentation of this finding or the rationale for restoring a tooth that appears, radiographically, to be non-restorable. If the X-ray was in conflict with the visual appearance of the tooth during clinical examination, and the clinical appearance of the tooth was used to justify the treatment decision, the discrepancy should have been noted in the dentist's notes or on the Tooth Chart.	

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	Section C of the Authorization form was not included with the requested materials.	
#21	The upper odontogram of the Tooth Chart did not document buccal decay on tooth #K.	
#68	X-rays dated October 1, 2010, were not labeled right or left.	X-rays-(10/1/2010) Bite wing x-ray film are not properly labeled L-R.

The Monitor had the following observations:

- While we note that this observation is outside of the scope of the audit, the Monitor observed residual cement or restorative material between teeth #I and #J on the March 8, 2010, and September 9, 2010, bite-wing X-rays of patient #008. There was no documentation in the patient's record to show this was identified and/or removed.
- The CSHM Chart Audit Tool does not have a question to assess whether the decision to provide operative treatment without local anesthesia was appropriate. There were no comments in the CSHM chart audit results to the Clinic regarding the operative procedures performed without the documentation of the administration of local anesthesia.
- The Monitor was unable to find a question in CSHM's Chart Audit Tool to report when there was no documentation provided in the patient's record to support the modification of the Treatment Plan or the choice of restoration(s) provided on the audited date of service. The Monitor reported this finding for patients #001, #007, #008, and #010; however, the Monitor understands that the new testing attributes in the revised Chart Audit Tool will allow for the assessment of these findings.
- The time documentation section at the bottom of the Op Sheet was not fully visible on many of the copied Op Sheets, making it difficult for the Monitor to review accurately.

Below is a summary of the Monitor's findings of CSHM's audit of the Clinic:

- The Monitor did not receive the Acknowledgement and/or the entire Authorization forms with the requested materials for three records, whereas CSHM only reported one record in which these materials were not sent.
- One record did not have an explanation for the "yes" response given for ADHA on the Health History form. CSHM also reported this finding.
- CSHM did not report any findings related to the Tooth Chart. All 11 of the Monitor's findings related to the Tooth Chart were for QAP and Quality Score Items. Below is a summary of the Tooth Chart findings:
  - Three records did not show documentation of all existing conditions or restorations, pertaining to the treated quadrant, on the Tooth Chart. The Monitor was unable to determine the accuracy of charting existing conditions

and restorations in two records due to black-and-white copies used for the chart audit.
  - Four records did not show documentation of all decayed surfaces on the upper odontogram of the Tooth Chart. The Monitor was unable to determine the accuracy of charting decay on the upper odontogram of the Tooth Chart of two records due to black-and-white copies used for the chart audit.
- Of the 15 Hygiene Procedure forms reviewed, one form did not have the oral hygiene or occlusion findings recorded in the dental evaluation. CSHM did not identify this finding.
- Two records (patients #012, and #014) did not record involved tooth surfaces on the Treatment Plan for the teeth treated on the audited date of service. The September 15, 2010, Treatment Plan for patient #010 did not document a planned procedure for tooth #B; therefore, there was no consent obtained for the multiple-surface filling that was performed on tooth #B. These findings were not addressed by CSHM.
- The following are findings made by the Monitor pertaining to treatment rendered by one of the audited dentists. Since the majority of these findings were not addressed in the Guidelines and, therefore, not captured in the Chart Audit Tool, the audited dentist received a passing chart audit score. These findings were not identified or addressed by CSHM.
  - Patient #007 – While SSCs were treatment planned for two teeth, five-surface fillings were provided instead with no documentation for the rationale for the change. In addition, there was no consent obtained for the change in type of restoration provided.
  - Patient #008 – Teeth #L and #S had existing two-surface fillings with extensive recurrent decay that were replaced with multiple-surface fillings and no justification was documented in the patient's record to support the choice of restoration provided.
  - Patient #010 – Teeth #B and #C were restored with large multiple-surface fillings instead of SSCs with no justification for choice of restoration and no consent was provided for the change in restoration choice. In addition, tooth #A was not treated as planned (pulpotomy and SSC) because the dentist was "unable to access #A distal without damaging mesial of tooth #3 which is wedged into distal root structure of #A – will watch". Therefore diagnosed decay was left untreated to "watch" in a child with rampant decay.
  - Three records reviewed for this dentist had significant findings pertaining to local anesthesia.
    - The administration of local anesthesia was not documented in the records of two patients (patients #007 and #008) who received extensive dental treatment due to rampant decay. These findings did not impact the score of the audit because there was no question that addressed the finding.
    - One record (patient #010) did not show that the DCPW was calculated for the patient. According to the patient's weight, the local anesthesia dose

that was administered during treatment exceeded the maximum dose allowed.

- The Monitor had the following finding related to the treatment performed on tooth #S for patient #014.
  - According to the Monitor's pediatric dentist's review of the X-ray, tooth #S had extensive decay that appears to extend into the pulp chamber and a furcation radiolucency. Tooth #S appears on the X-ray to be abscessed and non-restorable. The patient's record did not show documentation of this finding or the rationale for restoring a tooth that appears to be non-restorable on the X-ray. If the X-ray was in conflict with the visual appearance of the tooth during clinical examination, and the clinical appearance of the tooth was used to justify the treatment decision, the discrepancy should have been noted in the dentist's notes or on the Tooth Chart. This finding was not addressed in the CSHM chart audit.
- The following findings are related to documentation on the Op Sheet:
  - One record did not indicate confirmation of obtained consent. This finding was not reported by CSHM.
  - One record did not have the section related to complications completed. CSHM did not identify this finding.
  - Six records did not record the initial concentration of nitrous oxide on the Op Sheet. CSHM's audit results reported this finding for only five records. This is the only QAP and Quality Score Item that was scored as "no" by CSHM.
- Seven records were found to have inconsistent documentation related to procedures, surfaces, and/or diagnosis recorded on the Op Sheet, Treatment Plan, and/or lower odontogram of the Tooth Chart. CSHM only reported findings for two of the seven records.
- All of the X-rays submitted to CSHM, and therefore the Monitor, for this desk review were not labeled right or left. Two records' X-rays were identified only by the Monitor as having the incorrect date of service recorded on the label.
- The Monitor found one record where the X-rays dated October, 11, 2010, were not documented on the Account History Report. CSHM did not report this finding.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 20 visit records:

- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.
- Ensure that staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure that consent is obtained when a change is made in restoration materials.

- Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members are trained and monitored in the proper completion of the Health History, Hygiene Procedure form, Op Sheet, and Treatment Plan.
- Ensure that further assessment by the CDO is provided to determine trends and training needs in this Clinic related to procedures involving multiple-surface fillings on primary molars and operative treatment provided without the use of local anesthesia.
- Ensure that patients are receiving local anesthesia when necessary.
- Ensure that staff members are using the available tools to determine the DCPW and monitor to ensure that the maximum dose of local anesthesia is not exceeded.
- Determine why a MO composite was billed for patient #006 when the dentist indicated that there was only a DO filling performed.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Further discussion is needed between the Monitor and CSHM regarding the *Clarification of Guidelines for Chart Audit Scoring*.
- Ensure that QAP and Quality Score Items are identified by CSHM's auditor and modifications are made to capture all unaddressed findings in the Chart Audit Tool.
- Add a testing attribute in the chart audit tool to assess whether local anesthesia was used when procedures performed would typically require it.

EXHIBIT 51

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Small Smiles Dental Centers of Augusta
Augusta, Georgia

Deliverable #1-27

July 1, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Augusta (Clinic), 1631 Gordon Highway, Suite 22, Augusta, GA 30906.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 15 records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of 15 records that CSHM audited during the first quarter of 2011.

All three dentists scored lower under the Monitor's review compared to the CSHM audit, with two dentists failing. The Monitor's overall Clinic score of 88 percent resulted in the Clinic's failure of the audit. The overall Clinic score was also significantly lower than CSHM's overall Clinic score of 96 percent.

CSHM did not report any findings related to the Tooth Chart. All 11 of the Monitor's findings related to the Tooth Chart were for Quality Assurance Protocol (QAP) and Quality Score Items. Four records (patients #001, #010, #011, and #013) did not show documentation of all existing conditions or restorations, pertaining to the treated quadrant, on the Tooth Chart. Seven records (patients #001, #002, #008, #010, #011, #012, and #013) did not show documentation of all decayed surfaces on the upper odontogram of the Tooth Chart.

The Monitor had the following findings that were not captured in the current CSHM chart audit tool:

- The Monitor did not find documentation in the record of patient #004 to show interpretation of the maxillary anterior X-ray or findings related to the chief complaint.
- Three records (patients #002, #003, and #005) included X-rays that were not duplicated correctly.
- Two records (patient #008 and #010) did not document the rationale for placement of multiple surface fillings on posterior primary teeth as opposed to Stainless Steel Crowns (SSCs).
- Four records (patients #001, #002, #003, and #014) documented use of multiple surface fillings to restore anterior primary teeth as opposed to SSCs without documentation of rationale.

- Poorly performed pulpotomies were found during the review of the record for patient #003. A pulpotomy and SSC was performed on tooth #I on December 3, 2010, and the loss of the SSC three days later further compromised the health of the tooth. Pulpotomies were poorly performed on teeth #K and #L on August 18, 2010. Tooth #K was extracted on November 19, 2010.
- One record (patient #011) documented a pulpotomy and SSC was performed on a tooth that appeared to be non-restorable.

Eight of the 15 records showed documentation of local anesthesia delivery via a mental nerve block recorded on the Operative Procedures from (Op Sheet) (patients #001, #002, 005, #008, #009, #010, #011, and #015) for procedures that required pulpal anesthesia of lower teeth.

Nine of the 15 records (patients #001, #002, #005, #006, #007, #008, #011, #012, and #013) recorded "R" on the upper and/or lower odontogram of the Tooth Chart with no documentation or inadequate documentation related to the techniques prescribed to achieve remineralization.

Overall Summary of Recommendations

Set forth below are the Monitor's recommendations:

The following recommendations are related to CHSM's chart audit process and the *Guidelines*:

- Ensure CSHM requests the Health History and the Hygiene Procedures forms completed prior to and/or on the audited date of service.
- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.
- Ensure that staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are correctly identifying and documenting the type of X-ray(s) exposed in the appropriate area of the patient's record.
- Ensure staff members are providing documentation of diagnosis and/or findings related to a patient's chief complaint.
- Ensure staff members are documenting X-ray interpretation in the patient's record.
- Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual* and *Chart Documentation Guide*.
- Ensure staff members are trained and monitored in the documentation on the lower odontogram of the Tooth Chart and treatment planning of remineralization as directed in the *Patient Care Manual* and *Chart Documentation Guide*.

- Ensure staff members are trained and monitored in the proper completion of the Health History, Hygiene Procedure form, Op Sheet, and Treatment Plan.
- Ensure that the *Patient Care Manual* and *Chart Documentation Guide* provide specific instructions for acceptable documentation in the crown option boxes on the Treatment Plan.
- Ensure all billing errors are corrected in accordance with the Monitor's findings.
- Ensure that QAP and Quality Score Items are identified by CSHM's auditor and modifications are made to capture all unaddressed findings in the chart audit tool.
- Ensure that CSHM auditors are adequately trained to review X-rays, identify quality of care issues, and understand when to consult the Chief Dental Officer (CDO).
- Establish a process to evaluate and standardize CSHM auditors in order to establish a high degree of reliability in CSHM audit findings.
- Provide clear communication to the Clinic regarding the chart audit findings related to each patient's record.

In addition, the Monitor recommends the CDO:

- Provides further assessment to determine trends and training needs in this Clinic related to procedures involving X-rays, administration of local anesthesia, multiple surface fillings as opposed to SSCs, and pulpotomies.
- Reviews the records for patients #001, #002, #003, #008, #010, #011, and #014 to determine quality and/or appropriateness of treatment.
- Reviews the records for patients #001, #002, #005, #008, #009, #010, #011, and #015 to determine the appropriateness of anesthetic technique used for the procedures performed.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Augusta (Clinic), 1631 Gordon Highway, Suite 22, Augusta, GA 30906.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of Augusta, 1631 Gordon Highway, Suite 22, Augusta, GA 30906. On April 25, 2011, the Monitor notified CSHM's Compliance Officer by e-mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from the Clinic and CSHM on May 2, 2011. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the first quarter of 2011
  - E-mail to the Clinic with results for the first-quarter audit
  - First-quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*

- *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*

CSHM initially requested the Clinic's charts on February 23, 2011. The Clinic provided the charts on March 2, 2011. The chart audit was completed on April 6, 2011, by a dental assistant who was trained by the Audit Manager. CSHM indicated the Clinic and all dentists passed the audit; therefore, no CAP was required, according to the *Chart Audit Policy*. The Chief Dental Officer (CDO) did not participate in the review of any charts for this audit.

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the first quarter of 2011 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 8 of the 15 visit records reviewed.

Review of CSHM Chart Audit

Fifteen records were reviewed, five for each dentist, following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentists. All three dentists scored lower under the Monitor's review compared to the CSHM audit, with two dentists failing. The Monitor's overall Clinic score of 88 percent resulted in the Clinic's failure of the audit. The overall Clinic score was also significantly lower than CSHM's overall Clinic score of 96 percent.

	Monitor Score	CSHM Score
[redacted]	90%	100%
	88%	100%
	82%	100%
Clinic Total Audit Score	**88%**	**96%**

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified. These findings are also included below.

[redacted] Small Smiles Dental Centers of Augusta

[redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement of Receipt of Notice of Privacy Practices (Acknowledgement form) was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#15	There was no "yes" or "no" answer given for rheumatic fever on the January 5, 2011, Health History form.	
#20	Teeth #L, #S, and #T were not circled on the upper odontogram of the Tooth Chart to indicate they were present. X-rays show teeth #A, #B, #D, #E, #F, #G, #O, and #P to be missing. The Tooth Chart shows #A, #B, #D, #E, #F, #G, #L, #O, #P, #S, and #T to be missing, as they are not circled. Teeth #L, #S, and #T are visible on the X-ray. They were charted on the upper odontogram with decay and documented to have been treated.	

#21	The decay for tooth #R was not properly charted on the upper odontogram of the Tooth Chart. Tooth #R has very large facial decay visible on the photograph dated January 5, 2011. According to the Monitor's pediatric dentist, decay involved most of the entire facial surface and appeared to undermine the incisal cusp. There was also distal caries visible on the X-ray. The Tooth Chart only shows a red circle on the distal of tooth #R and does not clearly document the decay on the facial surface, which is evident on the X-ray and photograph.	
#60	The surfaces recorded on the Treatment Plan, the lower odontogram of the Tooth Chart, and the Operative Procedures form (Op Sheet) do not match.	
There is no question on the current CSHM Audit Tool to address this issue.	According to the Monitor's pediatric dentist, due to the size of the facial lesion, the distal decay evident on the X-ray, and the age of the child (5 years old), a stainless steel crown (SSC) on tooth #R would be indicated. No explanation was given in the Op Sheet notes dated January 5, 2011, regarding the rationale for providing a filling on tooth #R as opposed to a SSC. The Op Sheet also documents tooth #R was restored with a facial, incisal composite filling with no mention of the distal lesion being included.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
	were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#21	Facial decay was not recorded for tooth #M on the upper odontogram of the Tooth Chart.	
#45	The *Patient Care Manual* and *Chart Documentation Guide* do not state that "n/a" must be used as opposed to a slash mark in an option box on the Treatment Plan; therefore, the Monitor did not have this finding.	Treatment Plan 2/3/2011 Crown Options, N/A was not put in the box for W-SSC. Only a line is marked thru. If the option is not applicable then a N/A must be put in the box SC
#60	Tooth surfaces recorded on the Treatment Plan and the lower odontogram of the Tooth Chart for tooth #R do not match the tooth surfaces recorded on the Op Sheet.	
There is no question on the current CSHM Audit Tool to address this issue.	The periapical X-ray of tooth #I was not duplicated correctly. Both posterior periapical X-rays appeared to be of the lower right posterior teeth.	
There is no	Due to the size and extent of the decay, the degree of compromised	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
question on the current CSHM Audit Tool to address this issue.	tooth structure, the age of the patient (4 years old), and the amount of root remaining, SSCs on teeth #M, #O, #P and #R would be indicated. According to the Monitor's pediatric dentist, the photographs dated January 7, 2011, show clinically visible decay on the mesial and facial of tooth #R that extends below the gingiva on the facial and the tooth is structurally compromised by the size of the lesion. Tooth #M demonstrates similar mesial facial caries, though not quite as large as tooth #R. Tooth #O appears to have gingival facial decay and possible mesial decay. These teeth were restored with composite fillings. Tooth #P shows large mesial and distal decay involving the incisal edges, which are gone, and appears to have gingival facial decay. With the proximity of the caries to the pulp, it would be anticipated that the pulp would be encountered in tooth #P. The lower anterior occlusal did not include the periapical area of the lower incisors; therefore, it is not possible to determine if this tooth was vital and could sustain an indirect pulp cap. No explanation was given in the Op Sheet notes dated January 7, 2011, regarding the rationale for providing multiple surface fillings on teeth #M, #O, #P, and #R as opposed to SSCs.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#60	Tooth surfaces recorded on the Op Sheet for teeth #A, #B, and #I do not match the surfaces recorded on the Treatment Plan.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#62	The initials "DH" were recorded in the initial box on the Op Sheet but there was no signature for "DH" at the bottom of the form.	
#68	The duplicate X-rays dated December 6, 2010, and November 11, 2010, did not include the patient's name or date of birth.	
There is no question on the current CSHM Audit Tool to address this issue.	The duplicate X-ray of an upper left periapical X-ray, dated December 6, 2010, was duplicated incorrectly.	
There is no question on the current CSHM Audit Tool to address this issue.	According to the Monitor's pediatric dentist, due to the size of the decay visible on the X-ray (the mesial incisal involving the incisal angles on both teeth), the patient's age (5 years old), and the teeth are fully rooted, SSCs on teeth #E and #F would be indicated. No explanation was given in the Op Sheet notes dated December 3, 2010, regarding the rationale for providing multiple surface fillings on teeth #E and #F as opposed to SSCs.	
There is no question on the current CSHM Audit Tool to address this	Upon review of the X-ray dated December 6, 2010, the Monitor's pediatric dentist found a poor quality pulpotomy performed on tooth #I with incomplete removal of pulp tissue from the coronal aspect of the pulp chamber and incomplete placement of the base. The SSC placed on December 3, 2010, was lost and the success of the pulpotomy was further	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
issue.	compromised due to a poorly placed base and the tooth's exposure to oral fluids. X-rays dated August 4, 2010, showed deep decay on teeth #K and #L with no evidence of furcation radiolucency. Pulpotomies and SSCs were performed on these teeth by [redacted] on August 18, 2010. Upon review of the X-rays dated November 11, 2010, the Monitor's pediatric dentist found very poor quality pulpotomies on teeth #K and #L. Both pulpotomies appear to have incomplete pulp removal from the coronal aspect of the pulp chamber and incomplete placement of the base. On the same date, an abscess was recorded on the upper odontogram of the Tooth Chart for tooth #K, which was then extracted on November 19, 2010.	

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#60	The November 11, 2010, Op Sheet did not record the tooth surfaces for teeth #A, #B, and #J.	
There is no question on the current CSHM Audit Tool to address this issue.	A chief complaint was documented on the Hygiene Procedures form as: "Pt has complaint of crown at upper anterior." An upper periapical X-ray was taken; however, the record did not show that the chief complaint had been addressed. The Monitor did not find documentation in the record to show interpretation of the maxillary anterior X-ray or findings related to the chief complaint.	

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#45	The *Patient Care Manual* and *Chart Documentation Guide* do not state that "n/a" must be used as opposed to a slash mark in an option box on the Treatment Plan; therefore, the Monitor did not have this finding.	Treatment Plan - 2/17/2011 Crown Options, N/A was not put in the box for W-SSC. Only a line is marked thru. If the option is not applicable then a N/A must be put in the box SC
There is no question on the current CSHM Audit Tool to address this issue.	X-rays appeared as if two periapical X-rays were taken of tooth #S when the Hygiene form records periapical X-rays were taken of teeth #S and #L. The *Guidelines* do not capture when X-rays are not duplicated correctly.	

[redacted] Small Smiles Dental Centers of Augusta

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
	No findings	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#59	The Op Sheet records the anesthetic start time at 2:08 and the stop time at 3:15. There was no documentation in the record for an explanation for treatment time exceeding one hour.	
#60	The tooth surfaces recorded on the Op Sheet and the Treatment Plan for teeth #D and #G do not match.	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
	questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#21	Decay was not charted correctly on the upper odontogram of the Tooth Chart for tooth #J. The distal surface charted on the upper odontogram does not match the treatment that was provided or the disease that was radiographically demonstrable.	
#60	The tooth surfaces recorded on the Treatment Plan for tooth #J do not match the tooth surfaces recorded on the Op Sheet.	
#68	The digital photos of teeth #K, #L, #I, and #J were dated December 16, 2011, instead of December 16, 2010.	
There is no question on the current CSHM Audit Tool to address this	According to the Monitor's pediatric dentist, due to the size and extent of decay, SSCs on teeth #J and #K would be indicated. Upon review of the X-rays, the decay on tooth #J, of apparent occlusal origin, is large and invasive and weakens the tooth structure. In addition, the Monitor's pediatric dentist noted mesial decay on tooth #J. There is also a large	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
issue.	occlusal lesion on tooth #K that appears to undermine the distal marginal ridge in addition to radiographically demonstrable mesial decay. No explanation was given in the Op Sheet notes dated December 16, 2010, regarding the rationale for providing multiple surface fillings on teeth #J and #K as opposed to SSCs.	

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#60	The tooth surfaces recorded on the Treatment Plan and the Op Sheet for tooth #K do not match.	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	"Asthma, Allergies" was the explanation for the "yes" answers given for "Asthma/Breathing Problems" and "Allergies." According to the *Patient Care Manual*, each "yes" answer should be explored and related details should be documented on the Health History form. "Asthma, Allergies" does not describe the type, severity, or management of the patient's reported health conditions.	
#20	According to the Monitor's pediatric dentist, X-rays dated November 23, 2010, show severe perforating internal resorption involving alveolar bone of tooth #L. This is a failed pulpotomy and should have been noted as such on the upper odontogram of the Tooth Chart. The Hygiene Procedures form records "internal root resorption #L" in the diagnosis notes section; however,	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
	this finding was not recorded on the upper odontogram of the Tooth Chart or addressed in the Treatment Plan. According to the X-rays dated May 29, 2010, tooth #S had an existing filling. The Tooth Chart does not document a lost filling for tooth #S.	
#21	The upper odontogram of the Tooth Chart documents lingual decay on tooth #B; however, the lingual surface was not included in the amalgam filling performed on tooth #B.	
#60	The tooth surfaces recorded on the Treatment Plan and the Tooth Chart for tooth #B do not match the tooth surfaces recorded on the Op Sheet. In addition, the Prior Service Acknowledgment (PRSA) did not record a Previous Restoration Missing (PRM) for tooth #B.	
#67	The November 23, 2010, panoramic X-ray is non-diagnostic. The anterior teeth on the upper and lower arches are too dark.	
There is no question on the current CSHM Audit Tool to address this issue.	No explanation was given in the Op Sheet notes dated December 1, 2010, regarding the rationale for providing a multiple surface filling on tooth #B as opposed to an SSC. According to CDO [redacted] October 21, 2010, webinar and the policy titled *Intracoronal Restorations Documentation,* which went into effect November 1, 2010, documentation is required regarding the rationale for restoring a primary first molar with a multiple surface filling instead of an SSC.	

[redacted]

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#20	According to the Monitor's pediatric dentist, the upper odontogram of the Tooth Chart did not document the pulpal pathology visible on the X-ray for teeth #B and #S.	
#21	According to the Monitor's pediatric dentist, decay was not charted correctly for tooth #B or #S. The upper odontogram of the Tooth Chart appeared as if the surfaces marked for tooth #S had been erased. Radiographically demonstrable mesial decay on tooth #B was not recorded on the upper odontogram of the Tooth Chart.	
#45	The *Patient Care Manual* and *Chart Documentation Guide* do not state that "n/a" must be used as opposed to a slash mark in an option box on the Treatment Plan; therefore, the	Treatment Plan - 1/24/2011 Crown Options, N/A was not put in the box for W-SSC. Only a line is marked thru. If the option is not applicable then a N/A must be put in the box

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
	Monitor did not have this finding.	SC
#55	The nitrous oxide section of the Op Sheet dated February 7, 2011, did not have the post operative vital signs recorded for oxygen saturation and heart rate.	
#60	The tooth surfaces recorded on the Treatment Plan and the Op Sheet for tooth #B do not match.	
#71	Tooth #S was a fully rooted tooth; therefore, the billing code (07140) documented on the Op Sheet for the extraction of tooth #S was correct. The Account History Report shows the extraction of tooth #S was billed using code 07111 instead of 07140. CSHM's auditor recorded "can't verify" for this question.	Billing- 02/07/2011 tooth S charted 07140 billed 07111 SC
There is no question on the current CSHM Audit Tool to address this issue.	According to the Monitor's pediatric dentist, tooth #B appears to have a radiographically demonstrable furcation radiolucency indicating that the pulp is necrotic, and the clinical photograph and X-ray demonstrate a tooth that appears to be non-restorable.	

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in	

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
	the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#21	The facial decay on tooth #C, diagnosed and treated on the audited date of service, was not recorded on the upper odontogram of the Tooth Chart.	
#60	The lower odontogram of the Tooth Chart did not include the facial surface on tooth #C; therefore, the tooth surfaces recorded on the Op Sheet did not match the lower odontogram of the Tooth Chart. Caries "C" was the diagnosis used to support the medical necessity for SSCs on teeth #A and #B instead of Multi-surface Caries "MSC", High Caries Risk "HCR", and/or Compromised Tooth Structure "CTS".	Operative Sheet 1/26/2011 Diagnosis for teeth A and B should be HCR and or CTS on the Op sheet for SSC indication.
#61	There is no checkmark placed beside "No Complications" or "Complications" at the bottom of the Op Sheet.	
#67	The January 19, 2010, panoramic X-ray is non-diagnostic. The anterior teeth on the upper and lower arches are too dark.	
#71	Tooth #C was billed as a two surface filling; however, the Op Sheet recorded a three surface white filling was performed.	Billing / tooth C was documented on the OP sheet dated 1/26/2011 as code 2332 but tooth C is documented on the account history dated 1/26/2011 as code 2331.

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#20	The existing fillings on teeth #A and #T were not recorded on the upper odontogram of the Tooth Chart.	
#21	According to the Monitor's pediatric dentist, the X-ray dated December 6, 2010, revealed distal decay on tooth #S that was not recorded on the upper odontogram of the Tooth Chart.	
#28	The dental evaluation section of the Hygiene Procedures form did not record the patient's oral hygiene.	

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
There is no question on the current	According to the Monitor's pediatric dentist, due to carious involvement of the mesial incisal angles and the patient's age (3 years old), SSCs on teeth #D and #G would be indicated.	

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
CSHM Audit Tool to address this issue.	Teeth #E and #F received pulpotomies and SSCs; however, a four surface filling was performed on tooth #D and a three surface filling was performed on tooth #G. No explanation was given in the Op Sheet notes dated December 6, 2010, regarding the rationale for providing multiple surface fillings on teeth #D and #G as opposed to SSCs.	

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Acknowledgement form was not included in the requested materials. CSHM's auditor recorded "no" for questions #7 and #9 on the chart audit spreadsheet; however, there were no findings reported for this patient in the e-mail to the Clinic. Instead, CSHM included a general statement that read: "The following errors were most commonly found in the audit: Acknowledgement of Receipt of Notice of Privacy Practices is not currently being used per the Office Manager. This document must be included in the requested material. Please use this form for all patients going forward Thank You SC." The Monitor scored "no" for question #7 and "n/a" for question #9 as directed in the *Guidelines*.	
#45	The *Patient Care Manual* and *Chart Documentation Guide* do not state that "n/a" must be used as opposed to a slash mark in an option box on the Treatment Plan; therefore, the Monitor did not have this finding.	Treatment Plan - 1/24/2011 Crown Options, N/A was not put in the box for W-SSC. Only a line is marked thru. If the option is not applicable then a N/A must be put in the box SC
#71	The February 2, 2011, Op Sheet	

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
	shows that nitrous oxide was administered; however, it was not recorded on the Account History Report.	

The Monitor had the following observations:

- Eight of the 15 records showed documentation of local anesthesia delivery via a mental nerve block recorded on the Op Sheet (patients #001, #002, 005, #008, #009, #010, #011, and #015) for procedures that required pulpal anesthesia of lower teeth.
- Nine of the 15 records (patients #001, #002, #005, #006, #007, #008, #011, #012, and #013) recorded "R" on the upper and/or lower odontogram of the Tooth Chart. The Monitor noted inadequate treatment planning related to remineralization. According to Page 29 of the *Patient Care Manual*, "R" for "Remineralization" is to be recorded on the lower odontogram of the Tooth Chart and "in the notes section, write out the techniques that might be used to attempt remineralization. For example: RX given for Prevident Plus to be used nightly for 6 months. We will re-evaluate in 6 months." The following observations are related to the documentation of remineralization in 3 of the 15 records:
  - While outside of the scope of the audit, upon review of the Tooth Chart for patient #001, the Monitor noted remineralize ("R") was recorded on the upper odontogram for the facial of tooth #C without any documentation pertaining to a plan or follow-up.
  - In the record for patient #002, teeth #H and #Q are marked for remineralization, a procedure that has marginal chance for success absent an aggressive plan for a patient with the level of caries demonstrated. The plan contained in the record only referenced oral hygiene and flossing.
  - Patient #013 – X-rays reveal that teeth #L and #S have distal decay but no restorative treatment planned. Both are marked to receive remineralization treatment.
- The Hygiene Procedures form for patient #002 documents two periapical X-rays were taken of teeth #E and #O; however, the X-rays reviewed by the Monitor were mandibular and maxillary occlusal X-rays. The difference between a periapical and occlusal X-ray was defined and this issue addressed in the June 2011 Clinical Issues Review given by [redacted] CDO.
- There is no question in CSHM's chart audit tool to address when there was no documentation provided in the patient's record to support the choice of a multiple surface filling performed on anterior or posterior teeth instead of an SSC. The Monitor understands that the new testing attributes in the revised chart audit tool will allow for the assessment of the rationale for restoring posterior teeth with multiple surface fillings; however, anterior teeth have not been addressed.

- According to CSHM's e-mail, the Clinic was asked to send "just the most recent" Health History form and "the most recent and any from the dates listed above" of the Hygiene Procedures form(s). The Clinic provided the requested materials as directed for patient #008. The Health History and Hygiene Procedures forms dated January 21, 2011, were sent and audited by CSHM's auditor. The January 21, 2011, Health History and Hygiene Procedures forms were completed after the audited date of service and therefore do not apply. The Monitor was unable to review the Health History form and the Limited Oral Exam assessment that related to the audited date of service.

Below is a summary of the Monitor's findings of CSHM's audit of the Clinic:

- The Monitor did not receive the Acknowledgment form for 9 (patients #001, #002, #005, #007, #008, #011, #012, #013, and #015) of the 15 records. CSHM's auditor reported these findings with a general statement in the e-mail to the Clinic and did not identify which records were missing this form. CSHM's chart audit spreadsheet also showed that the auditor scored "no" for questions #7 and #9. According to the *Guidelines,* "when requested material is not sent, the points are deducted in the 'Requested Material' section of the audit template and an 'N/A' is entered in the section of the template of the document not sent."
- The Health History form for patient #001 did not have a "yes" or "no" response indicated for rheumatic fever and there was an inadequate explanation for asthma and allergies for patient #010.
- CSHM did not report any findings related to the Tooth Chart. All 11 of the Monitor's findings related to the Tooth Chart were for QAP and Quality Score Items. Below is a summary of the Tooth Chart findings:
  - Four records (patients #001, #010, #011, and #013) did not show documentation of all existing conditions or restorations, pertaining to the treated quadrant, on the Tooth Chart.
  - Seven records (patients #001, #002, #008, #010, #011, #012, and #013) did not show documentation of all decayed surfaces on the upper odontogram of the Tooth Chart.
- Of the 15 Hygiene Procedure forms reviewed, one form (patient #013) did not have the oral hygiene status recorded in the Dental Evaluation Section.
- The Monitor had the following findings related to question #60 which asks, "Were procedures, surfaces, and diagnosis on op sheet properly documented? Do they match tooth chart and treatment plan?"
  - Nine of the 15 records (patients #001, #002, #003, #007, #008, #009, #010, #011, and #012) showed discrepancies in the tooth surfaces recorded on the Treatment Plan, Op Sheet, and/or lower odontogram of the Tooth Chart.
  - One record (patient #004) did not record the tooth surfaces in the designated area on the Op Sheet.
  - One record (patient #010) did not record PRM in the PRSA section of the Op Sheet for a tooth that had a missing filling.

- There was one finding reported by the Monitor and CSHM (patient #012) regarding incorrect diagnosis used for the indication of SSCs.

- The following findings are related to documentation on the Op Sheet:
  - One record (patient #011) did not have the nitrous oxide post operative vital signs recorded for oxygen saturation and heart rate.
  - One record (patient #007) did not document an explanation for operatory time that exceeded one hour.
  - One record (patient #003) was missing the dental assistant's signature.
  - One record (patient #012) did not have the section related to complications completed.
- The following findings are related to the digital photographs or X-rays that were reviewed by the Monitor:
  - Two records (patients #010 and #012) included non-diagnostic panoramic X-rays.
  - Two records (patients #003 and #008) included X-rays or photographs that were not labeled correctly.
- The Monitor found three records (patients #011, #012, and #015) where the services provided did not match the procedures recorded on the Account History Report.
- The Monitor had the following findings that were not captured in the current CSHM chart audit tool:
  - The Monitor did not find documentation in the record of patient #004 to show interpretation of the maxillary anterior X-ray or findings related to the chief complaint.
  - Three records (patients #002, #003, and #005) included X-rays that were not duplicated correctly.
  - Two records (patient #008 and #010) did not document the rationale for placement of multiple surface fillings on posterior primary teeth as opposed to SSCs.
  - Four records (patients #001, #002, #003, and #014) documented use of multiple surface fillings to restore anterior primary teeth as opposed to SSCs without documentation of rationale.
  - Poorly performed pulpotomies were found during the review of the record for patient #003. A pulpotomy and SSC was performed on tooth #I on December 3, 2010, and the loss of the SSC three days later further compromised the health of the tooth. Pulpotomies were poorly performed on teeth #K and #L on August 18, 2010. Tooth #K was extracted on November 19, 2010.
  - One record (patient #011) documented a pulpotomy and SSC was performed on a tooth that appeared to be non-restorable.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 15 visit records:

- Ensure CSHM requests the Health History and the Hygiene Procedures forms completed prior to and/or on the audited date of service.
- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.
- Ensure that staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are correctly identifying and documenting the type of X-ray(s) exposed in the appropriate area of the patient's record.
- Ensure staff members are providing documentation of diagnosis and/or findings related to a patient's chief complaint.
- Ensure staff members are documenting X-ray interpretation in the patient's record.
- Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual* and *Chart Documentation Guide*.
- Ensure staff members are trained and monitored in the documentation on the lower odontogram of the Tooth Chart and treatment planning of remineralization as directed in the *Patient Care Manual* and *Chart Documentation Guide*.
- Ensure staff members are trained and monitored in the proper completion of the Health History, Hygiene Procedure form, Op Sheet, and Treatment Plan.
- Ensure that the *Patient Care Manual* and *Chart Documentation Guide* provide specific instructions for acceptable documentation in the crown option boxes on the Treatment Plan.
- Ensure all billing errors are corrected in accordance with the Monitor's findings.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure that QAP and Quality Score Items are identified by CSHM's auditor and modifications are made to capture all unaddressed findings in the chart audit tool.
- Ensure that CSHM auditors are adequately trained to review X-rays, identify quality of care issues, and understand when to consult the CDO.
- Establish a process to evaluate and standardize CSHM auditors in order to establish a high degree of reliability in CSHM audit findings.
- Provide clear communication to the Clinic regarding the chart audit findings related to each patient's record.

In addition, the Monitor recommends the CDO:

- Provides further assessment to determine trends and training needs in this Clinic related to procedures involving X-rays, administration of local anesthesia, multiple surface fillings as opposed to SSCs, and pulpotomies.

- Reviews the records for patients #001, #002, #003, #008, #010, #011, and #014 to determine quality and/or appropriateness of treatment.
- Reviews the records for patients #001, #002, #005, #008, #009, #010, #011, and #015 to determine the appropriateness of anesthetic technique used for the procedures performed.

EXHIBIT 52

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Texas Smiles Dental Center of Austin
Austin, Texas

Deliverable #1-29

July 29, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Texas Smiles Dental Center of Austin (Clinic), 500 West William Cannon, Suite 438-A, Austin, TX 78745.

Overall Summary of Critical Findings and Observations

[redacted] reviewed ten records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical observations and findings from the Monitor's review of ten records that CSHM audited during the first quarter of 2011.

Both dentists scored lower under the Monitor's review compared to the CSHM audit. The Monitor's overall Clinic score of 94 percent was also lower than CSHM's overall Clinic score of 98 percent. The CSHM Chart Audit Tool, however, did not capture all of the findings the Monitor had concerning quality of care and therefore these were not scored.

The Hygiene Procedures form sent for patient #008 was dated November 16, 2010, after the audited date of service of November 15, 2010. The November 8, 2010, Hygiene Procedures form used for the limited oral exam was not included in the requested materials; therefore, the Monitor was unable to review documentation that applied to the audited date of service.

The documents received for patient #009 did not include forms related to treatment provided to tooth #3 on September 10, 2010, and September 15, 2010. These documents would have been beneficial in determining the medical necessity for the root canal provided to tooth #3.

Three of the ten records (patients #005, #007, and #010) reviewed documented the use of slot restorations. Two of those records (patients #005 and #007) involved primary molars while the other record (patient #010) involved both the mesial and distal surfaces of a permanent premolar. The Monitor was unable to locate a CSHM policy regarding slot restorations.

CSHM did not report any findings related to the Tooth Chart and reviewed black-and-white copies of the Tooth Chart for this chart audit. All nine of the Monitor's findings related to the Tooth Chart were for *Quality Assurance Protocol* (QAP) and Quality Score Items.

The following are additional findings that were not captured in CSHM's Chart Audit Tool:

- Four records (patients #002, #007, #008, and #010) did not show documentation of the interpretation of X-rays. Three of the four records (patients #002, #007, and #010) did not document interpretation of panoramic X-rays. Two records (patients #008 and #010) did not document interpretation of periapical X-rays.
- Patient #005 – According to the Monitor's pediatric dentist, the December 10, 2010, bitewing X-ray shows deep distal caries approximating the pulp of tooth #I. This X-ray does not show the furcation area of the tooth, and because the decay is large and may be already into the pulp, there is need to rule out furcation radiolucency. Tooth #I was treatment planned for a pulpotomy; however, the January 25, 2011, Operative Procedures form (Op Sheet) does not show that a pulpotomy was performed on this tooth. Documentation related to the treatment of tooth #I would have been helpful in understanding the treatment choice made by the provider.
- Two records (patients #008 and #009) had insufficient documentation to support the medical necessity for root canal therapy (RCT).

Overall Summary of Recommendations

The following recommendations are based on the Monitor's observations and findings from the review of the ten visit records:

- Ensure that all Op Sheets and/or Hygiene Procedures forms that relate to the tooth or teeth treated on the audited date of service are sent with the requested materials to accurately assess the medical necessity of the treatment provided.
- Develop a policy to establish acceptable criteria for providing a slot restoration, the billing procedure for such restoration, and how to proceed when a slot restoration fails.
- Monitor slot restoration failure rates to identify quality of care issues and to determine the need for further training and/or policy development.
- Due to the observations reported above, the Monitor recommends the CDO review the records for patients #005, #007, and #010 to determine the appropriateness of the slot restorations provided.
- Ensure staff members are verifying correct completion of the Authorization for Disclosure of Protected Health Information and the Authorization of Persons to Consent for Treatment forms.
- Ensure staff members are properly reviewing the patient's Health History form and documenting findings related to missing information or explanations to "yes" responses.
- Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members are documenting all new disease, conditions, or pathology found at subsequent appointments on the upper odontogram and/or in the notes section of the Tooth Chart.

- Ensure staff members are trained and monitored in the proper completion of the Hygiene Procedure form, Op Sheet, and Treatment Plan.
- Ensure staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure the billing error related to patient #003 is corrected.
- Ensure staff members are documenting interpretation of all exposed X-rays.
- Due to the findings related to patients #005, #008, and #009, the Monitor requests the CDO review these records to determine medical necessity, quality, and appropriateness of treatment. In addition, due to missing documentation related to treatment provided to tooth #3 on patient #009, the Monitor recommends that the Op Sheets dated September 10, 2010, and September 15, 2010 be provided to the and CDO for further review to determine the medical necessity of the treatment provided to tooth #3.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure that QAP and Quality Score Items are identified by CSHM's auditors.
- Ensure that CSHM auditors are adequately trained to review X-rays, identify quality of care issues, and can properly determine when to consult the CDO.
- Establish a process to evaluate and standardize CSHM auditors to establish a high degree of reliability in CSHM audit findings.
- Provide clear communication to the Clinic regarding the chart audit findings related to each patient's record.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Texas Smiles Dental Center of Austin (Clinic), 500 West William Cannon, Suite 438-A, Austin, TX 78745.

Implementation

The OIG approved a desk audit for Texas Smiles Dental Center of Austin. On May 23, 2011, the Monitor notified CSHM's Compliance Officer by e-mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from CSHM on May 27, 2011. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the first quarter of 2011
  - E-mail to the Clinic with results for the first quarter audit
  - First quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted] RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*
    - *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*

CSHM initially requested the Clinic's charts on February 4, 2011. The Clinic provided the charts on February 10, 2011. The chart audit was completed on February 21, 2011,

by a licensed dental hygienist. CSHM indicated the Clinic and all dentists passed the audit; therefore, no CAP was required, according to the *Chart Audit Policy*. The Chief Dental Officer (CDO) was consulted in the review of one record (patient #005), which resulted in no findings.

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the first quarter of 2011. It mirrors the testing attributes employed by CSHM by conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on six of the ten visit records reviewed.

Review of CSHM Chart Audit

Ten records were reviewed, five for each dentist, following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentists. Both dentists scored lower under the Monitor's review compared to the CSHM audit. The Monitor's overall Clinic score of 94 percent was also lower than CSHM's overall Clinic score of 98 percent. However, the CSHM Chart Audit Tool did not capture all of the findings the Monitor had concerning quality of care.

	Monitor Score	CSHM Score
[redacted]	94%	100%
[redacted]	94%	100%
Clinic Total Audit Score	**94%**	**98%**

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified. These findings are also included below.

[redacted] Texas Smiles Dental Center of Austin

[redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#3	The abnormal root resorption on tooth #E, which is visible on the X-ray dated December 10, 2010, and is indicative of an abscess, was not noted on the December 10, 2010, Tooth Chart. The Operative Procedures form (Op Sheet) dated December 17, 2010, noted a "facial localized fistula on #F." This finding is also not on the Tooth Chart.	
#21	The Monitor was unable to verify the correct documentation of decay for teeth #C and #D due to the difficulty in determining red marks on the black-and-white copy of the Tooth Chart. It appears the distal surface is the only surface recorded on the upper odontogram of the Tooth Chart for tooth #C when the distal, lingual, and facial surfaces were recorded on the Op Sheet and Treatment Plan. Tooth #D also appears to have the distal, lingual, and incisal surfaces marked on the upper odontogram when the Op Sheet and Treatment Plan record the lingual, facial, and incisal surfaces.	
#28	Oral hygiene was not marked in the dental evaluation section of the Hygiene Procedures form.	
#37	Initials or a diagonal line did not follow the notes recorded in the written summary of the Hygiene Procedures form's appointment section.	Hygiene-page- (12/9/2010) – notes are not documented with a diagonal line or initials to end notes.

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The Monitor was unable to determine the correct documentation of existing fillings due to the black-and-white copy of the Tooth Chart.	Nice job
#21	The Monitor was unable to determine whether decay was charted correctly on the upper odontogram of the Tooth Chart due to the black-and-white copy of the Tooth Chart. It appears the distal surface is marked on the upper odontogram for tooth #T when only the mesial and occlusal surfaces are recorded on the Op Sheet and Treatment Plan.	
The current CSHM Audit Tool does not address this issue.	There was no documentation for the interpretation of the December 22, 2010, panoramic X-ray.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The Health History form did not record an explanation for the "yes" answer given for asthma/breathing problems. There was a comment recorded in the left margin of the Health History form; however, the comment was cut off on the copied document. Thus, the Monitor was unable to determine if this was an explanation related to the answer.	Health History page- (12/9/2010)-
#21	Facial decay was not recorded on the upper odontogram of the Tooth	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
	Chart for teeth #D and #E. The Op Sheet and the Treatment Plan list the facial surface for these teeth.	
#28	Eating Routines were not indicated in the dental evaluation section of the Hygiene Procedures form.	
#60	The tooth surfaces recorded for tooth #E on the Op Sheet and the Treatment Plan do not match. The Treatment Plan recorded distal lingual facial and the Op Sheet recorded mesial lingual facial.	Operative sheet-(12/16/2010)-tooth #E is treatment planned with distal lingual facial decay. The operative sheet documents mesial lingual facial decay. Surfaces do not match. Please provide correct surfaces even when the tooth is completely crowned.
#68	The December 9, 2010, X-rays were labeled on the wrong side and were not labeled right or left.	X-rays- (12/9/2010) – the film are not labeled correctly. The film was labeled backwards.

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The Spanish Health History form dated December 3, 2010, did not show a response to the question asking if the child has any other health problems.	
#30	The chief complaint recorded in Spanish on the Health History form was not recorded on the Hygiene Procedures form. Instead, the Hygiene Procedures form recorded "none" on the line designated for the chief complaint.	
#60	The Op Sheet recorded the wrong tooth surface for the filling provided to tooth #E; therefore, the tooth surfaces recorded on the Op Sheet did not match the surfaces recorded	Operative sheet-(12/13/2010) Tooth # E is treatment planned with distal lingual decay. The operative sheet documents mesial lingual decay. They do not match.

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
	on the Treatment Plan or the lower odontogram of the Tooth Chart. The upper odontogram documents distal decay on tooth #E and the lower odontogram shows that a distal lingual filling was performed as planned on the December 3, 2010, Treatment Plan. However, the Op Sheet recorded a mesial lingual composite filling was performed on tooth #E on December 14, 2010.	
#71	Tooth #E was billed incorrectly due to a documentation error on the December 14, 2010, Op Sheet. Tooth #E should have been billed as a distal lingual composite filling. The bitewing X-rays taken during the December 3, 2010, hygiene visit were not recorded on the Account History Report.	

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#46	A witness did not sign he Local Anesthesia and Nitrous Oxide Consent Form dated December 10, 2010.	Nice job Document from [redacted] with patient file.
The current CSHM audit tool does not address this issue.	According to the Monitor's pediatric dentist, the December 10, 2010, bitewing X-ray shows deep distal caries approximating the pulp of tooth #I. This X-ray does not show the furcation area of the tooth. Since the decay on tooth #I is large and may already be into the pulp, there is need to rule out a furcation radiolucency that would indicate the pulp is necrotic. Tooth #I was	

[redacted] Texas Smiles Dental Center of Austin

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
	treatment planned for a pulpotomy; however, the January 25, 2011, Op Sheet does not show a pulpotomy was performed on this tooth. Had a pulpotomy been performed, the ability to visualize the pulp tissue and determine its vitality status would have negated the fact that no periapical X-ray was taken to rule out an abscess. However, without seeing the pulp, it is impossible to know whether the pulp is vital and will withstand such a close encounter during caries removal. Documentation related to the decision not to perform a pulpotomy on tooth #I would have been helpful in understanding the provider's treatment choice. Tooth #J appears to have had a slot restoration that has failed and fallen out. The Op Sheet shows a mesial occlusal composite filling was performed on tooth #K with a narrative that states: "Small mesial decay slot prep only."	

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#21	The upper odontogram of the January 19, 2011, Tooth Chart did not document facial decay on tooth #C, as noted on the Treatment Plan and the Op Sheet.	
#60	The lower odontogram of the Tooth Chart did not document the pulpotomies performed on teeth #C, #D, and #G.	Operative sheet-(1/26/2011)-surfaces of decay are not documented properly on the treatment plan for teeth #s E and F therefore they do not match the

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
	The January 26, 2011, Op Sheet did not record decayed tooth surfaces for teeth #E and #F.	operative sheet. The pulpotomies performed on teeth #s C, D, and G are not documented on the bottom of the odontogram as completed procedures.

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#10	Section B of the Authorization for Disclosure of Protected Health Information and the Authorization of Persons to Consent for Treatment forms was not completed correctly. Section B contained the aunt's information instead of the mother's.	Nice job
#15	The Spanish Health History form dated January 11, 2011, did not have a response to the questions related to other health problems and dental concerns.	
The current CSHM audit tool does not address this issue.	There was no documentation for the interpretation of the January 11, 2011, panoramic X-ray.	
The current CSHM audit tool does not address this issue.	The January 12, 2011, Op Sheet narrative for tooth #K states: "slot prep sealed remainder of occlusal surface." Tooth #K was billed as a mesial occlusal composite filling.	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	The existing condition and diagnosis related to tooth #3 was not recorded on the upper odontogram of the August 9, 2010, Tooth Chart.	Nice job
The current CSHM audit tool does not address this issue.	Tooth #3 appears normal on the August 9, 2010, bitewing X-ray with the exception of an enamel etch on the mesial surface. According to the Account History Report, tooth #3 was restored with a mesial occlusal lingual composite filling on August 10, 2010. On November 15, 2010, tooth #3 received root canal therapy (RCT). The following tracks the available documentation related to the RCT provided to tooth #3 on the audited date of service (November 15, 2010): The filling visible on tooth #3 on X-rays dated November 8, 2010, appears to be a mesial occlusal composite prep of normal depth. The Monitor's pediatric dentist determined that both periapical X-rays taken on November 8, 2010, of tooth #3 are negative for radiographically demonstrable pathology associated with this tooth. The Op Sheet dated November 15, 2010, documents pulp vitality testing was done, but gives no findings from the test. The second page of the Op Sheet dated November 15, 2010, documents pulpitis, acute periradicular periodontology and pain on the diagnosis line, but there was no documentation for the rationale for these diagnoses. There was also no additional information added to the Tooth Chart	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
	dated August 9, 2010, which would have been appropriate according to CSHM's policy that Tooth Charts can be updated for six months. In addition, the word "pain" is written in the surface line of the November 8, 2010, Treatment Plan. There is no organized documentation to indicate that tooth #3 was given the appropriate diagnostic work up, commonly called SOAP (subject, objective, assessment, and planning), to determine that a root canal was the proper treatment. The diagnosis of "pain" is insufficient without additional documentation about the pain. Vitality testing performed and billed without documenting the outcome is meaningless. Providing no diagnostic rationale for the diagnostic terms written on the Op Sheet is insufficient. Given the documentation provided, the Monitor's pediatric dentist determined there is no documentation of medical necessity for the RCT provided to tooth #3.	
The current CSHM audit tool does not address this issue.	There was no documentation for the interpretation of the November 8, 2010, periapical X-rays of tooth #3.	

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#20	Proper documentation of the existing	Nice job

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
	filling on tooth #3 could not be determined because a black-and-white copy of the Tooth Chart was used for this audit.	
#21	Proper documentation of decay on tooth #3 could not be determined because a black-and-white copy of the Tooth Chart was used for this audit. The X-rays dated August 30, 2010, show an existing mesial occlusal filling on tooth #3. Due to the black-and-white copy of the Tooth Chart provided, the Monitor was unable to determine if decay was charted for tooth #3 on the upper odontogram of the Tooth Chart.	
The CSHM audit tool does not address this issue.	The documentation provided to CSHM, and therefore to the Monitor, was incomplete regarding treatment provided to tooth #3. According to the Account History Report, a sedative filling was placed in tooth #3 on September 10, 2010, and the patient was seen again on September 15, 2010, for further treatment to tooth #3. Documentation related to those appointments would have been beneficial in determining the medical necessity for the root canal therapy provided to tooth #3 on November 16, 2010. However, they were not sent with the requested materials. Upon review of the documents provided, the Monitor's pediatric dentist found no documentation of pain or any reason to start a root canal, no vitality testing was performed, and the periapical X-ray	

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
	taken on September 15, 2010, the same day the RCT was started, is light but looks normal.	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#65	The Monitor did not have a finding related to this question. This question reads, "Clinicians taking x-rays noted/identified." Periapical X-rays of teeth #8/9 and #24/25 were recorded on the December 17, 2010, Op Sheet along with four bitewing X-rays and a panoramic X-ray. While the Op Sheet did not record the clinician's name that exposed the X-rays, the staff initials "KR" were recorded on the duplicate X-rays.	X-rays-(12/17/2010) x-rays were documented as taken on the day of operative the clinician taking the x-ray film was not documented.
The CSHM audit tool does not address this issue.	There was no documentation for the interpretation of the December 17, 2010, maxillary and mandibular periapical X-rays or the panoramic X-ray.	
The CSHM audit tool does not address this issue.	The December 17, 2010, Op Sheet narrative for tooth #4 states: "slot prep" on the mesial occlusal of tooth #4 and "slot prep" on the distal occlusal of tooth #4 with an additional note that the restorations were "not connected." According to the Account History Report, two separate two-surface composite fillings were billed for tooth #4.	

The Monitor had the following observations:

- The Hygiene Procedures form sent for patient #008 was dated November 16, 2010, after the audited date of service of November 15, 2010. The November 8, 2010, Hygiene Procedures form used for the limited oral exam was not included in the requested materials; therefore, the Monitor was unable to review documentation that applied to the audited date of service.
- The documents received for patient #009 did not include forms related to treatment provided to tooth #3 on September 10, 2010, and September 15, 2010. These documents would have been beneficial in determining the medical necessity for the root canal provided to tooth #3.
- Three of the ten records (patients #005, #007, and #010) reviewed documented the use of slot restorations. Two of those records (patients #005 and #007) involved primary molars while the other record (patient #010) involved both the mesial and distal surfaces of a permanent premolar. According to the Monitor's pediatric dentist, in the record for patient #005, tooth #J appears to have had a slot restoration that has failed and fallen out. The Op Sheet shows a mesial occlusal composite filling was performed on tooth #K with a narrative that states: "Small mesial decay slot prep only." The Monitor was unable to locate a CSHM policy regarding slot restorations.

Below is a summary of the Monitor's findings of CSHM's audit of the Clinic:

- One record (patient #007) did not have Section B of the Authorization for Disclosure of Protected Health Information and the Authorization of Persons to Consent for Treatment forms completed correctly. Section B contained the aunt's information instead of the mother's.
- Three records (patients #003, #004, and #007) did not have answers for questions that required a "yes" or "no" response on the Health History or there was no explanation given for a "yes" response.
- CSHM did not report any findings related to the Tooth Chart and reviewed black-and-white copies of the Tooth Chart for this chart audit. All nine of the Monitor's findings related to the Tooth Chart were for QAP and Quality Score Items. Below is a summary of the Tooth Chart findings.
  - Two records (patients #001 and #008) did not show documentation of all existing conditions or restorations, pertaining to the treated quadrant, on the upper odontogram of the Tooth Chart. The Monitor was unable to determine the accuracy of charting existing conditions and restorations on the Tooth Chart of two records (patients #002 and #009) due to black-and-white copies used for the chart audit.
  - Two records (patients #003 and #006) did not show documentation of all decayed surfaces on the upper odontogram of the Tooth Chart. The Monitor was unable to determine the accuracy of charting decay on the upper odontogram of the Tooth Chart of three records (patients #001, #002, and #009) due to black-and-white copies used for the chart audit.
- The following findings are related to the Hygiene Procedures form:

  - Two records (patients #001 and #003) did not have the dental evaluation section completed correctly.
  - One record (patient #004) did not record the patient's chief complaint. The chief complaint was recorded in Spanish on the Health History form; however, the Hygiene Procedures form recorded "none" on the line designated for the chief complaint.
  - One record (patient #001) did not have notes documented correctly.
- One record (patient #005) did not have a witness signature on the Local Anesthesia and Nitrous Oxide Consent Form.
- Three records (patients #003, #004, and #006) were found to have inconsistent documentation related to procedures, surfaces, and/or diagnosis recorded on the Op Sheet, Treatment Plan, and/or lower odontogram of the Tooth Chart.
  - Patient #003 – The tooth surfaces recorded for tooth #E on the Op Sheet and the Treatment Plan do not match. The Treatment Plan recorded distal lingual facial and the Op Sheet recorded mesial lingual facial.
  - Patient #004 – The Op Sheet recorded the wrong tooth surface for the filling provided to tooth #E; therefore, the tooth surfaces recorded on the Op Sheet did not match the surfaces recorded on the Treatment Plan or the lower odontogram of the Tooth Chart.
  - Patient #006 – The lower odontogram of the Tooth Chart did not document the pulpotomies that were performed on teeth #C, #D, and #G. The Op Sheet did not record decayed tooth surfaces for teeth #E and #F.
- The duplicate X-rays in one record (patient #003) were labeled on the wrong side and were not labeled right or left.
- As a result of a documentation error on the Op Sheet, the filling provided to tooth #E of patient #003 was not billed correctly.
- The following are additional findings that were not captured in CSHM's Chart Audit Tool:
  - Four records (patients #002, #007, #008, and #010) did not show documentation of the interpretation of X-rays. Three of the four records (patients #002, #007, and #010) did not document interpretation of panoramic X-rays. Two records (patients #008 and #010) did not document interpretation of periapical X-rays.
  - Patient #005 – According to the Monitor's pediatric dentist, the December 10, 2010, bitewing X-ray shows deep distal caries approximating the pulp of tooth #I. This X-ray does not show the furcation area of the tooth, and because the decay is large and may be already be into the pulp, there is need to rule out furcation radiolucency. Tooth #I was treatment planned for a pulpotomy; however, the January 25, 2011, Op Sheet does not show that a pulpotomy was performed on this tooth. Documentation related to the treatment of tooth #I would have been helpful in understanding the provider's treatment choice.
  - Two records (patients #008 and #009) had insufficient documentation to support the medical necessity for root canal therapy (RCT).

Recommendations

The following recommendations are based on the Monitor's observations and findings from the review of the ten visit records:

- Ensure that all Op Sheets and/or Hygiene Procedures forms that relate to the tooth or teeth treated on the audited date of service are sent with the requested materials to accurately assess the medical necessity of the treatment provided.
- Develop a policy to establish acceptable criteria for providing a slot restoration, the billing procedure for such restoration, and how to proceed when a slot restoration fails.
- Monitor slot restoration failure rates to identify quality of care issues and to determine the need for further training and/or policy development.
- Due to the observations reported above, the Monitor recommends the CDO review the records for patients #005, #007, and #010 to determine the appropriateness of the slot restorations provided.
- Ensure staff members are verifying correct completion of the Authorization for Disclosure of Protected Health Information and the Authorization of Persons to Consent for Treatment forms.
- Ensure staff members are properly reviewing the patient's Health History form and documenting findings related to missing information or explanations to "yes" responses.
- Ensure staff members are trained and monitored in the documentation of existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members are documenting all new disease, conditions, or pathology found at subsequent appointments on the upper odontogram and/or in the notes section of the Tooth Chart.
- Ensure staff members are trained and monitored in the proper completion of the Hygiene Procedure form, Op Sheet, and Treatment Plan.
- Ensure staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure the billing error related to patient #003 is corrected.
- Ensure staff members are documenting interpretation of all exposed X-rays.
- Due to the finding related to patients #005, #008, and #009, the Monitor requests the CDO review these records to determine medical necessity, quality, and appropriateness of treatment. In addition, due to missing documentation related to treatment provided to tooth #3 on patient #009, the Monitor recommends that the Op Sheets dated September 10, 2010, and September 15, 2010 be provided to the and CDO for further review to determine the medical necessity of the treatment provided to tooth #3.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure that QAP and Quality Score Items are identified by CSHM's auditors.

- Ensure that CSHM auditors are adequately trained to review X-rays, identify quality of care issues, and can properly determine when to consult the CDO.
- Establish a process to evaluate and standardize CSHM auditors to establish a high degree of reliability in CSHM audit findings.
- Provide clear communication to the Clinic regarding the chart audit findings related to each patient's record.

EXHIBIT 53

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
Church Street Health Management

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Small Smiles Dental Centers of Mattapan
Mattapan, MA

Deliverable #1-34

September 6, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Mattapan (Clinic), 90 River Street, Mattapan, MA 02126.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 15 records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of 15 records that CSHM audited during the second quarter of 2011.

All three dentists scored significantly lower under the Monitor's review compared to the CSHM audit, with all three dentists failing the chart audit. The Monitor's overall Clinic score of 23 percent was also significantly lower than CSHM's overall Clinic score of 86 percent.

This was the Monitor's first review of CSHM's chart audit process using the revised audit tool. The Monitor saw noticeable improvement in CSHM's auditor's efforts to follow the Guidelines and capture related findings in the audit tool; however, significant issues related to medical necessity, quality of care, and a potential adverse event were not identified. The revised audit tool has added 29 questions; however, the majority of the focus of the Guidelines continues to be on areas related to completing forms correctly instead of clearly capturing lack of medical necessity, potential quality of care issues, and identifying adverse events. The audit tool's ability to capture medical necessity related to treatment and X-rays is still not clearly defined in the Guidelines; therefore, it is not captured in the audit tool. Treatment performed without consent is also not captured as a QAP or Quality Score item; therefore, it has no significant impact on the dentist's score.

The Monitor received poor quality duplicate X-rays and poor quality color copies of the Tooth Chart. Three records (patients #003, #004, and #008) included non-diagnostic X-rays.

Medical necessity for treatment provided could not be determined in two records (patients #002 and #014) because all documents and X-rays related to the treated teeth were not sent or requested by CSHM's auditor. CSHM's audited date of service, March 21, 2011, and January 24, 2011, for patients #002 and #014 respectively, were for delivery of crowns.

Three records (patients #006, #007, and #013) did not provide documentation to support the medical necessity for treatment provided.

In the record for patient #002, there was no additional consent obtained for the crowns performed on teeth #12 and #13. According to the CDO, the Op Sheet stated the mother was happy with the shade of the crowns; however, this does not show that consent was properly obtained. Without being able to review all documentation related to the treatment provided to teeth #12 and #13, the Monitor was unable to determine when or if proper consent for treatment for the RCT and crowns performed on teeth #12 and #13 had been obtained.

In the record for patient #011, there was no consent documented on the October 1, 2010, treatment plan for SSCs performed on teeth #I, #J, and #K or the pulpotomies performed on teeth #I, #J, #K, and #L. Therefore, this appears to be an adverse event not identified by the CSHM auditor.

Seven records (patients #001, #003, #005, #011, #012, #013, and #015) did not provide documentation on the Op Sheet of diagnosis or medical necessity for pulpotomies performed.

Four records (patients #002, #009, #011, and #015) did not document the rational or findings related to X-rays exposed during the hygiene visit. These records also showed routine exposure of anterior X-rays during hygiene visits.

One record (patient #002) did not document the rational or findings related to X-rays exposed during the March 21, 2011, operative visit.

Two records (patients #011 and #012) showed documentation that local anesthesia was delivered by infiltration when pulpotomies were performed on mandibular molars, which requires pulpal anesthesia.

Four records (patients #003, #004, #008, and #012) failed to use the proper method to note changes to the record.

Overall Summary of Recommendations

The following recommendations are based on the Monitor's findings from the review of the 15 visit records and CSHM's chart audit process:

- Ensure staff members understand the chart audit process and documentation requirements.
- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.
- Ensure staff members provide diagnostic radiographs that are duplicated and labeled properly.

- Ensure staff members are clearly documenting existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual.*
- Ensure staff members are properly completing the Health History and Hygiene Procedures forms, the Op Sheet, and the Treatment Plan.
- Ensure staff members understand the proper manner to notate errors in patient records.
- Ensure consent is obtained for all procedures performed.
- Ensure staff members are providing adequate documentation to support the medical necessity of treatment provided.
- Further assessment by the CDO is needed to determine trends and training needs in this Clinic specifically related to the pulpotomy-to-SSC ratio and the effectiveness of the local anesthesia methods used to treat lower primary molars in children.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure all relevant documentation and X-rays that relate to the teeth treated on the audited date of service are requested and received to perform a complete review.
- Ensure audit tools are updated to reflect changes to audit findings as a result of appeals.
- Ensure Monitor receives all documentation CSHM reviewed in obtaining chart audit results.
- Ensure that QAP and Quality Score items are clarified in the Guidelines, identified by CSHM's auditor, and modifications are made to capture all unaddressed findings in the Chart Audit Tool.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Mattapan (Clinic), 90 River Street, Mattapan, MA 02126.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of Mattapan. On June 30, 2011, the Monitor notified CSHM's Compliance Officer by e-mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from CSHM on July 8, 2011. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the second quarter of 2011
  - E-mail to the Clinic with results for the second-quarter audit
  - Second-quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*
    - *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*
    - *Chart Documentation Guide*
    - [redacted] *Best Practice Memo*

CSHM initially requested the Clinic's charts on April 4, 2011. The Clinic provided the charts on April 12, 2011. The chart audit was completed on April 20, 2011, by a licensed dental hygienist. CSHM reported that one dentist failed the audit and the Clinic received a failing score as well. A CAP was implemented on May 5, 2011. A re-audit was completed and the Clinic and all dentists received passing scores. The Chief Dental Officer reviewed one record (patient #002) as part of this chart audit.

This desk audit is to review the chart audit conducted by CSHM during the second quarter of 2011 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 10 of the 15 visit records reviewed.

Review of CSHM Chart Audit

Fifteen records were reviewed, five for each dentist, following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentists. All three dentists scored significantly lower under the Monitor's review compared to the CSHM audit, with all three dentists failing the chart audit. The Monitor's overall Clinic score of 23 percent was also significantly lower than CSHM's overall Clinic score of 86 percent.

	Monitor Score	CSHM Score
[redacted]	36%	90%
	20%	91%
	21%	89%
Clinic Total Audit Score	23%	86%

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified. These findings are also included below.

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#8	This question pertains to the Dentistry Practice Management form and was scored as "no" by CSHM's auditor on the audit tool spreadsheet. The Monitor was unable to determine why this question was scored as "no" from the explanation communicated in the e-mail to the Clinic. However, an e-mail dated June 1, 2011, records the auditor's response to an appeal by the Clinic and states: "a 'no' was given because the form was not appropriately completed." The parent signed and dated the form but the parent did not insert his or her name in the section that states he or she has read the information and understands it. The Monitor cannot determine whether the reason that the Clinic received a "no" was because this section was not completed or that the audit tool was not updated when the document was received.	Chart Audit Request-Dentistry Patient Management Techniques form and Restorative Dentistry Checklist were not included in the requested material. **Forms was copied and sent with materials. All materials was last check by clinical coordinator and OM**
#22	The upper odontogram of the Tooth Chart did not show decay on the distal of tooth #I, mesial of tooth #J, and buccal and lingual of tooth #K.	Tooth Chart-(12/20/2010): The Distal surface of decay was not documented for tooth #I. The Buccal and Lingual surfaces of decay were not documented for tooth #K.
#24 and #25	The color copy of the Tooth Chart provided to the Monitor was very light and of poor quality. It was difficult to read the patient's name, date, and signatures at the bottom of the form.	
#53	The Guidelines for question #53 pertaining to the Treatment Plan indicate "yes" is scored "when each tooth has a specific procedure documented for treatment that corresponds with the audited	TX Plan-(12/20/2010): A diagonal line should be documented on any unused lines in each section or on any unused lines after the last entry in each section.

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
	operative sheet." This finding is in accordance with the *Patient Care Manual*.	
#54	The Guidelines for question #54, pertaining to the Treatment Plan state: "yes" is given "when the crown options boxes have either the parents/responsible party's initials/signature or N/A documented appropriately." The parent initialed the stainless steel crown (SSC) box but a slash was marked through the "tooth-colored crown(s) Cap(s) (front teeth only)" box.	The crown option boxes should be either initialed or marked N/A.
#76	There was no diagnosis of carious pulp exposure (CPE) documented on the Operative Procedures form (Op Sheet) for the pulpotomies performed on teeth #I, #J, #K, and #L.	
#77	It did not appear the pulpotomies performed on teeth #I, #J, #K, and #L were documented on the lower odontogram of the Tooth Chart; however, due to the quality of the color copy of the Tooth Chart, the Monitor entered "can't verify" for this question.	
#82	The notes section of the Op Sheet did not have a diagonal line or initials following the final entry.	OP-(2/3/2011): Initials or diagonal line not documented after the last entry in the notes.
#102	CSHM's auditor scored "no" for this question in the audit tool; however, there was no explanation to communicate this finding in the e-mail to the Clinic. The abbreviation "C" was the only entry recorded on the diagnosis line of the Op Sheet. According to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or	

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
	the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
	This comment by CSHM's auditor was not captured in question #29 in the audit tool.	Please be consistent in documenting the patient's name. Some of the sheets have the last name first.
#7	The Account History Report and the Hygiene Procedures form show that a periapical X-ray of tooth #13 was taken on November 30, 2010; however, this X-ray was not included with the requested materials.	
#11	Acknowledgment of Receipt of Notice of Privacy Practices (Acknowledgment) form was not completed correctly.	Acknowledgement Notice of Privacy Practices dated 11/30/2010 was not documented completely
#17	The Health History form did not include an explanation for the positive history of ADHA (Attention Deficit Hyperactivity Disorder). Multiple medications were also listed without documentation of follow-up pertaining to other possible health conditions being treated.	HX-(11/30/2010): An explanation is needed for ADHD for the question "If you answered "Yes" to any of the above, please explain:" section.
#21	The X-rays dated November 30, 2010, show a large amalgam filling on tooth #15. This amalgam filling does not appear to be properly charted on the upper odontogram of the Tooth Chart.	
#22	The decay recorded on teeth #12 and #13 was difficult to see on the color copy of the Tooth Chart; therefore, the Monitor was unable to determine if all decayed surfaces were properly documented. The distal of tooth #12 and the mesial and distal of tooth #13 did not appear to be marked in red.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#29	The Hygiene Procedures form did not record the patient's name correctly and did not include the patient's weight.	HYG-(11/30/2011): Patient's weight was not documented.
#30	The Hygiene Procedures form did not have the periodontitis portion of the dental evaluation section completed.	Periodontitis section of the dental evaluation was not documented. If the section does not pertain to the patient an N/A should be documented.
#32	The Hygiene Procedures form did not document whether there was or was not a chief complaint by the patient.	Chief Complaint was not documented. If there is not a Chief Complaint then "none" should be documented.
#38	There was no documentation related to the rationale or interpretation of the bitewing X-ray and two periapical X-rays dated March 21, 2011 and taken during the operative visit.	
#42	The notes section of the Hygiene Procedures form was not completed correctly.	There should be a diagonal line or initials on the line if notes are not documented.
#51	This question asks, "Does the treatment plan reflect diagnostic findings from x-rays, digital photos, or odontogram for the area(s) being treated?" The periapical X-ray of tooth #13 and the Op Sheets dated December 31, 2010, January 28, 2011, February 4, 2011, and February 18, 2011, were not sent with the requested materials. In addition, the upper odontogram and notes section of the Tooth Chart did not document the diagnostic findings to support the medical necessity for the Root Canal Therapy (RCT) provided to teeth #12 and #13. Therefore, the Monitor was unable to verify the Treatment Plan reflected the diagnostic findings related to teeth #12 and #13.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#53	The November 30, 2010, Treatment Plan did not include consent for the crowns performed on teeth #12 and #13. CSHM's auditor reported this finding to CSHM's Patient Advocate. Upon review of the e-mail correspondence between the Patient Advocate and [redacted], Chief Dental Officer (CDO), this was considered a documentation error and not an adverse event. It also appears the initial Treatment Plan may have been modified; however, without all related Op Sheets it is difficult to determine when the diagnosis for the RCT and subsequently the crowns were made for teeth #12 and #13. Upon review of the Treatment Plan, it appears the initial treatment for teeth #12 and #13 was to perform fillings and, at some point, "RCT" was added for tooth #13 with another addition of "RCT post & core" added to include teeth #12 and #13. According to the Guidelines, "Consent must be obtained when the dentist elects to use a different restorative material" or "when pulp therapy is found to be necessary." Therefore, the date consent was obtained for these procedures should correlate to the date of the diagnosis.	
#60	There was no additional Treatment Plan provided to show that consent was obtained for the crowns performed on teeth #12 and #13.	
#69	The Op Sheet dated March 21, 2011, did not document a chief complaint; therefore, there is no documentation to support the billing for a limited oral exam or the periapical X-ray of teeth	OP-(3/21/2011): LOE was documented and no documentation for Chief Complaint.

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
	#12 and #14. CSHM's auditor included a finding associated with this question; however, it was scored as "n/a" on the audit tool spreadsheet.	
#77	The RCT and crowns performed on teeth #12 and #13 were not documented on the lower odontogram of the Tooth Chart.	
#78	This question asks, "If treatment for an individual tooth was different from the treatment plan, was need for change documented in the notes section?" The only Op Sheet received for review showed that services had already been provided and the audited date of service was for the delivery of crowns. The Monitor was unable to determine if documentation existed on an additional Op Sheet that would support the need for the change in the Treatment Plan.	Completed crowns for teeth #'s 12 & 13 were not documented on the Treatment Plan. The Treatment Plan dated 11/30/2010 planned teeth #'s 12 & 13 as RCT, Post & Core and Fillings. No documentation for change in treatment. See email attached to the chart- Per [redacted] Documentation error.
There is no question in CSHM's audit tool to address this issue.	The November 30, 2010, Hygiene Procedures form did not document the need for or interpretation of the periapical X-ray of tooth #13. There was no chief complaint documented on the Hygiene Procedures form to indicate a need for the X-ray. Question #38 asks, "If interim x-rays were taken, are the rationale for films and the radiographic findings documented?" The Monitor did not score the above finding in this question because the Guidelines refer to interim X-rays as those "taken between recall appointments." This X-ray was not taken between hygiene appointments but during the November 30, 2010, hygiene/recall appointment.	
There is	Medical necessity for treatment	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
no question in CSHM's audit tool to address this issue.	provided cannot be determined without receiving all documents that relate to the treatment provided to teeth #12 and #13. Therefore, it would seem necessary for CSHM's auditor to obtain the additional documentation to perform a complete review.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#11	The Acknowledgment form was not completed correctly. The parent/guardian relationship to the patient was not documented on the form.	Consents & Acknowledgements-Parent/Guardian relationship to patient was not documented for the Acknowledgement Notice of Privacy Practices.
#21	The Monitor was unable to determine the condition of teeth #B and #S due to non-diagnostic X-rays.	
#22	The decay did not appear clearly recorded on teeth #A, #B, #S, and #T and was difficult to see on the color copy of the Tooth Chart; therefore, the Monitor was unable to determine if all decayed surfaces were properly documented.	
#30	The Hygiene Procedures form did not have the eating routines and occlusion sections of the dental evaluation completed.	HYG-(3/21/2011): 2 sections of the dental evaluation were not documented.
#32	The Hygiene Procedures form did not show documentation of the chief complaint. According to the Health History form, "she may have problems with her teeth, she also has very bad breath."	If there is not a Chief Complaint then "none" should be documented.
#46	The bitewing X-rays dated March 21, 2011, are non-diagnostic with very poor clarity, density, contrast, and visibility of tooth structure for the first molars, and there is overlap in the	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
	contact areas.	
#48	The patient's date of birth was recorded incorrectly on the Hygiene Procedures form and then corrected without proper error notation.	
#51	The Monitor was unable to determine if the Treatment Plan reflected the diagnostic findings from X-rays or the Tooth Chart because of non-diagnostic X-rays and an inability to clearly see documentation of diagnostic findings on the provided Tooth Chart.	
#53	A diagonal line was not recorded on the unused portions of the Treatment Plan.	TX Plan-(3/21/2011): A diagonal line should be documented on any unused lines in each section or on any unused lines after the last entry in each section.
#54	The "Tooth-Colored Crown(s) CAP(s) (Front teeth only)" box was left blank.	The crown option boxes should be either initialed or marked N/A.
#58	The patient's date of birth was recorded incorrectly on the Treatment Plan and then corrected without proper error notation.	
#67	Question 4 of the restorative dentistry checklist on the Op Sheet dated March 24, 2011, did not have the first box checked to show verification of consent for treatment and the use of nitrous oxide.	OP-(3/24/2011): Consent for Treatment was not documented on the Restorative Dentistry Checklist.
#70	The chief complaint line was left blank on the Op Sheet.	Chief Complaint was not documented. If there is not a Chief Complaint then "none" should be documented.
#76	Carious Pulp Exposure, "CPE," was not recorded on the diagnosis line of the Op Sheet for the pulpotomies performed on teeth #A, #B, #S, and #T.	
#77	The completed treatment documented on the lower odontogram of the Tooth Chart was	A "p" was not documented above teeth #'s S & T on the Tooth Chart dated 3/21/2011.

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
	difficult to see on the copy provided; however, the pulpotomies performed on teeth #S and #T did not appear to be documented.	
#79	The complications section of the Op Sheet was not completed.	Complications section was not documented.
#102	The abbreviation "C" was the only entry recorded on the diagnosis line of the Op Sheet. According to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	CTS/HCR was not documented on the diagnosis for crowns completed on teeth #'s A, B, S & T.

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	CSHM's auditor scored "no" for this question because the Dentistry Practice Management form was not included in the requested materials. This form was not necessary for managing this 24-year-old patient. Although the CSHM e-mail to the Clinic dated June 1, 2011, acknowledges this fact and indicates the audit score was changed for this question, the audit tool spreadsheet provided to the Monitor showed "no" was scored and did not reflect the change.	Chart Audit Request-Dentist Practice Management form was not included in the requested material. **Pt DOB: is** [redacted]
#21	The upper odontogram of the Tooth Chart did not document the existing occlusal filling on tooth #19.	Tooth Chart-(10/29/2010): A visible restoration on the X-ray for #19 was not documented.
#32	The Hygiene Procedures form did not document whether there was or was not a chief complaint by the patient.	HYG-(10/24/2010): Chief Complaint was not documented. If there is not a Chief Complaint then "none" should be documented.
#33	The diagnosis section of the Hygiene Procedures form was not completed	Diagnosis section was not documented.

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
	correctly.	
#46	The right premolar bitewing X-ray dated October 29, 2010, was non-diagnostic. The Account History Report shows billing for all four bitewing X-rays.	
#82	There was no diagonal line or initials following the last entry in the notes section of the Op Sheet.	OP-(2/9/2011): Initials or diagonal line not documented after the last entry in the notes.
#83	The error in the local anesthesia section of the Op Sheet was not corrected as instructed in the *Patient Care Manual*. The correction did not include the date or the notation of "error."	An error was corrected in the Local Anesthetic without proper error notation.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#12	The Authorization for Disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian (Authorization) form was not completed correctly. The parent did not complete Section B.	Authorization for disclosure of Protected Health Information and Authorization of Persons to Consent for Treatment in the Absence of Parent/Guardian- section B was not documented.
#30	The Hygiene Procedures form did not have the eating routines section of the dental evaluation completed.	HYG-(2/15/2011): One section of the Dental Evaluation was not documented.
#54	The parent initialed the Treatment Plan SSC box and a slash was marked through the "tooth-colored crown(s) Cap(s) (front teeth only)" box.	TX Plan-(2/15/2011): The crown option boxes should be either initialed or marked N/A.
#68	The Op Sheet dated February 17, 2011, did not document the X-rays were reviewed. Although the Restorative Dentistry Checklist dated February 17, 2011, did document the radiographic findings were confirmed, the Monitor scored "no" for this question as instructed in the Guidelines.	OP-(2/17/2011): X-Rays reviewed was not documented.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#76	Carious Pulp Exposure, "CPE," was not recorded on the diagnosis line of the Op Sheet for the pulpotomy performed on tooth #I.	
#77	The pulpotomy performed on tooth #I was not documented on the lower odontogram of the Tooth Chart.	A "p" was not documented above tooth #I on the Tooth Chart dated 2/15/2011.
#82	There was no diagonal line through the notes section of the Op Sheet.	Initials or diagonal line not documented after the last entry in the notes.
#102	The abbreviation "C" was the only entry recorded on the diagnosis line of the Op Sheet. According to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	CTS/HCR was not documented for the diagnosis on teeth #'s A, B, I & J.

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#17	The Health History did not provide an explanation for the "yes" answers given for asthma and allergies.	HX-(12/2/2011): An explanation is needed for Asthma/Breathing Problems and Allergies in the "If you answered "Yes" to any of the above, please explain:" section.
#21	There was no documentation of the existing condition of tooth #19 on the upper odontogram or in the notes section of the Tooth Chart to support the medical necessity for RCT.	
#22	Decay was not recorded on the upper odontogram of the Tooth Chart for teeth #18 and #19.	Tooth Chart-(12/2/2011): Occlusal surface of decay for tooth #18 and Occlusal Buccal surface of decay for tooth #19 were not documented.
#25	The Monitor entered "can't verify" for this question because documentation of the patient's name, date, the	

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
	assistant/hygienist signature, existing conditions, and disease recorded on the Tooth Chart was difficult to see and appeared very light on the copy provided to the Monitor.	
#30	The Hygiene Procedures form did not have the oral hygiene section of the dental evaluation completed.	HYG-(12/2/2011): 3 sections of the Dental Evaluation were not documented.
#65	The patient's weight was not recorded on the Op Sheet.	OP-(3/2/2011): Patient's weight was not documented.
#76	The molar root canal section of the Op Sheets (sheets #8 and #9), used to document the RCT on teeth #18 and #19, did not record rubber dam isolation or irrigation.	
#77	The lower odontogram of the Tooth Chart did not record the completed RCT performed on teeth #18 and #19.	Completed RCT's for teeth #'s 18 & 19 were not documented on the Tooth Chart dated 12/2/2011.
#79	The complications section of the Op Sheet used to record the RCT performed on tooth #19 (sheet #8) was not completed.	Complications section for Operative Sheet dated 3/2/2011 page #8 was not documented.
There is no question in CSHM's audit tool to address this issue.	There is no record to show that X-rays were taken during RCT or post-treatment. According to the Monitor's pediatric dentist, without documentation of symptoms, tooth vitality testing, a SOAP (subjective, objective, assessment, and planning) note, or radiographic findings on the upper odontogram, there is no medical necessity to support the RCT performed on teeth #18 and #19.	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#11	Acknowledgment form was not completed correctly.	Relationship of Parent/Guardian to patient was not documented on the Acknowledgement Notice of Privacy Practices.

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#13	The Monitor was provided with two copies of sheet #3 titled "Consent for Protective Stabilization." One copy was not signed or dated by a witness, but the additional copy was signed by a witness and dated March 18, 2011, the audited date of service.	Consents & Acknowledgements-Consent for Protective Stabilization-Witness signature and date was not documented.
#21	The Monitor was unable to determine whether existing conditions were charted correctly on the upper odontogram of the Tooth Chart because no X-rays or digital photos were taken.	Tooth Chart-(3/17/2011): Radiographs and digital photos were not taken therefore, can't verify.
#30	The Hygiene Procedures form did not have the eating routines section of the dental evaluation completed.	
#36	No X-rays or digital photos were taken.	
#37	No reason was documented to indicate why digital photos were not taken.	HYG-(3/17/2011): Reason for not taking digital photos was not documented.
#42	The notes section of the Hygiene Procedures form was not completed correctly.	Initials or diagonal line should be documented immediately after the last entry in the notes.
#53	A diagonal line was not recorded on the unused portions of the Treatment Plan.	TX Plan-(3/17/2011): A diagonal line should be documented on any unused lines in each section or on any unused lines after the last entry in each section.
#54	A parent initialed the SSC box and a slash was marked through the "tooth-colored crown(s) Cap(s) (front teeth only)" box on the Treatment Plan.	The crown option boxes should be either initialed or marked N/A.
#99	The stabilization verification section of the Consent for Protective Stabilization form was not completed.	OP-(3/18/2011): Stabilization Verification- Time increments were not documented.
#100	The outcome of stabilization was not documented on the Consent for Protective Stabilization form.	Outcome of Stabilization was not documented.
#102	Teeth #D, #E, #F, and #G received pulpotomies and SSCs. The Op Sheet does not show "CTS" or "HCR"	OP-(3/18/2011): CTS/HCR was not documented for the diagnosis on teeth #'s D, E, F & G. Initials or

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
	recorded on the diagnosis line, instead "CPE" (carious pulp exposure) was recorded and the lingual surface of each tooth was listed to show the medical necessity for the SSCs. The Monitor recorded "no" for this QAP & Quality Score question to adhere to the Guidelines. The findings related to the initials or diagonal line, not documented after the last entry in the notes section of the Op Sheet, appear to be included in error. The notes section was documented correctly and the audit tool spreadsheet does not have a "no" entered for the question related to this finding.	diagonal line not documented after the last entry in the notes.
There is no question in CSHM's audit tool to address this issue.	Due to lack of X-rays, photos, and inadequate documentation, the record did not show medical necessity for pulpotomies and SSCs performed on teeth #D, #E, #F, and #G.	

Patient #008		
Question	Monitor's Findings	CSHM's Findings
#7	CSHM's auditor scored "no" for this question because the Dentistry Practice Management form was not included in the requested materials. This form was not necessary for managing this 39-year-old patient. Although the CSHM e-mail to the Clinic dated June 1, 2011, acknowledges this fact and indicates the audit score was changed for this question, the audit tool spreadsheet provided to the Monitor showed "no"	Chart Audit Request-Dentist Practice Management form was not included in the requested material. **Pt DOB: is** [redacted]

Patient #008		
Question	Monitor's Findings	CSHM's Findings
	was scored and did not reflect the change.	
#30	The Hygiene Procedures form did not have the eating routines and periodontitis section of the dental evaluation completed.	HYG-(2/8/2011): Two sections of the Dental Evaluation were not documented.
#32	The Hygiene Procedures form did not document whether there was or was not a chief complaint by the patient.	If there is not a Chief Complaint then "none" should be documented.
#42	The notes section of the Hygiene Procedures form was not completed correctly. CSHM's auditor scored this finding for question #43 instead of #42.	There should be a diagonal line or initials on the line if notes are not documented.
#46	Non-diagnostic duplicate X-rays were provided for the review of this record.	
#53	The Treatment Plan was not completed correctly. There was no diagonal line after the last entry in the fillings, permanent crowns, and referrals sections.	TX Plan-(2/8/2011): A diagonal line should be documented on any unused lines or on any unused lines after the last entry in each section.
#83	An error was not properly corrected on the Op Sheet dated February 8, 2011. The total amount box was marked through multiple times and the error notation was not dated.	OP-(2/8/2011): An error was corrected without documenting the date of the error.

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#30	The Hygiene Procedures form did not have the oral hygiene section of the dental evaluation completed.	HYG-(3/2/2011): One section of the Dental Evaluation was not documented.
#32	The Hygiene Procedures form did not document whether there was or was not a chief complaint by the patient.	Chief Complaint was not documented. If there is not a Chief Complaint then "none" should be documented.
#42	The notes section of the Hygiene Procedures form was not completed correctly.	There should be a diagonal line or initials on the line if notes are not documented.
#54	The crown option boxes on the Treatment Plan were left blank.	TX Plan-(3/2/2011): Crown Options box was not documented.

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#67	The restorative dentistry checklist section of the Op Sheet had the "local anesthetic not required" box checked when local anesthetic was used.	OP-(3/9/2011): "Local Anesthetic not required" was documented but Local Anesthetic was used.
#77	The lower odontogram of the Tooth Chart did not document the pulpotomies performed on teeth #B and #I.	A "P" was not documented above teeth #'s B & I on the tooth chart dated 3/2/2011.
#82	There was no diagonal line through the notes section of the Op Sheet.	Initials or diagonal line should be documented immediately after the last entry in the notes.
#88	The Nitrous Oxide Consent form did not record the minutes for the initial concentration.	Working Concentration-100%_ min was not documented.
#91	The "Vitals Check-Points During Treatment" portion of the Nitrous Oxide Consent form was not completed.	Vitals signs were not documented every 15 minutes.
#102	The abbreviation "MSC" for multiple surface caries was used on the diagnosis line. However, according to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	CTS/HCR was not documented on the diagnosis line for teeth #'s A, I, B & J.
There is no question in CSHM's audit tool to address this issue.	The Hygiene Procedures form dated March 3, 2011, did not document the need for or interpretation of the maxillary and mandibular periapical X-rays. Furthermore, the Account History Report shows routine exposure of anterior X-rays during hygiene visits.	

[redacted] Small Smiles Dental Centers of Mattapan

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#12	Section B was not completed on the Authorization form.	Consents & Acknowledgements-Section B was not documented on the HIPAA form dated 12/20/2010.
#32	The Hygiene Procedures form did not document whether there was or was not a chief complaint by the patient.	HYG-(12/20/2010): Chief Complaint was not documented. If there is not a Chief Complaint then "none" should be documented.
#33	The diagnosis section of the Hygiene Procedures form was not completed correctly.	Diagnosis section was not documented.
#53	A diagonal line was not recorded on the unused portions of the Treatment Plan.	TX Plan-(12/20/2010): A diagonal line should be documented on any unused lines or on any unused lines after the last entry in each section.
#54	The SSC crown option box on the Treatment Plan was left blank.	The crown option boxes should be either initialed or marked N/A.
#82	The Op Sheet notes were not completed correctly.	OP-(1/28/2011): There should be a diagonal line or initials on the line if notes are not documented.
#102	The abbreviation "MSC" for multiple surface caries was used on the diagnosis line. However, according to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	CTS/HCR was not documented on the diagnosis line for tooth #A.

[redacted]

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	An old version of the Dentistry Patient Management Techniques form was sent with the requested materials and did not have an area for the parent's signature. According to CSHM's e-mail to the Clinic, the score was changed to "yes"; however, the audit tool spreadsheet	Chart Audit Request-Dentist Practice Management form was not included in the requested material. Form was copied and sent with materials. All materials was last check by clinical coordinator and OM.

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
	provided to the Monitor did not show this change.	
#30	The Hygiene Procedures form did not have the eating routines and periodontitis section of the dental evaluation completed.	HYG-(10/1/2010): Two sections of the Dental Evaluation were not documented.
#32	The Hygiene Procedures form did not document whether there was or was not a chief complaint by the patient.	Chief Complaint was not documented. If there is not a Chief Complaint then "none" should be documented.
#42	The notes section of the Hygiene Procedures form was not completed correctly.	There should be a diagonal line or initials on the line if notes are not documented.
#53	The Treatment Plan dated October 1, 2010, shows all teeth are planned for "silver/white fillings" and "poss. SSC," which is written on the line by tooth #L. There is questionable consent for SSCs on teeth #I, #J, and #K and no consent obtained for the pulpotomies performed on teeth #I, #J, #K, and #L. Therefore, this appears to be an adverse event not identified by CSHM's auditor.	
#54	The crown options boxes on the Treatment Plan were left blank.	TX Plan-(10/1/2010): The crown option boxes should be either initialed or marked N/A.
#55	There was no witness signature on the Local Anesthesia and Nitrous Oxide Consent form.	Witness Signature and Date on the Local Anesthesia and Nitrous Oxide Consent form was not documented.
#67 and #68	Questions 4 and 6 in the restorative dentistry checklist section of the Op Sheet were not completed. The maximum safe dose of local anesthetic and confirmation that consent was obtained for all treatment planned was not documented.	OP-(3/11/2011): Maximum safe dose of local anesthetic calculated was not documented and Consent for treatment was not documented on the Restorative Dentistry Checklist.
#76	Carious Pulp Exposure, "CPE," was not recorded on the diagnosis line of the Op Sheet for the pulpotomies performed on teeth #I, #J, #K, and	

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
	#L.	
#78	The procedures performed to teeth #I, #J, #K, and #L were different than the procedures recorded on the Treatment Plan dated October 1, 2010. There was no documentation on the Op Sheet or the Tooth Chart indicating the reason for a change in the planned treatment or the medical necessity for the pulpotomies performed on teeth #I, #J, #K, and #L.	
#91	The "Vitals Check-Points During Treatment" section of the Nitrous Oxide Consent form was not completed correctly.	Nitrous Oxide: Vitals check-points during treatment are not consistent. Time for Nitrous Oxide is 50 minutes. Time increments are 9:35, 9:50 and 10:40 as Post time checked. There should have been time increments documented after 10:05 until post which is 20 minutes.
#102	The abbreviation "C" was the only entry recorded on the diagnosis line of the Op Sheet. According to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	CTS/HCR was not documented on the diagnosis line for teeth #'s I, J, K & L.
There is no question in CSHM's audit tool to address this issue.	The Hygiene Procedures form dated October 1, 2010, did not document the need for or interpretation of the maxillary and mandibular occlusal X-rays. Furthermore, the Account History Report shows routine exposure of anterior X-rays during hygiene visits.	
There is no	Documentation on the Op Sheet dated March 11, 2011, shows local	

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
question in CSHM's audit tool to address this issue.	anesthesia was delivered by method of infiltration for mandibular teeth #K and #L that received pulpotomies.	

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
#11	The Acknowledgment form was not completed correctly.	Consents & Acknowledgements-Parent/Guardian relationship to Patient was not documented on the Acknowledgement Notice of Privacy Practices.
#12	Section B of the Authorization form was not completed.	Section B of the HIPAA form was not completed.
#18	There was no "yes" or "no" response to the question: "Does the patient have any dental problems/concerns at this time?"	HX-(2/23/2011): One question under the Patient Health History was not documented.
#32	The Hygiene Procedures form did not document whether there was or was not a chief complaint by the patient.	HYG-(2/23/2011): Chief Complaint was not documented. If there is not a Chief Complaint then "none" should be documented.
#33	The diagnosis section of the Hygiene Procedures form was not completed correctly.	Diagnosis section was not documented.
#47	X-rays dated February 23, 2011, were not labeled correctly. The label was applied making the X-rays appear upside down.	X-Rays-(2/23/2011): Label was placed upside down from the films.
#53	A diagonal line was not recorded on the unused portions of the Treatment Plan.	TX Plan-(2/23/2011): A diagonal line should be documented on any unused lines or on any unused lines after the last entry in each section.
#54	The tooth colored crown option box on the Treatment Plan was left blank.	The crown option boxes should be either initialed or marked N/A.
#67	The health history section and the "no local anesthesia required" portion of the restorative dentistry checklist	OP-(3/2/2011): Restorative Dentistry Checklist- Health History section was not completed. No

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
	on the Op Sheet were not completed correctly.	documentation for health history reviewed.
#76	The Op Sheet did not show documentation of the involved tooth surfaces or the diagnosis to support the medical necessity for the SSCs. There was also no documentation of CPE on the diagnosis line for the pulpotomies performed on teeth #A, #B, #S, and #T.	Surfaces of decay, DX and PRSA were not documented for teeth #'s A, B, S & T.
#79	"Y" was circled on the Op Sheet to indicate that a prescription was written; however, there was no documentation of a prescription. The post operative instructions and complications sections were also not completed.	Complications and Post Operative Instruction sections were not documented. RX was documented "Y" but no documentation for Prescription.
#102	There was no diagnosis recorded on the Op Sheet for the SSCs performed on teeth #A, #B, #S, and #T. According to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	No documentation for DX for teeth #'s A, B, S & T.
There is no question in CSHM's audit tool to address this issue.	Documentation on the Op Sheet dated February 23, 2011, shows local anesthesia was delivered by method of infiltration for mandibular teeth #S and #T that received pulpotomies.	

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#11	The Acknowledgment form was not	Consents & Acknowledgements-

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
	completed correctly.	Parent/Guardian relationship to Patient was not documented on the Acknowledgement Notice of Privacy Practices.
#12	Section B of the Authorization form was not completed.	Section B & C was not documented completely on the HIPAA form.
#18	There was no "yes" or "no" recorded on the Health History form for the question: "Is the patient taking any medications at this time?"	HX-(1/17/2011): One question was not documented under the Patient Health History section.
#42	The notes section on the Hygiene Procedures form was not completed correctly.	HYG-(1/17/2011): There should be a diagonal line or initials on the line if notes are not documented
#47	There were two sets of X-rays provided to the Monitor. One set dated January 21, 2010, and the other dated January 17, 2010. According to the Account History Report and the Hygiene Procedures form, the January 17, 2010, X-rays were labeled with the wrong year. The label should have read January 17, 2011.	
#54	The crown options boxes were left blank on the Treatment Plan.	TX Plan-(1/17/2011): The crown option boxes should be either initialed or marked N/A. No documentation for the crown option box.
#67	The Restorative Dentistry Checklist form dated February 7, 2011, contained an error that was not properly corrected and consent for nitrous oxide was also not marked as confirmed.	OP-(2/7/2011): An error was corrected without proper error notation for "Type of restoration must be changed (e.g., from amalgam to SSC) on the Restorative Dentistry Checklist. Consent for Nitrous, if planned was not documented. Nitrous Oxide was used during treatment.
#75	The incorrect Dose Calculation for Patient's Weight (DCPW) for Septocaine was recorded on the Op Sheet dated February 7, 2011.	2.2 was documented for DCPW for Septocaine but according to the Local Anesthetic Calculation Table the DCPW for a patient weighing 50 lbs is 4.9.

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#76	Carious Pulp Exposure, "CPE," was not recorded on the diagnosis line of the Op Sheet for the pulpotomies performed on teeth #A, #B, and #C.	
#81	There were two staff members' initials but only one signature.	2 sets of initials for staff and 1 signature.
#82	The Op Sheet notes were not completed correctly.	Initials or diagonal line should be documented immediately after the last entry in the notes.
#83	The CSHM audit tool did not show "no" was not scored for this finding.	Proper error notation was not documented for the teeth being treated.
#91	The vitals section of the Nitrous Oxide Consent form did not show correct documentation related to time increments.	Nitrous Oxide Consent Form-(2/7/2011): Time increments were not documented after 10:20. 20 minutes were not documented.
#101	The documentation of treatment time at the bottom of the Op Sheet was not visible; therefore, the length of treatment time could not be determined.	
#102	The abbreviation "C" was the only entry recorded on the diagnosis line of the Op Sheet. According to page 55 in the *Patient Care Manual*, diagnosis documentation on the Op Sheet for SSCs "must include the CTS (compromised tooth structure) and/or the HCR (high caries risk patient), and additional diagnosis information from the Diagnosis box."	CTS/HCR was not documented on the diagnosis line for teeth #'s A, B & C.
There is no question in CSHM's audit tool to address this issue.	After review of the incorrectly dated X-rays, which were dated as January 17, 2010, the Monitor's pediatric dentist did not find the evidence of decay that would warrant treatment with pulpotomies on teeth #A and #B. Therefore, neither the X-rays nor the documentation provided showed support for the medical necessity of the pulpotomies performed on teeth #A and #B.	

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	The Monitor scored "no" for this question because the bitewing X-rays dated August 13, 2010, which were used to complete the Tooth Chart and Treatment Plan related to the audited date of service, January 24, 2011, were not included in the requested materials. CSHM's auditor scored "no" for this question because the Dentistry Practice Management form was not included in the requested materials. This form was not necessary for managing this 55-year–old patient. Although the CSHM e-mail to the Clinic dated June 1, 2011, acknowledges this fact and indicates the audit score was changed for this question, the audit tool spreadsheet provided to the Monitor showed "no" was scored and did not reflect the change.	Chart Audit Request-Dentist Practice Management was not included in the requested material. **Pt DOB is:** [redacted]
#21	The Monitor was unable to verify existing conditions were documented correctly on the Tooth Chart dated August 13, 2010, because the missing X-rays were dated August 13, 2010.	
#22	The Monitor was unable to verify decay was documented correctly on the Tooth Chart dated August 13, 2010, because the missing X-rays were dated August 13, 2010.	
#30	The Monitor did not have this finding. The dental evaluation section of the Hygiene Procedures form dated August 13, 2010, appeared to be completed.	HYG-(2/24/2011): One section of the Dental Evaluation was not documented.
#32	The Hygiene Procedures form did not document whether there was or	If there is not a Chief Complaint then "none" should be documented.

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
	was not a chief complaint by the patient.	
#33	The diagnosis section of the Hygiene Procedures form dated August 13, 2010, was not completed correctly.	Diagnosis section was not documented.
#51 and #62	This question asks, "Does the treatment plan reflect diagnostic findings from x-rays, digital photos, or odontogram for the area(s) being treated?" The bitewing X-rays taken on August 13, 2010, and the Op Sheets dated December 31, 2010, January 28, 2011, and February 7, 2011, were not sent with the requested materials. The upper odontogram and notes section of the Tooth Chart dated August 13, 2010, did not document decay or other related diagnostic findings to support the medical necessity for the crown performed on tooth #14. Therefore, the Monitor was unable to verify the Treatment Plan reflected the diagnostic findings related to tooth #14.	
#79	The "Y" or "N" for "RX written" was not circled on the Op Sheet.	OP-(1/24/2011): RX was not documented Y or N.
#82	The notes section of the Op Sheet was not completed correctly.	Initials or diagonal line not documented after the last entry in the notes.
There is no question in CSHM's audit tool to address this issue.	Medical necessity for treatment provided cannot be determined without receiving all documents and X-rays that relate to the treatment provided to tooth #14. Therefore, it would seem necessary for CSHM's auditor to obtain the additional documentation to perform a complete review.	

Patient #015		
Question	Monitor's Findings	CSHM's Findings
#7	The Dentistry Practice Management form was not provided to the Monitor with the requested materials. If CSHM did receive this form, it was not supplied to the Monitor and the CSHM audit tool spreadsheet was not changed to indicate the form was received.	Chart Audit Request-Dentist Practice Management was not included in the requested material. **Form was copied and sent with materials. All materials was last check by clinical coordinator and OM.**
#11	The Acknowledgment form was not completed correctly.	Consents & Acknowledgements-Parent/Guardian relationship to Patient was not documented on the Acknowledgement Notice of Privacy Practices.
#16 and #17	The Health History form showed "yes" was marked for all health conditions listed in the far right column. Clinic staff did not confirm or correct this. The Monitor was unable to verify if there was a need for explanation of "yes" answers on the Health History because it appeared the parent completed the form incorrectly without making corrections.	HX-(2/16/2011)-Patient Information was documented incorrectly. Kidney or Liver Disease, Diabetes, Bleeding/Clotting Problems, Disabilities/Special Needs, Prosthetic Joints, Plates or Pins, Heart Murmur, Alcohol/Drug Abuse and Birth Defects were all documented "Yes" on the Patient Health History. Therefore can't verify if a supporting explanation was needed for "If you answered "Yes" to any of the above, please explain:" section.
#21	The upper odontogram did not document the existing distal occlusal composite filling on tooth #I, mesial occlusal composite filling on tooth #J, mesial occlusal composite filling on tooth #K, and distal occlusal composite filling on tooth #L. These fillings are evident on the X-rays dated February 16, 2011.	
#30	The Hygiene Procedures form did not have the oral hygiene, gingival, or eating routines sections of the dental evaluation completed.	HYG-(2/16/2011): 3 sections in the Dental Evaluation were not documented.
#32	The chief complaint line was left blank on the Hygiene Procedures	If there is not a Chief Complaint then "none" should be documented.

Patient #015		
Question	Monitor's Findings	CSHM's Findings
	form.	
#33	The diagnosis section of the Hygiene Procedures form was not completed correctly.	Diagnosis section was not documented.
#53	The Treatment Plan did not record the decayed tooth surfaces for tooth #I.	
#54	The crown option boxes on the Treatment Plan were left blank.	
#76	The Op Sheet did not show documentation of CPE for the pulpotomies performed on teeth #I and #J. The prior service acknowledgment (PRSA) was not recorded on the Op Sheet for tooth #K.	
#77	The pulpotomies performed on teeth #I and #J were not documented on the lower odontogram of the Tooth Chart.	
#102	HCR and CTS were not recorded on the diagnosis line for the SSCs performed on teeth #I and #J.	
There is no question in CSHM's audit tool to address this issue.	There was no documentation of the rationale for or interpretation of the anterior occlusal X-rays exposed on February 16, 2011. Maxillary and mandibular anterior occlusal X-rays were also taken on August 10, 2010. Question #38 asks: "If interim x-rays were taken, are the rational for films and the radiographic findings documented?" This question does not address the rationale or interpretation for the X-rays exposed at the hygiene visit.	

Summary

This was the Monitor's first review of CSHM's chart audit process using the revised audit tool. The Monitor saw noticeable improvement in CSHM's auditor's efforts to follow the Guidelines and capture related findings in the audit tool; however, significant issues related to medical necessity, quality of care, and a potential adverse event were not identified. The revised audit tool has added 29 questions; however, the majority of the focus of the Guidelines continues to be on areas related to completing forms correctly instead of clearly capturing lack of medical necessity, potential quality of care issues, and identifying adverse events. The audit tool's ability to capture medical necessity related to treatment and X-rays is still not clearly defined in the Guidelines; therefore, it is not captured in the audit tool. Treatment performed without consent is also not captured as a QAP or Quality Score item; therefore, it has no significant impact on the dentist's score.

The following is a summary of the Monitor's significant findings and observations related to CSHM's chart audit process:

- The Clinic received the April 2011 chart audit results on May 5, 2011. On May 6, 2011, the Compliance Liaison sent an e-mail to [redacted] requesting an appeal or re-review concerning several questions. She stated the information pertaining to correct completion of the HIPAA form has been inconsistent and unclear. She also stated the Dentistry Management Technique form was only needed for children and was not necessary for adult patients. The response from the auditor indicated the findings related to the HIPAA forms were sound and were not changed; however, the findings related to the Dentist Practice Management form for patients #004, #008, and #014 were changed because of their adult age. The finding for patient #011 was also changed to "yes" because it was an older form that did not require a signature. Although the e-mail from CSHM's auditor indicates these findings were changed, the audit tool spreadsheet provided to the Monitor did not show these changes.
- All requested materials were provided to the Monitor with the exception of patients #002, #014, and #015. The materials received for patients #002 and #014 did not include requested X-rays and there was no Dentistry Patient Management form received for patient #015. CSHM's auditor initially reported the Dentistry Patient Management form for patients #004, #008, #011, #014, and #015 was not included in the requested materials; however, it appears that at some point those forms were provided. The comments recorded above are from the most recent e-mail dated June 1, 2011, regarding the April 2011 chart audit results. Upon review of the April 2011 chart audit request e-mail sent to the Clinic on April 4, 2011, the Monitor noticed the Dentistry Practice Management form was not included in the list of requested documents.
- The Monitor received poor quality duplicate X-rays and poor quality color copies of the Tooth Chart. Three records (patients #003, #004, and #008) included non-diagnostic X-rays. The color copies of the Tooth Charts provided to the Monitor were either poor quality or the documentation was not recorded in ink; therefore, it was very difficult to determine correct documentation of existing conditions,

restorations, decay, and completed treatment in several records. It was also difficult to read the patient's name, date of service, and staff signatures.

- Medical necessity for treatment provided could not be determined in two records (patients #002 and #014) because all documents and X-rays related to the treated teeth were not sent or requested by CSHM's auditor. CSHM's audited date of service, March 21, 2011, and January 24, 2011, for patients #002 and #014 respectively, were for delivery of crowns.
  - Patient #002 – Teeth #12 and #13 had already received RCT, post and core build-ups, and had been prepared for permanent crowns; therefore, the medical necessity for the treatment provided was most likely documented on Op Sheets from previous appointments. The e-mail to the Clinic requested "just the op sheets with the dates listed above." Therefore, the Clinic did not send additional Op Sheets that related to the audited date of service, which were needed to determine the medical necessity for the treatment provided to teeth #12 and #13.
  - Patient #014 – The Op Sheets dated December 31, 2010, and January 7, 2011, as well as the X-rays dated August 13, 2010, were not sent with the requested materials. These materials were needed in order to determine the medical necessity for the crown performed on tooth #14.
- Three records (patients #006, #007, and #013) did not provide documentation to support the medical necessity for treatment provided.
  - Patient #006 – According to the Monitor's pediatric dentist, without documentation of symptoms, tooth vitality testing, a SOAP (subjective, objective, assessment, and planning) note, or radiographic findings on the upper odontogram, there is no medical necessity to support the RCT performed on teeth #18 and #19.
  - Patient #007 – Due to lack of X-rays, photos, and inadequate documentation, the record did not show medical necessity for pulpotomies and SSCs performed on teeth #D, #E, #F, and #G.
  - Patient #013 – Neither the X-rays nor the documentation provided showed support for the medical necessity of the pulpotomies performed on teeth #A and #B.
- Seven records (patients #001, #003, #005, #011, #012, #013, and #015) did not provide documentation on the Op Sheet of diagnosis or medical necessity for pulpotomies performed.
- In the record for patient #002, there was no additional consent obtained for the crowns performed on teeth #12 and #13. According to the CDO, the Op Sheet stated the mother was happy with the shade of the crowns; however, this does not show that consent was properly obtained. Without being able to review all documentation related to the treatment provided to teeth #12 and #13, the Monitor was unable to determine when or if proper consent for treatment for the RCT and crowns performed on teeth #12 and #13 had been obtained.
- In the record for patient #011, there was no consent documented on the October 1, 2010, Treatment Plan for SSCs performed on teeth #I, #J, and #K or the

pulpotomies performed on teeth #I, #J, #K, and #L. Therefore, this appears to be an adverse event not identified by the CSHM auditor.

- Four records (patients #002, #009, #011, and #015) did not document the rational or findings related to X-rays exposed during the hygiene visit. These records also showed routine exposure of anterior X-rays during hygiene visits. This issue was not addressed in the Guidelines; therefore, it was not captured in the chart audit tool spreadsheet.
- One record (patient #002) did not document the rational or findings related to X-rays exposed during the March 21, 2011, operative visit.
- Two records (patients #011 and #012) showed documentation that local anesthesia was delivered by infiltration when pulpotomies were performed on mandibular molars, which requires pulpal anesthesia.
- Four records (patients #003, #004, #008, and #012) failed to use the proper method to note changes to the record.
- One dentist, [redacted], recorded the DCPW on the Op Sheet using the milligram (mg) calculation (e.g. "225.3") without notation that this was the maximum dose of local anesthetic in milligrams, but then recorded the dose delivered in number of carpules. Without the notation of mg, the DCPW appears incorrect. The *Patient Care Manual* shows DCPW recorded in the patient's record as maximum dose in cartridges.

Recommendations

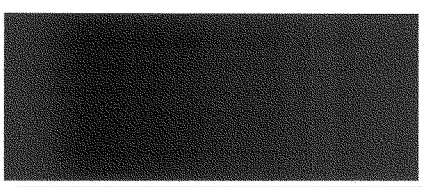
The following recommendations are based on the Monitor's findings from the review of the 15 visit records:

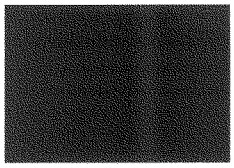
- Ensure staff members understand the chart audit process and documentation requirements.
- Ensure staff members provide all requested materials that are of an adequate quality to allow for review.
- Ensure staff members provide diagnostic radiographs that are duplicated and labeled properly.
- Ensure staff members are clearly documenting existing conditions, restorations, decay, and completed treatment on the designated odontograms of the Tooth Chart as described in the *Patient Care Manual*.
- Ensure staff members are properly completing the Health History and Hygiene Procedures forms, the Op Sheet, and the Treatment Plan.
- Ensure staff members understand the proper manner to notate errors in patient records.
- Ensure consent is obtained for all procedures performed.
- Ensure staff members are providing adequate documentation to support the medical necessity of treatment provided.
- Further assessment by the CDO is needed to determine trends and training needs in this Clinic specifically related to the pulpotomy-to-SSC ratio and the effectiveness of the local anesthesia methods used to treat lower primary molars in children.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure all relevant documentation and X-rays that relate to the teeth treated on the audited date of service are requested and received to perform a complete review.
- Ensure audit tools are updated to reflect changes to audit findings as a result of appeals.
- Ensure Monitor receives all documentation CSHM reviewed in obtaining chart audit results.
- Ensure that QAP and Quality Score items are clarified in the Guidelines, identified by CSHM's auditor, and modifications are made to capture all unaddressed findings in the Chart Audit Tool.

EXHIBIT 54





To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Compliance Officer
Church Street Health Management, LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor
Church Street Health Management

Desk Audit
Oklahoma Smiles Dental Centers of Oklahoma City
Oklahoma City, Oklahoma

Deliverable #1-41

November 4, 2011

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Oklahoma Smiles Dental Centers of S. Oklahoma City (OK1), 309 SW 59th Street #105, Oklahoma City, OK 73109.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 15 records previously reviewed by CSHM as part of its internal audit program. The purpose of [redacted] desk audit was to test CSHM's effectiveness in monitoring its Clinics and ensuring appropriate quality of care. The following are critical findings from the Monitor's review of 15 records that CSHM audited during the second quarter of 2011.

CSHM's audit resulted in passing scores for the Clinic and the three dentists. The Monitor's review resulted in a passing score for the Clinic and two dentists. The additional dentist had an automatic failure because of inadequate documentation and radiographic evidence to support the medical necessity of treatment provided. The overall scoring differences are less significant than in past desk reviews showing improvement in CSHM's chart audit process.

The following is a summary of the critical findings:

- One record did not document existing conditions on the Tooth Chart. Upon review of the X-rays, the Monitor's pediatric dentist found generalized abnormal supporting bone loss around the remaining primary molars, which was not documented on the Tooth Chart.
- Three records did not properly document all decayed surfaces on the upper odontogram of the Tooth Chart.
- One record did not provide documentation on the Tooth Chart or show radiographic evidence to support the medical necessity for the stainless steel crowns (SSCs) performed on teeth #I, #K, and #S. This finding resulted in an automatic failure of the chart audit for this dentist.
- Twelve records did not document rationale for exposed X-rays or document findings to show X-rays were read and interpreted.
- One record contained non-diagnostic X-rays.
- In one record, a defective restoration was treatment planned for a pulpotomy and SSC; however, the X-rays revealed an existing pulpotomy, which appeared to be failing because of visible radiolucency. The tooth received another pulpotomy and SSC without documentation of rationale to support the choice of treatment.

- In one record, the Anesthesia-Delivering Provider Signature line on the Consent for Nitrous Oxide form was not signed by the dentist but another staff member. The Monitor was unable to determine if this staff member was someone who was certified to administer nitrous oxide.
- In one record, there was no documentation on the Tooth Chart of the existing condition of radiographically evident perforating internal resorption in the distal pulp chamber of tooth #T, the failed pulpotomy on tooth #S, the failed pulpotomy on tooth #L, and the open margin on tooth #K. These teeth were not treated on the audited date of service; therefore, these findings were not identified by CSHM and reported to the Clinic.

Overall Summary of Recommendations

The following recommendations are based on the Monitor's findings from the review of the 15 visit records:

- Ensure staff members correctly document existing conditions, restorations, decay, and completed treatment on the designated odontogram of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure staff members provide adequate documentation and/or radiographic evidence to support the medical necessity for all treatment provided.
- Ensure fluoride documentation is completed correctly and all Post-it notes are removed from documents prior to copying.
- Ensure staff members document rationale when not following the *American Dental Association (ADA)/ Food and Drug Administration (FDA) Guide to Patient Selection for Dental Radiographs* and documenting interpretation of all exposed X-rays.
- Ensure all X-rays exposed are of diagnostic quality.
- Evaluate the need for additional training to ensure defective restorations are treated appropriately.
- Ensure the restorative dentistry checklist and the complications sections on the Op Sheet are completed correctly.
- Ensure the initial concentration for nitrous oxide is recorded for each patient and vital signs are documented at each 15-minute interval.
- Determine if the staff member who signed as the anesthesia-delivering provider for patient #015 was certified to administer nitrous oxide.
- Ensure the Account History Report accurately reflects the services provided on the date of service.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure all findings captured in the audit tool are clearly communicated to the Clinic.
- Ensure the CSHM audit tool used to conduct the chart audit is provided to the Monitor in a format that allows data entry and is provided with the requested materials.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly-owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Oklahoma Smiles Dental Centers of S. Oklahoma City (OK1), 309 SW 59th Street #105, Oklahoma City, OK 73109.

Implementation

The OIG approved a desk audit for Oklahoma Smiles Dental Centers of S. Oklahoma City. On August 31, 2011, the Monitor notified CSHM's Compliance Officer by mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from CSHM on September 6, 2011. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the second quarter of 2011
  - E-mail to the Clinic with results for the second-quarter audit
  - Second-quarter audit spreadsheet
- Audit tool used to conduct the chart audit
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by [redacted], RDH, Audit Manager, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Audit Manager, Clinical Review
  - Training reference tools used
    - *Chart Audit Policy*
    - *Guidelines for Chart Audit Scoring (Guidelines)*
    - *Methodology for Calculating Individual Dentist Chart Audit Scores*
    - *Crosswalk-Concordance of Audit Tool with American Academy of Pediatric Dentistry (AAPD) and CSHM Clinical Guidelines*
    - *Chart Documentation Guide*
    - [redacted] *Best Practice Memo*

CSHM initially requested the Clinic's charts on April 28, 2011. The Clinic provided the charts on May 5, 2011. A licensed dental hygienist completed the chart audit on June 14, 2011.

Scope of Desk Audit

This desk audit is to review the chart audit conducted by CSHM during the second quarter of 2011 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 8 of the 15 visit records reviewed.

Review of CSHM Chart Audit

Fifteen records were reviewed, five for each dentist, following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentists. CSHM's audit resulted in passing scores for the Clinic and the three dentists. The Monitor's review resulted in a passing score for the Clinic and two dentists, and one automatic failure due to inadequate documentation and radiographic evidence to support the medical necessity of treatment provided. The overall scoring differences are less significant than in past desk reviews showing improvement in CSHM's chart audit process.

	Monitor Score	CSHM Score
[redacted]	Automatic Failure	97%
[redacted]	95%	95%
[redacted]	93%	95%
Clinic Total Audit Score	95%	98%

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The findings reported by CSHM are verbatim from the e-mail sent to the Clinic with the chart audit results. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the tables that follow. After completing the chart audit, additional findings were identified, which are included below.

[redacted] Oklahoma Smiles Dental Centers of Oklahoma City

[redacted]

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#21	Upon review of the X-rays, the Monitor's pediatric dentist found generalized abnormal supporting bone loss around the remaining primary molars that was particularly severe around teeth #I and #S. The bone loss on tooth #I appeared to be significant, possibly involving the periapical area of the distal root of tooth #I. The periodontal condition visit was not documented on the Tooth Chart dated March 1, 2011.	Nice job!
#22	There was no decay documented on the upper odontogram of the Tooth Chart dated March 1, 2011, for teeth #C, #I, #K, #S, and #T, which were treated on the audited date of service. Additionally, the Operative Procedures form (Op Sheet) documents mesial occlusal "caries [visually] evident #T upon prep #S"; however, there is no decay documented with CT designation on the Tooth Chart for tooth #T.	
#23	The Tooth Chart dated March 1, 2011, notes "Severe attrition on #I & S," and the Op Sheet dated March 9, 2011, documents decay was evident on the distal occlusal of tooth #I and mesial occlusal of tooth #K. The Monitor's pediatric dentist did not find decay evident on teeth #I, #K, and #S on the X-rays dated March 1, 2011, and there was no documentation of decay recorded on the Tooth Chart dated March 1, 2011. Therefore, according to the Guidelines, this finding results in an automatic failure.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#22	The Op Sheet dated April 1, 2011, documents decay as follows: tooth #9 distal facial, #10 mesial facial distal, and #11 mesial facial distal; however, the Tooth Chart dated January 5, 2011, documents only facial decay for teeth #9, #10, and #11.	
#34	On the Hygiene Procedures form dated January 5, 2011, it appeared that a Post-it note was attached over the method of fluoride delivery and was not removed prior to copying the form. Therefore, it could not be determined if the method of fluoride delivery was appropriately marked.	
#37	A periapical X-ray was taken of tooth #24 on January 5, 2011, with no rational for exposure or documentation of interpretation.	
#91	The Nitrous Oxide form did not document vital signs for the last 15-minute interval of treatment.	Nitrous oxide form (4/1/2011) there was a check at 1:25 and the next one is documented at 1:45 pm.

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	There was no documentation to show the panoramic X-ray dated December 7, 2010, was read or interpreted. CSHM's auditor scored this question as "no" in the audit tool but did not describe the finding in the e-mail to the Clinic.	
#66	The premedication section of the Op Sheet's restorative dentistry checklist was not completed correctly.	Operative sheet (3/29/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry.
Observation by the Monitor and CSHM	The Monitor recognized on the Op Sheet dated March 29, 2011, that "MSC CTS HCR" were noted under the diagnosis column on only the first line in the Stainless Steel	Note for the DX line "CTS" or "HCR" should be done on each line or with ditto marks, not a line from top to bottom.

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
	Crown (SSC) section and followed with a down arrow in place of ditto marks.	

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#34	On the Hygiene Procedures form dated February 18, 2011, there was no check mark by the type or method of fluoride delivered.	
#66	The premedication section of the Restorative Dentistry Checklist dated March 7, 2011, was not completed correctly.	Operative sheet (3/7/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list Either it was taken or it was not required.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	A panoramic X-ray was taken on this five-year-old patient on December 30, 2010, with no rational for exposure or documentation of interpretation.	
#66	The premedication section of the Op Sheet's restorative dentistry checklist was not completed correctly.	Operative sheet (3/7/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list .Either that it was take or it was not required.
#79	On the Op Sheet dated March 25, 2011, there was no check mark to indicate whether there were complications during treatment.	
Observation by the Monitor and CSHM	The Monitor recognized on the Op Sheet dated March 25, 2011, that "MSC CTS HCR" were noted under the diagnosis column on only the first line in the SSC section and followed with a down arrow in place of ditto marks.	Note for the DX line "CTS" or "HCR" should be done on each line or with ditto marks, not a line from top to bottom.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
There was no question on CSHM's audit tool to capture this finding.	There was no documentation on the Tooth Chart dated December 30, 2010, of the existing condition of radiographically evident perforating internal resorption in the distal pulp chamber of tooth #T, the failed pulpotomy on tooth #S, the failed pulpotomy on tooth #L, and the open margin on tooth #K. These teeth were not treated on the audited date of service; therefore, these findings were not identified by CSHM and reported to the Clinic.	

[redacted]

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	The Hygiene Procedures form did not document rationale for the exposure of occlusal X-rays.	Hygiene page (3/3/2011) there is no written documentation for the need of medical necessity for the occlusal maxillary and mandibular x-rays taken on 3/3/2011.
Observation by the Monitor and CSHM	Teeth #A and #T received two surface fillings without the involvement of interproximal tooth surfaces. Since there was no radiographic evidence to support the need for SSCs, the Monitor did not see the need for rationale to explain why fillings were performed instead of SSCs.	Protective stabilization section (3/7/2011) tooth# T was treated with an occlusal buccal composite CDT code 2392 and tooth# A was treated with an occlusal lingual composite CDT code 2392. There is no written documentation for why fillings were done rather than stainless steel crowns.
Observation by CSHM		Note there are two operative sheets for this patient. An AM form and afternoon form. Nice work.

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	There was no rationale for the panoramic X-ray dated February 15, 2011. Additionally, there was no documentation to show the X-ray	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
	was read or interpreted.	
#66	The premedication section of the Restorative Dentistry Checklist dated March 9, 2011, was not completed correctly.	Operative sheet (3/9/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list. Either it was taken or it was not required.

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	There was no documentation to show the panoramic X-ray dated February 18, 2011, was read or interpreted.	
#66	The premedication section of the Restorative Dentistry Checklist dated March 10, 2011, was not completed correctly.	Operative sheet (3/10/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list. Either it was taken or it was not required.

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	There was no documentation to show the panoramic X-ray dated March 29, 2011, was read or interpreted.	
#58	Question #58 asks "Were defective restorations treatment planned to be properly restored?" The Monitor's pediatric dentist reviewed this record and determined the X-rays dated March 29, 2011, revealed previous pulpotomies on teeth #L and #S, which appear to be failing due to visible radiolucency. According to the Op Sheet dated April 18, 2011, tooth #L received a pulpotomy and SSC.	
#66	The premedication section of the Op Sheet's restorative dentistry checklist was not completed	Operative sheet (4/18/2011) the pre medication question must be answered on all operative sheets

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
	correctly.	under the restorative dentistry check list. Either it was taken or it was not required.

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	The panoramic X-ray dated January 27, 2011, was taken with no rationale for exposure or documentation of interpretation. In addition, there was no documentation of the panoramic X-ray on the Account History Report or the Hygiene Procedures form.	
#66	The premedication section of the Restorative Dentistry Checklist dated February 23, 2011, was not completed correctly.	Operative sheet (2/23/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list. Either it was taken or it was not required.

[redacted]

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	The panoramic X-ray dated April 4, 2011, was taken with no rationale for exposure or documentation of interpretation. CSHM's auditor scored this question as "no" in the audit tool but did not describe the finding in the e-mail to the Clinic.	
#66	The premedication section of the Op Sheet's restorative dentistry checklist was not completed correctly.	Operative Sheet (4/4/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list. Either it was taken or it was not required.
#91	Vital signs were not documented correctly on the Nitrous Oxide form dated April 4, 2011.	Nitrous oxide consent (4/4/2011) the vitals are not documented in 15 min increments.

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
#22	The Op Sheet dated March 7, 2011, documented the surfaces treated on tooth #E as incisal lingual and on tooth #F as mesial incisal lingual; however, the Tooth Chart dated February 18, 2011, documents the areas of decay for tooth #E as lingual and for tooth #F as lingual. Therefore, the surfaces of decay were not accurately recorded on the Tooth Chart. (According to the *Guidelines*, "the teeth that are documented on the audited operative sheet should have decayed surfaces for the area (quadrant) documented on the top portion of the tooth chart.")	
#37	There was no documentation of rationale for exposure of bitewing X-rays on this two-year-old patient.	
#45	The bitewing X-rays dated February 18, 2011, were non-diagnostic because of blurring on the right side and scratches on the left.	
#66	The premedication section of the Restorative Dentistry Checklist dated March 7, 2011, was not completed correctly.	Operative sheet (3/7/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list. Either it was taken or it was not required.
Observation by the Monitor and CSHM	The Monitor identified this finding but there was no direction in the *Guidelines* regarding how to capture the finding.	Tooth chart (2/18/2011) note the tooth chart appears to have the incorrect date. It should be 2/18/2011 not 2/17/2011.

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	Two occlusal X-rays were taken on October 14, 2009. There was no rationale documented for the two additional occlusal X-rays taken on December 21, 2010.	

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#66	The premedication section of the Restorative Dentistry Checklist dated February 28, 2011, was not completed correctly.	Operative sheet (2/28/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list. Either it was taken or it was not required.
#88	On the Op Sheet dated February 28, 2011, under the Nitrous Oxide section, there was a line drawn through the initial concentration line.	The initial concentration had a line drawn through it. This is incorrect documentation. Complete both sets of numbers even if they are the same.

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
#37	There was no documentation of rationale for the occlusal X-rays taken on March 2, 2011.	Hygiene page (3/21/2011) there is not written documentation for the need of medical necessity for the maxillary and mandibular occlusal film taken on 3/21/2011.
#66	The premedication section of the Restorative Dentistry Checklist dated March 21, 2011, was not completed correctly.	Operative sheet (3/21/2011) the pre medication question must be answered on all operative sheets under the restorative dentistry check list. Either it was taken or it was not required.
#88	On the Op Sheet dated March 21, 2011, under the Nitrous Oxide section, there was a line drawn through the initial concentration line.	The initial concentration had a line drawn through it. This is incorrect documentation. Complete both sets of numbers even if they are the same.
#104	Documentation shows nitrous oxide was administered during the operative appointment on March 21, 2011; however, it was not recorded on the Account History Report.	
Observation by the Monitor and CSHM	Tooth #J received a two surface filling without the involvement of interproximal tooth surfaces. Since there was no radiographic evidence to support the need for an SSC, the Monitor did not see the need for rationale to explain why a filling was	Stabilization section (3/21/2011) there is not a documented reason for the occlusal lingual restoration done on tooth# J CDT code 02392 rather than a stainless steel crown.

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
	performed instead of an SSC.	

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#93	The Anesthesia-Delivering Provider Signature line on the Consent for Nitrous Oxide form was not signed by the dentist but another staff member. The Monitor was unable to determine if this staff member was someone who was certified to administer nitrous oxide.	Nice job!

Summary

The Monitor continues to see noticeable improvement in CSHM's auditor's efforts to follow the Guidelines and capture related findings in the audit tool. The audit tool used for this audit was a revised version of CSHM's audit tool; however, the Monitor was not provided with the audit tool CSHM used to conduct this audit. This was discovered after careful comparison of CSHM's audit results and the audit tool used in the previous audit. After this discovery, the Monitor requested the revised audit tool to perform an accurate assessment of CSHM's chart audit process. CSHM has not been including the Excel spreadsheet document of the audit tool as requested by the Monitor.

It is apparent CSHM is making efforts to improve its audit tool and chart audit process. CSHM's auditor addressed issues based on interpretation of the *Guidelines* as well as CSHM's policies and procedures. In addition, a summary was provided to the Clinic regarding the most common errors and instructions regarding chart documentation. CSHM provided the following information in the chart audit results e-mail to the Clinic:

CSHM Auditor's Summary

"The one thing that I noticed consistently throughout the audit was on the restorative dentistry check list. The question under the health history concerning the premedication question which must be completed on each operative sheet. Please do not N/A or leave it blank. Premedication not necessary or it was taken. Please complete this question."

The following is a summary of the Monitor's findings captured in CSHM's audit tool:

Tooth Chart

- One record (patient #001) lacked documentation of existing conditions on the Tooth Chart for teeth treated on the audited date of service.
- Three records (patients #001, #002, and #012) did not properly document all decayed surfaces on the upper odontogram of the Tooth Chart.

Medical Necessity

- One record (patient #001) did not provide documentation on the Tooth Chart or show radiographic evidence to support the medical necessity for the SSCs performed on teeth #I, #K, and #S. This finding resulted in an automatic failure of the chart audit for this dentist.

Hygiene Procedures Form

- One record (patient #004) did not provide documentation for the type and method of fluoride delivery on the Hygiene Procedures form. The method of fluoride delivery for patient #002 could not be determined by the Monitor because this section was covered by a Post-it note that was not removed before the document was copied.

X-rays

- Twelve records (patients #002, #003, #005, #006, #007, #008, #009, #010, #011, #012, #013, and #014) did not document rationale for exposed X-rays or document findings to show X-rays were read and interpreted.
- One record (patient #012) contained X-rays that were non-diagnostic. The bitewing X-rays dated February 18, 2011, were not diagnostic due to blurring on the right side and scratches on the left.

Re-treatment of Defective Restorations

- One record (patient #009) showed a defective restoration was treatment planned for a pulpotomy and SSC; however, the X-rays revealed an existing pulpotomy, which appeared to be failing due to visible radiolucency. The tooth received another pulpotomy and SSC without documentation of rationale to support the choice of treatment.

Op Sheet

- Eleven records (patients #003, #004, #005, #007, #008, #009, #010, #011, #012, #013, and #014) did not complete the restorative dentistry checklist section of the Op Sheet correctly.
- One record (patient #005) did not complete the complications section on the Op Sheet dated March 25, 2011.

Nitrous Oxide Form

- Two records (patients #013 and #014) did not record the initial concentration for nitrous oxide.
- Two records (patients #002 and #011) did not show correct documentation of the patient's vital signs.
- In one record (patient #015), the anesthesia-delivering provider signature line on the Consent for Nitrous Oxide form was not signed by the dentist but

another staff member. The Monitor was unable to determine if this staff member was someone who was certified to administer nitrous oxide.

Account History Report

- The administration of nitrous oxide was recorded on the Op Sheet for patient #014; however, nitrous oxide was not recorded on the Account History Report.

Observation

- CSHM found two records (patients #006 and #014) did not document the rationale for providing multiple surface fillings instead of SSCs; however, the treated teeth were primary second molars involving either the occlusal and lingual surfaces or the occlusal and buccal surfaces. Furthermore, there was no radiographic evidence to support the need for SSC's.

The following is a summary of the Monitor's finding related to a quality of care issue not addressed in the *Guidelines* and, therefore, could not be captured in CSHM's current audit tool. This finding was not identified by CSHM:

- In one record (patient #005), there was no documentation on the Tooth Chart dated December 30, 2010, of the existing condition of radiographically evident perforating internal resorption in the distal pulp chamber of tooth #T, the failed pulpotomy on tooth #S, the failed pulpotomy on tooth #L, and the open margin on tooth #K. These teeth were not treated on the audited date of service; therefore, these findings were not identified by CSHM and reported to the Clinic.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 15 visit records:

- Ensure staff members correctly document existing conditions, restorations, decay, and completed treatment on the designated odontogram of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure staff members provide adequate documentation and/or radiographic evidence to support the medical necessity for all treatment provided.
- Ensure fluoride documentation is completed correctly and all Post-it notes are removed from documents prior to copying.
- Ensure staff members document rationale when not following the *American Dental Association (ADA)/ Food and Drug Administration (FDA) Guide to Patient Selection for Dental Radiographs* and documenting interpretation of all exposed X-rays.
- Ensure all X-rays exposed are of diagnostic quality.

- Evaluate the need for additional training to ensure defective restorations are treated appropriately.
- Ensure the restorative dentistry checklist and the complications sections on the Op Sheet are completed correctly.
- Ensure the initial concentration for nitrous oxide is recorded for each patient and vital signs are documented at each 15-minute interval.
- Determine if the staff member who signed as the anesthesia-delivering provider for patient #015 was certified to administer nitrous oxide.
- Ensure the Account History Report accurately reflects the services provided on the date of service.

The following recommendations are related to CSHM's chart audit process and the *Guidelines*:

- Ensure all findings captured in the audit tool are clearly communicated to the Clinic.
- Ensure the CSHM audit tool used to conduct the chart audit is provided to the Monitor in a format that allows data entry and is provided with the requested materials.

EXHIBIT 55

[redacted] [redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Chief Compliance Officer
CSHM LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor

Church Street Health Management

Desk Audit
Small Smiles Dental Centers of Brockton
Brockton, Massachusetts

Deliverable #1-72

November 9, 2012

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Brockton (Clinic), 70 Westgate Drive, Brockton, MA 02301.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 10 records previously reviewed by CSHM as part of its internal audit monitoring of its clinics to ensure appropriate quality of care. The following are critical findings from the Monitor's review of the 10 records that CSHM audited during the second quarter of 2012.

Results from CSHM's initial chart audit showed one dentist received an automatic failure due to insufficient documentation of medical necessity for a root canal performed on a permanent tooth. Following an appeal, the Director of Clinical Quality Initiatives and Training (DCQIT) reversed the decision of the automatic failure after review of additional documentation. The Monitor's pediatric dentist agreed with the results of the appeal.

The Monitor was unable to perform a complete review of the procedures performed that related to the audited dates of service for patients #001, #008, and #010 because the relevant documentation and X-rays were not included in the requested materials. Therefore, the Clinic and dentists' scores may have been different had the Monitor received the required documents to complete the review. Further, it is unclear how CSHM completed the audit without this documentation.

The Monitor's review did not result in a failing score for the Clinic or dentists; however, there were scoring differences between CSHM and the Monitor related to under-treatment and insufficient rationale for restoring primary molars with multiple surface fillings instead of crowns.

The Monitor's pediatric dentist had the following findings with respect to under-treatment and rationale for multiple surface fillings. One record showed an instance of under-treatment where front primary teeth with decay in close proximity to the pulp were not evaluated for pulp therapy and did not receive SSCs because of insufficient planning and dental materials. An additional record displayed insufficient rationale for placing multiple surface fillings on primary teeth instead of crowns. CSHM did not identify these findings.

In two records, the Monitor had difficulty applying question #72 to the Additional Operative Procedures form because there was no place to document the prior service acknowledgement (PRSA) for certain procedures and the Guidelines did not address

PRSA documentation on this specific form; therefore, the Monitor scored question #72 differently than CSHM's auditor and did not penalize the Clinic.

Overall Summary of Recommendations

The following recommendations are based on the Monitor's findings from the review of the 10 visit records:

- Ensure staff members verify an Acknowledgement form is completed correctly for each patient and stored in the patient's record.
- Ensure staff members verify all questions are answered on the Health History form.
- Ensure staff members provide adequate and appropriate follow-up documentation for all "yes" responses on the Health History form.
- Ensure staff members correctly document completed treatment and existing conditions on the designated odontogram of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure the patient's chief complaint is properly addressed by staff members and documentation clearly shows assessment and findings.
- Ensure X-rays are of diagnostic quality.
- Ensure staff members acquire all necessary pre-treatment X-rays and, if not able to obtain because of patient safety factors, document sufficient rationale.
- Clarify documentation requirements and expectations with respect to fluoride treatment for adult patients.
- Ensure staff members document the patient's pre-operative and post-operative blood pressure on the Nitrous Oxide Consent Form as required in Massachusetts.
- Ensure staff members understand the expectations and requirements for PRSA documentation on all applicable forms.
- Perform a review of question #72 on CSHM's audit tool to clarify PRSA documentation requirements on applicable forms in order to better define scoring criteria.
- Ensure the X-rays for patient #001 are reviewed to determine if billing corrections related to non-diagnostic X-rays are warranted.
- Ensure documentation on the Op Sheet is legible.
- Ensure dentists are familiar with CSHM's policy regarding the use of Septocaine and are not using this agent in children under the age of 4.
- Ensure staff members document sufficient time notations to verify the time interval from administration of local anesthesia to the start of treatment.
- Ensure dentists allow sufficient time from administration of local anesthesia to the start of treatment.
- Ensure the Chief Dental Officer (CDO) or DCQIT reviews the record for patient #007 for the risk of under-treatment related to teeth #E and #F.

- Ensure post-operative review of patient #007 to evaluate outcome of treatment on teeth #E and #F.
- Ensure staff members document sufficient rationale to justify the placement of multiple surface fillings instead of SSCs.
- Ensure staff members determine materials needed for planned treatment are available prior to starting the procedure.
- Perform a root cause analysis to determine why all documentation and X-rays related to crown and bridge restorations were not included in the review of the audited date of service for patients #001, #008, and #010 and why the auditors did not note the absence of this documentation.
- Perform a root cause analysis to determine why the review of patient #008 included forms and X-rays that were not related to the audited date of service and how this was not discovered prior to release of chart audit results to the Clinic.
- Ensure CSHM's auditors review all relevant X-rays, Op Sheets, and other documentation pertaining to the audited date of service.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and Church Street Health Management (CSHM), (f/k/a FORBA Holding, LLC), on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Brockton (Clinic), 70 Westgate Drive, Brockton, MA 02301.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of Brockton. On August 31, 2012, the Monitor notified CSHM's Compliance Officer by mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from CSHM on September 10, 2012. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the second quarter of 2012
  - E-mail to the Clinic with results for the second-quarter audit
  - Second-quarter audit spreadsheet
- Blank audit tool used to conduct the chart audit, which includes guidelines to respond to the questions (*Guidelines).*
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by the Director, Clinical Audit Review prior to conducting audits; Auditor has received ongoing supervision by Director, Clinical Audit Review
  - Training reference tools used
    - *The CBC Chart Audit Policy*
    - *The Chart Documentation Guide*
    - *Clinical Policies and Guidelines for CSHM Affiliated Dental Centers*
    - *Quality Assurance Protocols and Guidelines for dental centers policy*
    - *White Paper dated February 2012 titled "Ectopic Eruption"*
    - *Best Practice Memo dated March 19, 2012, titled "Cognitively Impaired Adults and Active Stabilization"*

CSHM initially requested the Clinic's charts on April 3, 2012, and the documents were received on April 10, 2012. A licensed dental hygienist completed the original chart

audit on June 4, 2012. CSHM indicated the Clinic passed the chart audit; however, Dentist #1 failed the audit because of lack of medical necessity for a root canal that was performed. The failing dentist submitted an appeal and upon review of additional documentation, the Director of Clinical Quality Initiatives and Training (DCQIT) reversed the failure and determined there was sufficient medical necessity. A Corrective Action Plan (CAP) was developed but not implemented based on the success of an appeal. The DCQIT reviewed 4 of the 10 records for this chart audit.

Scope of Desk Audit

The purpose of this desk audit was to review the chart audit conducted by CSHM during the third quarter of 2012 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on 8 of the 10 records reviewed.

Review of CSHM Chart Audit

Ten records were reviewed for the two audited dentists following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the *Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM Provides Management Services*. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentist. Initially, CSHM issued a failing score for Dentist #1; however, the score was changed to a passing score after the appeals determination.

	Monitor Score	CSHM Score
Clinic Score	**90.9%***	**93.9%**
Dentist #1	91.5%*	90.5%
Dentist #2	90.4%*	95.5%

*The Monitor was unable to perform a complete review of the procedures that related to the audited dates of service for patients #001, #008, and #010 because the relevant documentation and X-rays were not included in the requested materials. Therefore, the Clinic and dentists' scores may have been different had the Monitor received the required documents to complete the review. Further, it is unclear how CSHM completed the audit without this documentation.

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The column titled "CSHM's Findings" records the verbatim findings reported by CSHM in the Clinic's chart audit spreadsheet, as well as the outcome of the appeals determination. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the following tables.

[redacted] Small Smiles Dental Centers of Brockton

Dentist #1

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	The Monitor's pediatric dentist indicated the posterior right bitewing and lower periapical X-rays dated September 30, 2011, appear indistinct with poor density and contrast, and are non-diagnostic for determining proximal decay. Also, the apices of the patient's third molars are not visible on the posterior periapical X-rays.	
#27	On the Health History form dated September 30, 2011, the patient answered "yes" for allergies; however, there was no follow-up or explanation documented.	The allergies is [sic] documented, but there is no documentation as to what kind, of allergies patient has.
#28	There was no follow-up for the "yes" answer to allergies; therefore, the follow-up was inadequate.	The allergies is [sic] documented, but there is no documentation as to what kind, of allergies patient has.
#58	According to the Account History Report, a full mouth series including bitewing X-rays was billed on September 30, 2011. The Monitor's pediatric dentist determined five of the 18 films in the full mouth series were non-diagnostic including the four lower periapical X-rays and the single right posterior bitewing X-ray.	
#61	The individual completing the Acknowledgment of Receipt of Privacy Practices (Acknowledgment) form did not document their relationship to the patient, which, in this case, was "self."	The relationship to the patient is not documented. In the case the psatient should have documented"self". [sic]

[redacted] Small Smiles Dental Centers of Brockton

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#72	The Monitor scored this question "yes," because the Additional Operative Procedures form dated March 23, 2012, documented only the delivery of the porcelain fused to metal 3-unit bridge and did not have a space requiring prior service acknowledgment (PRSA). Without the Operative Procedures form (Op Sheet) dated November 30, 2011, when the teeth were prepared for the bridge, it is not possible to determine if the PRSA was documented correctly at the initial appointment.	The abutment teeth#7,9 have RCT treatment it is not documented.as prior service [sic]

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#22	The Monitor was unable to determine if the dosage for local anesthetic was below the Dose Calculated for Patient's Weight (DCPW) because documentation on the Op Sheet dated March 26, 2012, was illegible.	
#25	The Monitor was unable to determine if local anesthetic was sufficient for the length of the procedure because documentation on the Op Sheet dated March 26, 2012, was illegible.	
#28	The patient recorded "yes" responses on the Health History form dated February 22, 2012, to questions on heart trouble, asthma/breathing problems, anemia, and high blood pressure with inadequate or no follow-up for each "yes" response.	Per [DCQIT] "The health history follow up is inadequate." I am not sure a consult was necessary in the case ,it is difficult to tell. The follow up to the positive health history answered about "heart trouble" is only heart trouble. Similar follow up was provided for asthma and anemia. No information is provided in writting [sic] to indicate whether the nature of the heart trouble requires prophylaxis."

[redacted] Small Smiles Dental Centers of Brockton

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#29	There was no documentation to show appropriate consultation or medical clearance was obtained prior to treatment due to the patient's heart condition.	Per [DCQIT] "The health history follow up is inadequate." I am not sure a consult was necessary in the case ,it is difficult to tell. The follow up to the positive health history answered about "heart trouble" is only heart trouble. Similar follow up was provided for asthman [sic] and anemia. No information is provided in writing to indicate whether the nature of the heart trouble requires prophylaxis."
#30	There was insufficient documentation to determine if the nature of the heart trouble required antibiotic premedication prior to treatment.	Per [DCQIT] "The health history follow up is inadequate." I am not sure a consult was necessary in the case ,it is difficult to tell. The follow up to the positive health history answered about "heart trouble" is only heart trouble. Similar follow up was provided for asthman [sic] and anemia. No information is provided in writting [sic] to indicate whether the nature of the heart trouble requires prophylaxis."
#48	CSHM's auditor scored the question "no" after consulting the DCQIT, who stated on the e-mail dated May 2, 2012, "documentation of medical necessity for the root canal [#20] is insufficient." After an appeal, the DCQIT reversed his decision on the automatic failure. The Monitor's pediatric dentist agreed with the results of the appeal and had no finding.	Per [DCQIT]," Documentation of medical necessity for RCT for tooth# 20 is insufficient."

[redacted] Small Smiles Dental Centers of Brockton

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#70	The Hygiene Procedures form (Hygiene form) dated February 22, 2012, did not document why an adult patient with a high caries risk did not receive a fluoride treatment following a prophylaxis. The Monitor agreed with CSHM's finding; however, CSHM's auditor only noted "the patient is 50 yr. old adult" as the rationale for scoring this question "no" and did not provide clear communication to the Clinic regarding the significance of the finding.	The patient is 50yr.old adult
#72	The Monitor scored this question "yes" because the Additional Operative Procedures form dated March 26, 2012, which documented root canal therapy on tooth #20 did not have a space requiring notation of PRSA; therefore, it was unclear where this should have been documented or if it was required documentation for a root canal procedure.	Tooth# 20 had existing restoration not documented on PRSA

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#40	The patient's pre-operative and post-operative blood pressure was not documented on the Nitrous Oxide Consent Form dated March 26, 2012, as required by the rules and regulations established by the Massachusetts Board of Registration in Dentistry.	The BP is not documented for the patient on the nitrous form
#61	The individual completing the Acknowledgment of Receipt of Privacy Practices (Acknowledgment) form did not document their relationship to the patient.	The relationship to the patient is not documented.

[redacted]

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#40	The patient's pre-operative and post-operative blood pressure was not documented on the Nitrous Oxide Consent Form dated March 20, 2012, as required by the rules and regulations established by the Massachusetts Board of Registration in Dentistry.	The BP is not documented and this is a Mass. Center.
#49	The Acknowledgment form was not included in the record for this patient.	The acknowledgment of privacy practices was not included with the requested materials.
#61	The Monitor was unable to determine if the Acknowledgment form was completed correctly because it was not included in the requested materials.	A correctly completed acknowledgment of privacy practices was not included with the requested materials. I can't verify if the form was correctly completed.
#72	On the Op Sheet dated March 20, 2012, there was no PRSA documented for tooth #13. According to the Account History Report, tooth #13 had an occlusal resin filling place on September 23, 2011.	

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	On the Op Sheet dated March 5, 2012, multiple surface fillings were performed on teeth #J and #L, instead of stainless steel crowns (SSCs) with the rationale: "[mom] did not want SSC if avoidable." Due to the extent of decay on tooth #L and the size of the existing multiple surface filling on tooth #J, it appeared SSCs were warranted for these teeth as supported by CSHM's *Intracoronal Restorations Documentation* policy.	

[redacted] Small Smiles Dental Centers of Brockton

Dentist #2

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
	No findings.	

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#3	According to the Account History Report, two anterior periapical X-rays were taken for the periodic oral examination performed on February 24, 2012. There was no explanation as to why bitewing X-rays were not taken to evaluate the posterior teeth at that appointment or when the patient returned on the audited date of service, March 7, 2012. This 3-year-old patient was noted as high caries risk and bitewing X-rays would have been essential to perform a thorough examination.	
#8	Following review of the X-rays dated February 24, 2012, the Monitor's pediatric dentist noted radiographic evidence of decay in close proximity to the pulp on teeth #E and #F along with external root resorption. No documentation showed these teeth were evaluated for pulp therapy.	

[redacted] Small Smiles Dental Centers of Brockton

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#15	The Op Sheet dated March 7, 2012, noted multiple surface fillings were performed on teeth #E and #F instead of crowns with the documented rationale "didn't have a second A3 size crown so decided to repair with composite." According to the rationale given, it appears Clinic members were not adequately prepared prior to treatment and did not have sufficient dental materials to complete the planned treatment, which is a quality of care concern. Due to the high caries risk of the patient, the extent of decay and close proximity of the decay to the pulp, SSCs were warranted.	
#18	Septocaine was used when administering local anesthesia to a patient under the age of 4, which was against CSHM's *Quality Assurance Protocols and Guidelines*.	Per [DCQIT], "Septocaine is not approved by the FDA for use in Children under the age of four years."
#24	The treatment start time documented on the Op Sheet dated March 7, 2012, is illegible; therefore, the Monitor is unable to verify the appropriateness of the time interval after administration of local anesthesia before treatment was started.	The writing is illegible.
#26	There was no documentation entered for the patient's school and grade on the Health History form dated February 24, 2012.	Please document with an N/A items not applicable to the patient on the top portion of the health history.
#40	The patient's pre-operative and post-operative blood pressure was not documented on the Nitrous Oxide Consent Form dated March 7, 2012, as required by the rules and regulations established by the Massachusetts Board of Registration in Dentistry.	The BP is not properly documented for the Mass.center.

[redacted] Small Smiles Dental Centers of Brockton

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	X-rays dated February 22, 2012, and April 2, 2012, were not provided; therefore, the Monitor was unable to verify the diagnostic quality of the X-rays related to the audited date of service, April 2, 2012.	
#6	The Monitor was unable to confirm radiographic evidence supporting the planned treatment on the audited date of service, April 2, 2012, because current X-rays were not provided.	
#7	The Monitor was unable to verify that the interpretation of the X-rays was appropriately documented on the Tooth Chart because current X-rays were not provided.	
#8	The Monitor was unable to determine the adequacy of the planned treatment because the Op Sheets and X-rays dated May 24, 2011, October 18, 2011, February 22, 2012, March 12, 2012, and April 2, 2012, that were related to the audited date of service, were not included in the requested materials.	
#12	The Hygiene form dated February 22, 2012, noted the patient's chief complaint as "tooth #30 made her face swollen after RCT [root canal therapy]." The Monitor was unable to verify that the chief complaint was addressed appropriately because Op Sheets and X-rays related to treatment of tooth #30 dated May 24, 2011, October 18, 2011, and March 12, 2012, were not included in the requested materials.	

[redacted] Small Smiles Dental Centers of Brockton

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#13	CSHM's auditor answered "can't verify" for this question; however, according to the times documented on the Op Sheet, the total operatory time did not exceed one hour. It appears the "Anesthetic Started" line was marked through initially and then a time was added later in order to perform additional procedures. Regardless, the operatory time was still less than one hour; therefore, the Monitor scored "yes" for this question.	Please ensure that the start and stop time is correctly documented.There is an error documented but a new time was not inserted, therefore the anesthetic time can't be accurately verified.
#24	It was apparent local anesthesia was not required initially in the appointment for cementation of the crown on tooth #30, but was indicated when treatment began on tooth #15. The Op Sheet dated April 2, 2012, documented "Anesthetic Started 4:05," "Treatment Started 3:36," and "End of Treatment 4:22." The Monitor was unable to verify the interval of time from administration of local anesthetic for tooth #15 to the start of treatment.	There is an error by the anesthectic [sic] start time ,but the correct time is not documented.
#26	There was no documentation of the patient's social security number on the Health History form dated February 14, 2012.	The social security line is not completed.
#27	The patient recorded "yes" responses on the Health History form dated February 14, 2012, to questions on heart trouble, asthma/breathing problems, surgery, and heart murmur. Documentation related to heart trouble was "Tetralogy of Fallot." There was no explanation for asthma/breathing problems and previous surgery.	There is no documentation as how the asthma is controlled or managed.
#28	There was inadequate explanation and follow-up for the patient's history of heart problems and asthma/breathing problems.	There is no documentation as how the asthma is comtrolled [sic] or managed.

[redacted] Small Smiles Dental Centers of Brockton

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#29	Documentation on the Health History form dated February 14, 2012, showed the patient had heart problems and "Tetralogy of Fallot." There was no evidence of medical consultation and/or physician's instructions associated with the patient's heart condition.	
#58	The Monitor was unable to determine if only diagnostic X-rays were billed because the X-rays related to the audited date of service, April 22, 2012, were not included in the requested materials.	
#72	On the Op Sheet dated April 2, 2012, there was no PRSA documented for the crown performed on tooth #30. According to the Account History Report, tooth #30 had a root canal on May 24, 2011.	The RCT treatment done on 5/24/2011 is not documented as PRSA.

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#12	The patient complained of pain associated with tooth #I as documented on the Op Sheet dated March 6, 2012; however, the Monitor's pediatric dentist did not find documentation that a periapical X-ray was taken of tooth #I to evaluate current pathology prior to treatment. The bitewing X-ray used to determine the treatment plan was taken October 5, 2011.	
#24	The Op Sheet dated March 6, 2012, documented the start time for anesthesia as 11:25 and the treatment start time as 11:27. The Monitor's pediatric dentist determined this was insufficient time for profound anesthesia to occur and therefore agreed with the DCQIT's findings.	Per [DCQIT],"2min is not adequate time from the start of the local anesthetic injection to start of dtreatment [sic] for profound anesthesia to occur."

[redacted] Small Smiles Dental Centers of Brockton

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#40	The patient's pre-operative and post-operative blood pressure was not documented on the Nitrous Oxide Consent Form dated March 6, 2012, as required by the rules and regulations established by the Massachusetts Board of Registration in Dentistry.	There is no documented BP taken on the nitrous oxide form for this Mass. Center.when initial and working concentration are the same,place a dash on the min line. [sic]
#71	The lower odontogram of the Tooth Chart dated October 5, 2011, did not document the completed pulpotomy on tooth #I.	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor noted inaccuracies in the completion of the Tooth Chart dated January 4, 2012. Teeth #B and #I were circled on the upper odontogram but were not present; while, teeth #5, #14, and #19 were not circled and were present according to the X-rays dated January 4, 2012. The Tooth Chart also did not clearly document the existing condition of tooth #25.	
#12	The chief complaint was documented as "filling fell out" on the Health History form dated January 4, 2012. The Monitor's pediatric dentist did not find additional narrative exploring the circumstances involved with the loss of the filling.	There is a complaint on the health history "filling fell out".
#26	Questions for heart trouble, tuberculosis, hepatitis, HIV/AIDS, asthma/breathing problems, autism, sickle cell anemia, fainting, and tobacco use were not answered on the Health History form dated January 4, 2012.	

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#72	On the Op Sheet dated March 22, 2012, there was no PRSA documented for the porcelain fused to metal crown placed on tooth #25. According to the Account History Report, a four surface resin filling was placed on December 2, 2011.	There was a 4 surface composite restoration done on 12/2/2011.

Summary

Below is a summary of the Monitor's findings from the 10 records reviewed:

Consents and Acknowledgments

Three records (patients #001, #003, and #004) had findings related to the Acknowledgment form.

- Patients #001 and #003 – The person completing the Acknowledgment form did not include their relationship to the patient.
- Patient #004 – The Acknowledgment form was not included in the record for this patient; therefore, the Monitor was unable to verify it was completed appropriately.

Health History

Five records (patients #001, #002, #007, #008, and #010) had findings related to the Health History. The following provides a summary of each:

- Patient #001 – Exploration of the patient's allergies was not documented.
- Patient #002 – The patient documented a "yes" response to health questions regarding heart trouble, asthma/breathing problems, anemia and high blood pressure. There were no follow-up notations related to high blood pressure and there was insufficient narrative to determine if the nature of the heart trouble required antibiotic premedication prior to treatment.
- Patient #007 – The Health History form did not document the patient's school and grade level. In order to follow the *Guidelines*, the Monitor agreed with CSHM's finding; however, the patient was 3 years of age and the relevance for documenting "n/a or a line" for the patient's school and grade seems insignificant.
- Patient #008 – The Health History form did not document the patient's social security number and did not document that the patient was questioned regarding their "yes" responses to heart trouble, asthma/breathing problems, and previous surgery. There was no documentation indicating that a physician consultation was requested or obtained regarding the patient's diagnosis of "Tetralogy of Fallot."
- Patient #010 – The Health History form was incomplete because it did not document answers for questions regarding heart trouble, tuberculosis, hepatitis,

HIV/AIDS, asthma/breathing problems, autism, sickle cell anemia, fainting, and tobacco use.

Tooth Chart

Two records (patients #009 and #010) did not document completed treatment or all existing conditions on the designated odontogram of the Tooth Chart. For patient #009, the completed pulpotomy on tooth #I was not documented on the lower odontogram of the Tooth Chart. The upper odontogram of the Tooth Chart for patient #010 did not accurately document the teeth that were present or clearly note the existing condition of tooth #25.

Chief Complaint

Two records (patients #009 and #010) did not show the chief complaint was appropriately addressed. The following provides a summary of each:

- Patient #009 – The Op Sheet dated March 6, 2012, noted the patient complained of pain associated with tooth #I. There was no bitewing or periapical X-ray taken to evaluate the health of tooth #I prior to treatment.
- Patient #010 – The patient's chief complaint was "filling fell out" as documented on the Health History form dated January 4, 2012. The Monitor's pediatric dentist found no additional documentation regarding the loss of the filling.

X-rays

Two records (patients #001 and #007) had findings related to X-rays. For patient #001, the posterior right bitewing and lower periapical X-rays appeared indistinct with poor density and contrast and were non-diagnostic for determining proximal decay. Also, the apices of the patient's third molars were not visible on the posterior periapical X-rays. The Monitor found no explanation as to why bitewing X-rays were not taken for patient #007.

Hygiene Procedures Form

One record (patient #002) did not document the rationale for why an adult patient with high caries risk did not receive a fluoride treatment following a prophylaxis. The Monitor agreed with CSHM's findings; however, CSHM's auditor noted "patient is 50 yr. old adult" as the only rationale for scoring this question as "no" and did not provide clear communication to the Clinic regarding the significance of the finding or expectations regarding documentation.

Nitrous Oxide Consent Form

Four records (patients #003, #004, #007, and #009) did not document the patient's pre-operative and post-operative blood pressure on the Nitrous Oxide Consent Form as required in the State of Massachusetts.

Op Sheet

Three records (patients #004, #008, and #010) did not document existing restorations on the PRSA line of the Op Sheet.

Other Scoring Differences

Two records (patients #001and #002) showed scoring differences between the Monitor and CSHM's auditor. CHSM's auditor scored question #72 "no" because the PRSA for patients #001 and #002 were not recorded on the Additional Operative Procedures form that was reviewed for the audited date of service. The Monitor had difficulty applying question #72 to the Additional Operative Procedures form because there was no place to document the PRSA for certain procedures and the Guidelines did not address PRSA documentation on this specific form; therefore, the Monitor scored question #72 as "yes" and did not penalize the Clinic.

Account History Report

The Account History report for one record (patient #001) showed billing for X-rays that were non-diagnostic.

Treatment Issues

Local Anesthesia

Four records (patients #002, #007, #008, and #009) had findings regarding local anesthesia.

- Patient #002 – The Monitor was unable to assess if the local anesthesia dosage administered was below the DCPW and sufficient for the length of the procedure because documentation on the Op Sheet dated March 26, 2012, was illegible.
- Patient #007 – The Op Sheet dated March 7, 2010, documented the use of Septocaine local anesthesia for a 3-year-old patient. The Monitor agreed with the DCQIT's finding "Septocaine is not approved by the FDA for use in children under the age of 4 years." Also, the treatment start time was illegible; therefore, the Monitor is unable to verify the time interval between local anesthetic administration and the start of treatment.
- Patient #008 – The Monitor was unable to verify the interval of time from administration of local anesthesia to start of treatment because of incomplete documentation on the Op Sheet dated April 2, 2012.
- Patient #009 – The interval of time from administration of local anesthesia to start of treatment documented on the Op Sheet dated March 6, 2012, was insufficient to allow for profound anesthesia to occur according to the DCQIT. The Monitor's pediatric dentist agreed with the DCQIT's finding.

Under-Treatment

One record (patient #007) showed planned treatment that did not adequately address the patient needs and showed an instance of under-treatment with respect to care provided in the Clinic. The Monitor's pediatric dentist noted radiographic evidence of decay at the pulp of teeth #E and #F along with external resorption of their roots. There was no documentation these teeth were evaluated for pulp therapy.

Multiple Surface Fillings

Two records (patients #005 and #007) did not document a rationale that sufficiently justified placement of multiple surface fillings instead of crowns on primary teeth. The following details pertain to these findings:

- Patient #005 – Treatment included multiple surface fillings on teeth #J and #L with the documented rationale "[mom] did not want SSC if avoidable." This 9-year-old patient was noted to be high caries risk and was given a sodium fluoride tablet prescription to aide in caries prevention. The Monitor's pediatric dentist's primary concern was the success rate of fillings versus SSCs, especially in a patient with high caries risk, and noted tooth #J was treated in September 2009 with a two-surface amalgam filling, and retreatment was required on the audited date of service as new decay was detected during treatment on the mesial surface.
- Patient #007 – This 3-year-old patient received multiple surface resin fillings instead of crowns on teeth #E and #F with the documented rationale "didn't have a second A3 size crown so decided to repair with composite." The Monitor's pediatric dentist's concerns were related to the success rate of fillings versus crowns in these small teeth for such a young patient and the Clinic's lack of preparation for planned treatment. The Restorative Dentistry Checklist on the Op Sheet had a check in the box documenting "materials to be used have been confirmed."

Observations

Upon review of the 10 records, the Monitor had the following observations:

With respect to three audited records (patients #001, #008, and #010) the requested materials did not include all documentation required to perform a complete review of the procedure performed on the audited date of service; therefore, the Monitor is uncertain how the CSHM auditor was able to complete the audit.

- Patient #001 – The Account History Report shows the patient's initial visit for preparation of a three-unit bridge was on November 30, 2011. The patient returned for "bridge try in" on December 21, 2011, and again on February 22, 2012, for "impression of bridge." The audited date of service was March 23, 2012, which was when the bridge was delivered to the patient and the fee for the bridge was billed. The Op Sheets for the services provided on November 30, 2011, December 21, 2011, and February 22, 2012, were not requested by CSHM's auditor; therefore, the Monitor was unable to perform a complete

assessment of the documentation related to the bridge including, administration of local anesthesia used during the treatment on November 30, 2011.

- Patient #008 – CSHM did not provide the most current X-rays taken on April 2, 2012, and February 22, 2012, or Op Sheets related to the patient's chief complaint regarding tooth #30 and the initial appointment for the tooth preparation of tooth #30 for the crown cemented on the audited date of service. There was also incomplete documentation pertaining to the patient's heart condition and no medical clearance. Because relevant documentation and current X-rays were not provided, the Monitor was unable to determine if: the patient's heart problems were properly assessed through a medical consultation and managed according to a doctor's instructions, the chief complaint was addressed properly, or if existing conditions and pathology were identified and treated within professionally recognized standards of care.
- Patient #010 – The Op Sheets for the services provided on January 13, 2012, and March 1, 2012, were not requested by CSHM's auditor; therefore, the Monitor was unable to perform a completed assessment of the documentation related to the crown cemented on the audited date of service.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 10 visit records:

- Ensure staff members verify an Acknowledgement form is completed correctly for each patient and stored in the patient's record.
- Ensure staff members verify all questions are answered on the Health History form.
- Ensure staff members provide adequate and appropriate follow-up documentation for all "yes" responses on the Health History form.
- Ensure staff members correctly document completed treatment and existing conditions on the designated odontogram of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure the patient's chief complaint is properly addressed by staff members and documentation clearly shows assessment and findings.
- Ensure X-rays are of diagnostic quality.
- Ensure staff members acquire all necessary pre-treatment X-rays and, if not able to obtain because of patient safety factors, document sufficient rationale.
- Clarify documentation requirements and expectations with respect to fluoride treatment for adult patients.
- Ensure staff members document the patient's pre-operative and post-operative blood pressure on the Nitrous Oxide Consent Form as required in Massachusetts.
- Ensure staff members understand the expectations and requirements for PRSA documentation on all applicable forms.

- Perform a review of question #72 on CSHM's audit tool to clarify PRSA documentation requirements on applicable forms in order to better define scoring criteria.
- Ensure the X-rays for patient #001 are reviewed to determine if billing corrections related to non-diagnostic X-rays are warranted.
- Ensure documentation on the Op Sheet is legible.
- Ensure dentists are familiar with CSHM's policy regarding the use of Septocaine and are not using this agent in children under the age of 4.
- Ensure staff members document sufficient time notations to verify the time interval from administration of local anesthesia to the start of treatment.
- Ensure dentists allow sufficient time from administration of local anesthesia to the start of treatment.
- Ensure the Chief Dental Officer (CDO) or DCQIT reviews the record for patient #007 for the risk of under-treatment related to teeth #E and #F.
- Ensure post-operative review of patient #007 to evaluate outcome of treatment on teeth #E and #F.
- Ensure staff members document sufficient rationale to justify the placement of multiple surface fillings instead of SSCs.
- Ensure staff members determine materials needed for planned treatment are available prior to starting the procedure.
- Perform a root cause analysis to determine why all documentation and X-rays related to crown and bridge restorations were not included in the review of the audited date of service for patients #001, #008, and #010 and why the auditors did not note the absence of this documentation.
- Perform a root cause analysis to determine why the review of patient #008 included forms and X-rays that were not related to the audited date of service and how this was not discovered prior to release of chart audit results to the Clinic.
- Ensure CSHM's auditors review all relevant X-rays, Op Sheets, and other documentation pertaining to the audited date of service.

EXHIBIT 56

[redacted]

To: [redacted]
Senior Counsel
Office of Counsel to the Inspector General

[redacted]
Chief Compliance Officer
CSHM LLC

From: [redacted]
Project Manager

Independent Quality of Care Monitor

Church Street Health Management

Desk Audit
Small Smiles Dental Centers of Denver

Deliverable #1-76

December 7, 2012

Executive Summary

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holdings, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Denver (Clinic), 1400 Grove Street, Denver, CO 80204.

Overall Summary of Critical Findings and Observations

[redacted] reviewed 20 records previously reviewed by CSHM as part of its internal audit monitoring of its Clinics to ensure appropriate quality of care. The following are critical findings from the Monitor's review of the 20 records that CSHM audited during the second quarter of 2012.

CSHM issued a passing score for the Clinic and the four dentists. The Monitor's review resulted in passing scores for two dentists; however, the remaining two dentists received an automatic failure because of lack of documentation and radiographic evidence to support the medical necessity for treatment. The Monitor also identified instances of under-treatment and undiagnosed decay, existing conditions, and pathology that resulted in a failing score for the Clinic and lower scores for the passing dentists. The Monitor was unable to perform a complete review of the Operating Room (OR) cases for five patients because the required OR documentation including X-rays were not included in the requested materials. Therefore, the Clinic and Dentist #4's scores may have been different had the Monitor received the required documents to complete the review. It appeared CSHM's auditor and the Director of Clinical Quality Initiatives and Training (DCQIT) completed the review of treatment performed in the OR without requiring all documentation and X-rays relevant to the audited date of service. In addition, the Monitor's score for Dentist #2 does not include a deduction for the finding related to disease that was not addressed on the Treatment Plan because question #73 in the Guidelines did not provide clear criteria for the discretionary point deduction process.

CSHM's auditor contacted the DCQIT for consultation on seven records. The DCQIT did recommend follow up for one of the patients after his review; however, there was no documentation provided to the Monitor to show the Clinic attempted any follow up regarding this finding.

Of the 20 records reviewed, 16 records did not document decay, existing conditions, pathology, or completed treatment on the designated odontograms of the Tooth Chart. CSHM reported findings in only 5 of the 16 records.

Three records contained non-diagnostic X-rays. The CSHM auditor identified two of the three records which had panoramic X-rays of poor quality. The other record contained an anterior X-ray which was too dark to be diagnostic and the positioning of the premolar bitewing X-rays did not include the distal of the canines. There was also one record that did not include the panoramic X-ray related to the audited date of service; therefore, the Monitor was unable to verify the diagnostic quality and this finding was not identified by the CSHM auditor.

Two records showed planned treatment that did not address radiographically demonstrable decay and showed instances of under-treatment with respect to care provided in the Clinic. One record showed risk of over-treatment because there was no radiographic evidence or documentation of decay on the Tooth Chart for six teeth which received stainless steel crowns (SSCs) in the OR.

In one record, the Monitor was unable to determine if all disease documented on the Tooth Chart had been adequately addressed because there was no updated Treatment Plan and no evidence to show CSHM's auditor contacted the Clinic to determine if there was an updated Treatment Plan. The Monitor's pediatric dentist noted radiographically demonstrable mesial decay on tooth #K that was recorded on the upper odontogram of the Tooth Chart but as of April 12, 2012, tooth #K had not received treatment.

Five records did not provide radiographic evidence or documentation on the upper odontogram to support the medical necessity for treatment performed. These findings resulted in automatic failures for an Associate Dentist and the Pediatric Dentist who provides treatment in the OR. Four of the five records with these findings resulted from insufficient documentation and X-rays provided for the review of OR cases.

For five records, there was incomplete documentation related to treatment in the OR setting. The Point System for Determining Appropriateness of Care under General Anesthesia form, Dictated Operation (or Operative) Note, and Radiographs and Photographs taken in the OR were not included in the requested materials for these patients. Also, for two patients, the Consent for Treatment under General Anesthesia form was not a part of the record. CSHM's auditor noted the VP, Training and Education, indicated the Clinic staff members were not informed appropriately in regard to OR forms; however, the Monitor noted the missing forms are required by CSHM's policy entitled *Required Documentation for General Anesthesia Cases*. The Monitor's pediatric dentist was concerned that without the appropriate forms there was no documented rationale for the necessity of general anesthesia for these patients. Also, CSHM completed the review of OR records without requiring the OR odontogram, X-rays taken in the OR, or other documentation relevant to the audited date of service.

Three records documented the inappropriate use of sodium hypochlorite as a medicament for pulpotomies performed on primary teeth. These three patients were treated in the OR setting and the Monitor's pediatric dentist is concerned about the possible adverse effect on the long-term prognosis for the teeth involved.

Overall Summary of Recommendations

The following recommendations are based on the Monitor's findings from the review of the 20 visit records:

- Ensure staff members verify an Acknowledgement form is completed correctly for each patient and stored in the patient's record.
- Ensure staff members verify the Consent for Treatment under General Anesthesia form is completed correctly.
- Ensure staff members verify all questions are answered on the Health History form.
- Ensure staff members provide adequate and appropriate follow-up documentation for all "yes" responses on the Health History form.
- Ensure staff members correctly document existing conditions, pathology, and completed treatment on the designated odontogram of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure the patient's chief complaint is properly addressed by staff members and documentation clearly shows assessment and findings.
- Ensure X-rays are of diagnostic quality.
- Ensure staff members are documenting all procedures on the hygiene form, properly correcting errors, and drawing lines through all unused sections.
- Ensure accurate completion of the Op Sheet including documentation related to PRSA, as directed in the *Chart Documentation Guide*.
- Ensure CSHM's auditors confirm that all documentation and X-rays pertaining to the audited date of service is received from the Clinic in order to perform an accurate record review.
- Ensure the dentists and staff members are compliant with CSHM's policy entitled *Required Documentation for General Anesthesia Cases* and understand the documentation requirements for patients who are treated in an OR setting.
- Perform a root cause analysis to determine why the record for patient #002 failed to include an updated Treatment Plan and why this was not requested by the CSHM auditor.
- Ensure staff members obtain initials of the parent/guardian indicating preference for crown type on the Treatment Plan when indicated.
- Ensure the accurate completion of the Treatment Plan including lines drawn completely across unused sections.
- Ensure any documentation errors are corrected properly.
- Ensure recommended follow-up was completed for patient #001.
- Ensure the Chief Dental Officer (CDO) or DCQIT review the record for patient #006 to determine risk of under-treatment and need for follow-up.
- Ensure medical necessity for treatment provided is evident on X-rays and/or sufficiently documented on the Tooth Chart.

- Ensure CSHM's *Guidelines* define the criteria used for question #73 to determine number of points deducted where a provider has not adequately addressed the patient's needs in the Treatment Plan.
- Review the Monitor's findings related to question #73 to determine the proper point deduction for the dentist who developed the Treatment Plan.
- Ensure patient #016 is monitored to ensure the success of the treatment performed on teeth # E, #F, #L, #M, and #R.
- Ensure patient #017 is monitored to ensure the success of the treatment performed on teeth #D, #E, #F, and #G.
- Clarify expectations related to documentation requirements when the Acknowledgment form is completed and notarized outside the Clinic.
- Ensure the Monitor is provided all documentation and X-rays of the same quality as provided to the CSHM auditor and/or the DCQIT.
- Ensure staff members provide clear documentation of decay in red ink on the upper odontogram of the Tooth Chart.
- Ensure copies of documents provided for the audit process are of good quality.
- Conduct a root cause analysis to determine why nitrous oxide/oxygen analgesia is not being used in the Clinic.
- Revise the OR Procedures form to include documentation of the DCPW in order to ensure the maximum dose of local anesthesia is calculated prior to administration in the OR setting.
- Perform a root cause analysis to determine why Dentist #4 opted to use sodium hypochlorite as a medicament for pulpotomies performed for patients #016, #017, and #018.
- Conduct a quality of care review to evaluate the success of pulpotomies performed with the use of sodium hypochlorite.
- Perform a root cause analysis to determine why CSHM's auditor did not consult the DCQIT regarding the use of sodium hypochlorite for pulpotomies or recognize that this agent is not listed as an acceptable medicament for pulpotomies per CSHM guidelines.
- Perform a root cause analysis to determine why OR cases were reviewed without the required documentation and X-rays from the OR.
- Ensure CSHM auditors perform a complete record review and require all documentation and X-rays relevant to the audited date of service be provided by the Clinic.

Clinic Desk Audit Report

Introduction

The Office of Inspector General (OIG) and CSHM LLC (CSHM) (f/k/a Church Street Health Management, LLC and FORBA Holding, LLC), a Tennessee corporation, on behalf of itself and its wholly owned subsidiaries and affiliates, negotiated a Corporate Integrity Agreement (CIA) dated January 15, 2010. One of the requirements of the CIA is that CSHM would engage an Independent Quality of Care Monitor (Monitor). The OIG chose [redacted] to serve as the Monitor. This is the Monitor's report on its desk audit review of Small Smiles Dental Centers of Denver (Clinic), 1400 Grove Street, Denver, CO 80204.

Implementation

The OIG approved a desk audit for Small Smiles Dental Centers of Denver. On September 28, 2012, the Monitor notified CSHM's Compliance Officer by e-mail about the desk audit. The Monitor requested Clinic records and findings from CSHM's chart audit, including the audit tool, instructions and training, reviewers' names and their credentials, review notes, calculations to determine results, any Corrective Action Plans (CAPs), and rationale for imposing them. The Monitor received the documentation from CSHM on October 9, 2012. The Monitor received the following documentation and information from CSHM related to its chart audit:

- Copies of all audit findings related to the chart audit performed in the second quarter of 2012
  - E-mail to the Clinic with results for the second-quarter audit
  - Second-quarter audit spreadsheet
- Audit tool used to conduct the chart audit, which includes guidelines to respond to the questions *(Guidelines)*
- Instructions and any training given to auditors conducting the review of dental records
  - Auditor trained by the Director, Clinical Review prior to conducting audits; Auditor has received ongoing supervision by Director, Clinical Review
  - Training reference tools used
    - *The CBC Chart Audit Policy*
    - *The Chart Documentation Guide*
    - *Clinical Policies and Guidelines for CSHM Affiliated Dental Centers*
    - *Quality Assurance Protocols and Guidelines for dental centers policy*

CSHM requested the Clinic's charts on May 2, 2012, and the documents were received on May 7, 2012. A licensed dental hygienist completed the chart audit on July 2, 2012. CSHM indicated the Clinic and the four dentists passed the audit. There were three

billing errors requiring correction. The Director of Clinical Quality Initiatives and Training (DCQIT) reviewed 7 of the 20 records selected for this chart audit.

Scope of Desk Audit

The purpose of this desk audit was to review the chart audit conducted by CSHM during the second quarter of 2012 by mirroring the testing attributes employed by CSHM in conducting its chart audit and evaluating the criteria employed. The Monitor's pediatric dentist provided consultation on all 20 records reviewed.

Review of CSHM Chart Audit

Twenty records were reviewed for the four audited dentists following the Clinical Guidelines and Quality Assurance Protocol (QAP) metrics as outlined in the *Quality Assurance Protocols and Guidelines for Dental Centers for whom CSHM provides Management Services*. The Monitor evaluated the records provided and used CSHM's chart audit tool to conduct the desk audit.

The following table shows the Monitor's and CSHM's scoring differences for the Clinic and dentist. CSHM issued a passing score for the Clinic and the four dentists. The Monitor's review resulted in passing scores for two dentists; however, the remaining two dentists received an automatic failure because of lack of documentation and radiographic evidence to support the medical necessity for treatment. The Monitor also identified instances of undiagnosed decay, existing conditions, and pathology that resulted in a failing score for the Clinic and lower scores for the passing dentists.

	Monitor Score	CSHM Score
Clinic Score	**87.4% ***	**92.5 %**
Dentist #1	Automatic Failure	96.2%
Dentist #2	93.4%*	96.3%
Dentist #3	97.4%	100.0%
Dentist #4	Automatic Failure *	96%

*The Monitor was unable to perform a complete review of the procedures that related to the audited dates of service for patients #016, #017, #018, #019, and #020 because the required Operating Room (OR) documentation including X-rays were not included in the requested materials. Therefore, the Clinic and Dentist #4's scores may have been different had the Monitor received the required documents to complete the review. It appeared CSHM's auditor and the DCQIT completed the review of treatment performed in the OR without requiring all documentation and X-rays relevant to the audited date of service. In addition, the Monitor's score for Dentist #2 does not include a deduction for the finding related to disease that was not addressed on the Treatment Plan because question #73 in the Guidelines did not provide clear criteria for the discretionary point deduction process.

The following tables summarize findings pertaining to the records reviewed for each dentist. The "question number" in each table corresponds to the question in the CSHM chart audit tool. The column titled "CSHM's Findings" records the verbatim findings reported by CSHM in the Clinic's chart audit spreadsheet, as well as the outcome of the appeals determination. If CSHM had no findings, the space was left blank. The Monitor completed the chart audit and then compared the information to CSHM's findings. The results of the comparison are included in the following tables.

Dentist #1

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist found radiographically demonstrable decay on the distal of tooth #R that was not documented on the upper odontogram of the Tooth Chart dated April 16, 2012. In addition, the following conditions were not documented on the upper odontogram of the Tooth Chart: the occlusal buccal decay on tooth #30, the remaining root tips of teeth #A, #K, and #L, and presence of existing mandibular anterior teeth.	Chart and x-rays reviewed by the DCQIT in regard to decay on the distal of teeth #R and #I? Should teeth #'s A, K and L should be charted in red ink on the upper odontogram to signify root tips. Root tips should be charted as existing conditions. [sic]
#8	Upon review of the Treatment Plan and X-rays, the Monitor's pediatric dentist found that the Treatment Plan did not address the radiographically demonstrable distal decay on tooth #R. Teeth #S and #T were treated on the audited date of service and the decay on tooth #R went untreated with no explanation.	Chart and x-rays reviewed by the DCQIT in regard to tooth #R. I see a radiolucency in the distal of #R that is consistent with caries in that surface. It does not appear that caries was charted on that surface in the upper odontogram, nor was treatment planned for that tooth on the lower odontogram or the treatment plan. The distal of #R could have been checked when #S was prepped on 4/23/12, but I see no evidence that this was done. The center should review the right BW taken 4/16/12 (I will return it via FedEx today or tomorrow) and consider recalling the patient to

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
		examine and restore this tooth, if they agree with my assessment.
#10	There was no documentation of the occlusal buccal decay on the upper odontogram of the Tooth Chart and the decay was not evident on the X-ray; therefore, there was no documentation to support the medical necessity for the filling performed on tooth #30.	
#26	The mother completed the Health History form dated April 16, 2012, but did not record a phone number in the patient information section at the top of the form; however, since the mother's address and phone number were the same as the patient's and this information was recorded at the bottom of the form, the Monitor scored this question as "yes" instead of "no."	The telephone number was not documented.
#64	On the Operative Procedures form (Op Sheet) dated April 23, 2012, there was no documentation indicating the presence or absence of complications during treatment.	A check mark should be documented beside either "no complications" or "complications."
#67	The Hygiene Procedures form (Hygiene form) dated April 16, 2012, documented three sets of initials and only two corresponding staff signatures; however, the Monitor scored the question "yes" because the assistant who took X-rays was not required to provide a signature at the bottom of the form and signed the X-ray section as directed in the Chart Documentation Guide.	Three sets of initials were documented on the hygiene sheet dated 4/16/12; however, only two signatures were documented.
#68	The error corrected on the upper odontogram of the Tooth Chart dated April 16, 2012, did not include the date of the correction.	Error correction was not documented appropriately on the odontogram. (date of odontogram not visible due to copying.)

Patient #001		
Question	**Monitor's Findings**	**CSHM's Findings**
#73	Dentist #2 developed the Treatment Plan for this case which did not address the decay on tooth #R; however, the Monitor will defer to CSHM to determine the proper point deduction for Dentist #2 because the Guidelines did not provide clear criteria for the discretionary point deduction process.	

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
#8	The Monitor was unable to determine if all disease documented on the Tooth Chart dated November 29, 2011, had been adequately addressed because there was no updated Treatment Plan provided. An older Treatment Plan dated May 18, 2011, was provided with the requested materials and did not address all disease diagnosed during the November 29, 2011, examination. There was no evidence CSHM's auditor contacted the Clinic to determine if there was an updated Treatment Plan. The Monitor's pediatric dentist noted radiographically demonstrable mesial decay on tooth #K that was recorded on the upper odontogram of the Tooth Chart but as of April 12, 2012, tooth #K had not received treatment. This question was scored as "can't verify" since the Monitor was unable to confirm that all disease had been adequately addressed.	
#26	The patient's date of birth, age, school, grade, and language preference were not documented on the Health History form dated November 29, 2011.	School, grade, age and preferred name were not documented. One question was not answered yes or no.
#53	Documentation related to crown options was noted as "n/a" on the Treatment Plan Authorization form (Treatment Plan)	Crowns were not marked in the Crown Option Box.

Patient #002		
Question	**Monitor's Findings**	**CSHM's Findings**
	dated May 18, 2011, and treatment for this patient did include crowns.	
#55	The pulpotomy performed on tooth #T was documented on the Op Sheet dated April 12, 2012, but was not recorded on the Account History Report.	Pulpotomy for tooth #T was documented on the OP sheet dated 4/12/2012 but was not listed on the account history.
#63	The patient's date of birth was not documented on the Health History form dated November 29, 2011.	

Patient #003		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist noted radiographic evidence of failing pulpotomies with root resorption and furcation radiolucency on teeth #I, #L, and #S. These findings were not documented on the Tooth Chart dated October 12, 2011.	

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	The panoramic X-ray dated October 18, 2010, was non-diagnostic because it was too dark.	Panoramic x-ray 10/18/2010 reviewed by the DCQIT for diagnostic quality. The image of the panoramic film that was sent to me is too dark to be diagnostic.
#6	There was no documentation of the existing filling on tooth #K, the pulpotomy on tooth #T, and teeth #I and #J were not circled as present on the upper odontogram of the Tooth Chart dated February 21, 2012. Also, the Monitor noted the existing filling on tooth #R and the missing filling on tooth #I were not documented on the Tooth Chart.	Chart and x-rays reviewed by the DCQIT. Teeth #'s I and J should be circled as existing teeth. The existing pulpotomy on tooth #T was not charted on the upper odontogram. The existing restoration `on tooth #K was not charted. The following existing conditions were not

[redacted] Small Smiles Dental Centers of Denver

Patient #004		
Question	**Monitor's Findings**	**CSHM's Findings**
		charted on the upper odontogram: teeth #I and J; pulpotomy in #T; restoration in #K.
#58	The Account History Report showed the Clinic billed for a non-diagnostic panoramic X-ray on October 18, 2010.	Panoramic film dated 10/18/2010 determined non diagnostic by the DCQIT. The image of the panoramic film that was sent to me is too dark to be diagnostic.
#67	The Hygiene form dated February 21, 2012, documented three sets of initials and only two corresponding staff signatures; however, the Monitor scored the question "yes" because the assistant who took X-rays was not required to provide a signature at the bottom of the form and signed the X-ray section as directed in the Chart Documentation Guide.	Three sets of initials were documented on the hygiene sheet dated 2/21/12; however, only two signatures were documented.

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	All existing teeth were not circled on the upper odontogram of the Tooth Chart dated April 16, 2012. The upper odontogram showed documentation of an existing filling on tooth #11; however, the decay on tooth #11 was not clearly marked in red ink.	Tooth #11 was charted on the lower odontogram in red ink, but on the upper odontogram in black ink. This tooth was planned for treatment on the treatment plan dated 4/16/12. Chart and x-rays reviewed by the DCQIT. Since I can see caries in #11, I'd consider this to be a documentation error.
#27	On the Health History form dated April 16, 2012, the patient recorded a "yes" response for "asthma/breathing problems" and there was no further explanation documented.	Follow up was not documented for "asthma/breathing problems."

[redacted] Small Smiles Dental Centers of Denver

Patient #005		
Question	**Monitor's Findings**	**CSHM's Findings**
#28	There was no documentation to show appropriate follow-up questions were explored for the patient's reported history of "asthma/breathing problems."	Adequate follow up should be documented for "asthma/breathing problems."
#69	On the Treatment Plan dated April 16, 2012, a left to right line was not drawn through the unused "comment section" where treatment for teeth #11, #30, and #31 was documented.	Line not drawn on all unused lines on the TX Plan dated 4/16/2012.

Dentist #2

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The upper odontogram of the Tooth Chart dated February 14, 2012, documented an existing filling on the distal occlusal surfaces of tooth #5, but the Monitor's pediatric dentist found no evidence of this filling on the X-rays taken on the same date. There was also radiographic evidence of decay under the distal filling on tooth #29 which was not documented on the Tooth Chart.	
#8	The Treatment Plan did not address the radiographically demonstrable distal decay on tooth #29.	
#12	The Hygiene form dated February 14, 2012, recorded a chief complaint of "molar hurts" but there was no documentation to show the patient's complaint of pain was addressed. There was no evidence noting assessment of the symptomatic tooth or periapical X-ray taken to evaluate for the possibility of an abscess to support the need for a referral to a root canal specialist.	

[redacted] Small Smiles Dental Centers of Denver

Patient #006		
Question	**Monitor's Findings**	**CSHM's Findings**
#26	The Health History dated December 27, 2011, did not document the patient's social security number and language preference.	Social security number was not documented.
#69	A left to right line was not drawn through the unused section beneath the treatment for tooth #4 on the Treatment Plan dated April 9, 2012. The Monitor also noted the back side of the Hygiene form dated February 14, 2012, did not have lines drawn through the unused sections.	Line not drawn on all unused lines on the Tx Plan dated 4/9/2012.

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	The panoramic X-ray dated January 26, 2011, was non-diagnostic.	Panoramic x-ray dated 1/26/2011 reviewed by the DCQIT for diagnostic quality. The panoramic x-ray is not diagnostic.
#6	The upper odontogram of the Tooth Chart dated March 20, 2012, did not document the existing upper teeth.	Exisitng [sic] teeth on the upper odontogram were not circled. Chart and x-rays reviewed by the DCQIT. The upper odontogram did not indicate which teeth were present on the upper arch at the time of the exam.
#8	There were no details documented on the Tooth Chart related to the remineralization plan for the distal surface of tooth #13.	Chart and x-rays reviewed by the DCQIT in regard to remineralization plan for patient. Remineralization plans must be provided on the lower odontogram (Rx high F dentifrice, OTC F mouthrinse, etc)
#51	The Treatment Plan dated March 20, 2012, was not signed by the dentist.	The treatment plan dated 3/20/2012 was not signed by the dentist. Documentation error regarding signature.

Patient #007		
Question	**Monitor's Findings**	**CSHM's Findings**
#58	The Account History Report showed the Clinic billed for a non-diagnostic panoramic X-ray on January 26, 2011.	Panoramic x-ray dated 1/26/2011 non diagnostic determined by the DCQIT.
#61	The Acknowledgment of Receipt of Notice of Privacy Practices (Acknowledgment) form was not included in the requested materials.	Acknowledgement Notice was not included with the requested material. [sic]
#69	The Op Sheet dated April 2, 2012, and the Treatment Plans dated March 20, 2012, and April 2, 2012, did not have lines drawn across all unused sections.	Line not drawn on all unused lines on the TX Plan dated 4/2/2012 and the TX Plan dated 3/20/2012 and the Op sheet dated 4/2/2012.
#72	The Prior Service Acknowledgment (PRSA) for tooth #4, which had an existing occlusal filling, was not documented on the Op Sheet dated April 2, 2012.	

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	There was incomplete documentation of existing teeth on the upper odontogram of the Tooth Chart dated March 26, 2012, and only teeth #2, #3, #14, and #15 were circled as present. Also, documentation of decay was not clearly recorded in red ink.	
#26	The patient's social security number and response to the question related to dental problems/concerns were not documented on the Health History form dated March 26, 2012.	Social security number was not documented. One question was not answered yes or no.
#27	On the Health History form dated March 26, 2012, the patient answered "yes" for disabilities/special needs; however, there was no further explanation documented.	No explanation for Disabilities/Special Needs.
#28	There was no documentation to show appropriate follow-up questions were explored for the patient's reported history of Attention Deficient Hyperactivity	Further explanation is needed for ADHD and special needs/disabilities.

[redacted] Small Smiles Dental Centers of Denver

Patient #008		
Question	**Monitor's Findings**	**CSHM's Findings**
	Disorder (ADHD) and disabilities/special needs.	
#67	The Hygiene form dated March 26, 2012, documented four sets of initials and only three corresponding staff signatures; however, the Monitor scored the question "yes" because the assistant who took X-rays was not required to provide a signature at the bottom of the form and signed the X-ray section as directed in the Chart Documentation Guide.	Four sets of initials and three signatures.
#69	The Treatment Plan dated April 18, 2012, did not have lines drawn across all unused sections.	Line not drawn on all unused lines on the Tx Plan dated 4/18/2012.

Patient #009		
Question	**Monitor's Findings**	**CSHM's Findings**
#26	The patient's complete address, telephone number, social security number, and language preference were not documented on the Health History form dated April 2, 2012.	Patient's address was not documented completely. Telephone number, preferred language and social security number were not documented.
#69	The Hygiene form dated April 2, 2012, did not have lines drawn across all unused sections.	Line not drawn on all unused lines in the note section on the Hyg sheet dated 4/2/2012.

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The occlusal decay on tooth #J was not clearly documented in red ink and there was no documentation of the buccal decay on tooth #30 that was diagnosed during treatment. The existing pulpotomies on teeth #S and #L were not recorded on the upper odontogram and there was no documentation of the failing pulpotomy on tooth #S.	

[redacted] Small Smiles Dental Centers of Denver

Patient #010		
Question	**Monitor's Findings**	**CSHM's Findings**
#68	The error corrected on the Op Sheet dated April 10, 2012, did not include the date of the correction.	Error notation on OP sheet dated 4/10/2012 was not complete.
#69	The Treatment Plan dated April 2, 2012, did not have lines drawn across all unused sections.	Line not drawn on all unused lines on the TX Plan dated 4/2/2012.
#72	The PRSA for teeth #J and #14 was not documented on the Op Sheet dated April 10, 2012. Tooth #J had an existing filling and tooth #14 received a sealant on March 29, 2010.	PRSA was not noted for tooth #J. Visible restoration on the radiograph and existing restoration on the upper odontogram for tooth #J.

Dentist #3

Patient #011		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The upper odontogram of the Tooth Chart dated April 12, 2012, does not document the patient's existing teeth nor provide evidence the panoramic X-ray taken the same date was reviewed and interpreted.	
#51	The Monitor scored this question "yes" because the Authorization form was completed correctly. The form was completed by the parent and notarized outside of the Clinic; therefore, a Clinic staff member would not have been able to witness the parent's signature.	Witness section was not documented on the HIPPA form section C.
#68	The Monitor scored this question "yes" because the Authorization form was completed outside of the Clinic; therefore, Clinic staff members would not have been able to ensure errors were properly corrected.	Error noted on the HIPPA form section C without error notation.

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**

[redacted] Small Smiles Dental Centers of Denver

Patient #012		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	The Monitor's pediatric dentist noted the mandibular anterior X-ray dated March 27, 2012, was non-diagnostic because the apices of the anterior teeth were not visible and it was too dark to evaluate the fracture on tooth #23. In addition, the two pre-molar bitewing X-rays were non-diagnostic because the distal of the canines and mesial of most first premolars were not visible on either film.	
#58	The Account History Report showed the Clinic billed for non-diagnostic X-rays taken on March 27, 2012.	
#68	The patient's year of birth on the Hygiene form dated March 27, 2012, was altered without the proper error correction notation.	Error corrected on the Hygiene sheet for the patient DOB did not have error notation.
#69	The Monitor noted there was not a left to right line drawn through the unused "sealant" section of the Op Sheet dated April 9, 2012.	Line not drawn on all unused lines and after the last entry in the notes on the OP sheet dated 4/9/2012.
#72	The PRSA was not documented for teeth #15, #18, and #19. The Account History Report showed these teeth had received sealants on August 9, 2010.	

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	Existing teeth #E, #F, and #G were not circled to show they were present and the stainless steel crown (SSC) placed on tooth #G on September 12, 2011, was not documented on the Tooth Chart dated March 13, 2012.	
#26	The patient's social security number and language preference were not documented on the Health History form dated March 13, 2012.	Social security number and preferred language were not documented.

[redacted] Small Smiles Dental Centers of Denver

Patient #013		
Question	**Monitor's Findings**	**CSHM's Findings**
#65	The Monitor scored this question "yes" because the Op Sheet dated March 23, 2012, showed "yes" was selected for "Post-Operative Instruction" and documentation indicated written and oral instructions were provided.	Post-Operative instruction was not documented.
#69	The Treatment Plan dated March 13, 2012, did not have lines drawn across all unused sections.	Line not drawn on all unused lines on the TX Plan dated 3/13/2012.
#72	The PRSA for tooth #A was not documented on the Op Sheet dated March 23, 2012. Tooth #A had an existing lingual filling.	

Patient #014		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Tooth Chart dated March 13, 2012, does not document evidence the panoramic X-ray taken February 7, 2011, and the bitewing X-rays taken March 13, 2012 were reviewed and interpreted in regard to teeth #17 and #32. The Monitor's pediatric dentist noted these teeth were impinging on the distal surfaces of teeth #18 and #31 and there was no documentation to indicate a need for follow-up or referral.	
#26	The patient's social security number was not documented on the Health History form dated March 13, 2012.	Social security number was not documented.

[redacted] Small Smiles Dental Centers of Denver

Patient #015		
Question	**Monitor's Findings**	**CSHM's Findings**
#8	The bitewing X-ray of tooth #30 taken April 16, 2012, had radiographic evidence of deep decay approximating the pulp and the patient was given a "referral for deep caries #30 (MBL)" and possible root canal therapy. There was no evidence of assessment of the tooth or periapical X-ray taken to rule out apical pathology and support the need for a referral to a root canal specialist.	
#67	The Monitor scored "yes" for this question because although the third staff member's initials and signature were light and difficult to read on the provided copy, there were three distinct initials and staff signatures documented on the Op Sheet dated April 16, 2012.	Three sets of initials and two signatures on the Op sheet dated 4/16/2012.
#69	There was a line drawn through the diagnosis box with a subsequent doctor's note added and no staff initials following the note at the bottom of the Hygiene form. The Monitor was unable to verify whether lines were drawn through unused sections of the back of the Hygiene form since it was not included with the requested materials.	Line not drawn on all unused lines on the Hyg sheet dated 4/16/2012.

Dentist #4

Patient #016		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	There was no documentation of the mesial decay on tooth #K diagnosed during treatment in the OR. Also, the existing filling on the occlusal surface of tooth #S was not documented on the upper odontogram of the Tooth Chart dated January 10, 2012. An e-mail from the DCQIT dated June 19, 2012, stated: "I see some markings on S in the upper odontogram. Assuming that those are in	

[redacted] Small Smiles Dental Centers of Denver

Patient #016		
Question	**Monitor's Findings**	**CSHM's Findings**
	red: The restoration in #S was not charted as an existing condition in the upper odontogram." It appeared the CSHM auditor noted the same finding as the Monitor for tooth #S, but failed to identify the documentation error for tooth #K and report the finding for this question in the audit tool.	
#8	The Monitor did not have a finding because the Treatment Plan appeared to adequately address the patient's needs. It is possible CSHM's auditor scored this question "no" in error because the note recorded in the cell for this question was a duplicate of the finding for patient #001, question #8.	Chart and x-rays reviewed by the DCQIT in regard to tooth #R. I see a radiolucency in the distal of #R that is consistent with caries in that surface. It does not appear that caries was charted on that surface in the upper odontogram, nor was treatment planned for that tooth on the lower odontogram or the treatment plan. The distal of #R could have been checked when #S was prepped on 4/23/12, but I see no evidence that this was done.
#9	The Tooth Chart showed decay only on the buccal surface of tooth #K and there was no additional narrative to explain the treatment change from a buccal filling to an SSC. The OR Procedures form dated March 8, 2012, showed a diagnosis of mesial occlusal decay; however, the X-rays dated January 10, 2012, do not show mesial decay on tooth #K.	
#10	The Tooth Chart dated January 10, 2012, did not show documentation of mesial decay on tooth #K and there was no evidence of mesial decay on the X-rays dated January 10, 2012, to support the medical necessity for an SSC.	
#26	The patient's social security number was	Social security number was not

Patient #016		
Question	**Monitor's Findings**	**CSHM's Findings**
	not documented on the Health History form dated January 10, 2012.	documented.
#28	There was inadequate follow-up for the "yes" response to "asthma/breathing problems."	
#46	It appeared CSHM's auditor scored this question "n/a" because of the rationale from the VP of Training and Education; however, the Monitor scored the question "no" because there was no evidence to show that a new odontogram was completed and the existing upper odontogram was not updated. Also, the following forms were not included in the requested materials: Point System for Determining Appropriateness of Care Under General Anesthesia form, Consent for Treatment under General Anesthesia, Dictated Operation (or Operative) Note, and Radiographs and Photographs taken in the OR as required by CSHM's policy, titled *Required Documentation for General Anesthesia Cases*, effective June 15, 2011.	Per Vice President (VP), Training and Education. OR doctors and staff were not informed appropriately in regard to OR procedures forms.
#52	The Treatment Plan dated January 10, 2012, showed consent for a buccal filling on tooth #K; however, an SSC was performed on tooth #K in the OR on March 8, 2012. Because the Consent for Treatment under General Anesthesia form was not included in the requested materials the Monitor was unable to confirm that proper consent was obtained for the SSC performed in the OR. The CSHM auditor scored the question "yes" without evidence of documented consent.	

[redacted] Small Smiles Dental Centers of Denver

Patient #017		
Question	**Monitor's Findings**	**CSHM's Findings**
#7	There was treatment planned on the lower odontogram of the Tooth Chart dated November 9, 2011, for teeth #A, #B, #C, #H, #I, and #J without decay/disease documented on the upper odontogram.	
#8	The Monitor's pediatric dentist noted risk of over-treatment because there was no radiographic evidence of decay for teeth #A, #B, #C, #H, #I, and #J on the X-rays dated November 9, 2011.	
#10	There was no radiographic evidence of decay or documentation of decay for teeth #A, #B, #C, #H, #I, and #J on the upper odontogram of the Tooth Chart dated November 9, 2011; therefore, there was no documentation to support the medical necessity for the SSCs performed in the OR. The OR Procedures form dated March 8, 2012, showed that two anterior periapical X-rays and a single bitewing X-ray were taken; however, these X-rays were not included in the requested materials.	
#46	It appeared CSHM's auditor scored this question "n/a" because of the rationale from the VP of Training and Education; however, the Monitor scored the question "no" because there was no evidence to show that a new odontogram was completed and the existing upper odontogram was not updated. Also, the following forms were not included in the requested materials: Point System for Determining Appropriateness of Care Under General Anesthesia form, Consent for Treatment under General Anesthesia, Dictated Operation (or Operative) Note, and Radiographs and Photographs taken in the OR as required by CSHM's policy, titled *Required Documentation for*	Per VP, Training and Education, OR doctors and staff were not informed appropriately in regard to OR procedures forms.

[redacted] Small Smiles Dental Centers of Denver

Patient #017		
Question	**Monitor's Findings**	**CSHM's Findings**
	General Anesthesia Cases, effective June 15, 2011.	
#52	Treatment for teeth #A, #B, #C, #H, #I, and #J was not documented on the Treatment Plan dated November 9, 2011, and the Consent for Treatment under General Anesthesia form was not included in the requested materials; therefore, the Monitor was unable to confirm that proper consent was obtained for all treatment provided in the OR. The CSHM auditor scored the question "yes."	Treatment covered by the Gen Anesthesia consent form.
#69	The Monitor agreed with this finding and noted the lines were drawn right to left and did not extend to the top of the unused boxes labeled "filling," "extraction," and "space maintainer" on the Treatment Plan dated November 9, 2011.	Lines not drawn on all unused lines on the TX Plan dated 11/9/2011

Patient #018		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The upper odontogram of the Tooth Chart dated January 24, 2012, did not document existing teeth.	
#10	Only two anterior occlusal X-rays dated April 9, 2011, were included with the requested materials. The OR Procedures form dated April 12, 2012, showed that two bitewing X-rays were taken; however, these X-rays were not included in the requested materials. Without bitewing X-rays, the Monitor was unable to determine the medical necessity for pulpotomies performed on teeth #B, #I, and #S. CSHM's DCQIT approved the treatment preformed on teeth #B, #I, and #S without requiring the X-rays to support medical necessity for pulpotomies.	

[redacted] Small Smiles Dental Centers of Denver

Patient #018		
Question	**Monitor's Findings**	**CSHM's Findings**
#26	The patient's social security number, school, and grade were not documented on the Health History form dated January 24, 2012; although, the patient was 2 years old, "n/a" was not noted for school and grade.	Social security number and preferred language were not documented. Three questions were not documented.
#46	It appeared CSHM's auditor scored this question "n/a" because of the rationale from the VP of Training and Education; however, the Monitor scored the question "no" because there was no evidence to show that a new odontogram was completed and the existing upper odontogram was not updated. Also, the following forms were not included in the requested materials: Point System for Determining Appropriateness of Care Under General Anesthesia form, Dictated Operation (or Operative) Note, and Radiographs and Photographs taken in the OR as required by CSHM's policy, titled *Required Documentation for General Anesthesia Cases*, effective June 15, 2011.	Per VP, Training and Education. OR doctors and staff were not informed appropriately in regard to OR procedures forms.
#47	This question asks: "Did the chart include documentation as to why a pulpotomy or pulpectomy was performed if decay was not into the dentin per review of the radiograph?" In order to answer this question, X-rays must be available to review; however, the X-rays taken in the OR were not provided and there were no bitewing X-rays available to review. The Monitor scored this question "no" per the Guidelines because the materials provided did not provide sufficient evidence to support the medical necessity for pulpotomies. CSHM's auditor consulted the DCQIT regarding the question in an e-mail dated June 19, 2012, and based on his	Chart and x-rays reviewed by the DCQIT in regard to rationale of pulpotomies for teeth #'s B, I & S. Without BWs it would be difficult to provide definitive proof that pulpotomies were necessary. The patient was not cooperative; photos might not even be helpful. So what we have is the odontogram and trust that the dentist treatment planned appropriately. Without evidence to the contrary, I accept his plan.

Patient #018		
Question	**Monitor's Findings**	**CSHM's Findings**
	response, completed the record review without requiring the X-rays that were taken in the OR and reported no findings.	
#51	The Consent for Treatment under General Anesthesia form did not note the relationship of the individual signing to the patient and there was not a witness signature documented.	General anesthesia consent form did not have question 7 completed.

Patient #019		
Question	**Monitor's Findings**	**CSHM's Findings**
#6	The Monitor's pediatric dentist found radiographically demonstrable mesial decay was not documented on the upper odontogram of the Tooth Chart for teeth #D and #G. Also, all existing teeth were not circled on the upper odontogram.	I see caries on the radiograph, so I consider not charting caries on #D and G to be a documentation error. I see caries on the radiograph, so I consider not charting caries on #D and G to be a documentation error.
#7	CSHM's auditor scored this question "no" with the same findings as question #6. The Monitor's pediatric dentist agreed that the treatment planned for teeth #D and #G on the lower odontogram did not have corresponding decay/disease documented on the upper odontogram.	I see caries on the radiograph, so I consider not charting caries on #D and G to be a documentation error. I see caries on the radiograph, so I consider not charting caries on #D and G to be a documentation error.
#26	The patient's social security number and language preference were not documented on the Health History form dated January 11, 2012.	Social security number and preferred language were not documented.
#46	It appeared CSHM's auditor scored this question "n/a" because of the rationale from the VP of Training and Education; however, the Monitor scored the question "no" because there was no evidence to show that a new odontogram was completed and the existing upper	Per VP, Training and Education. OR doctors and staff were not informed appropriately in regard to OR procedures forms.

[redacted] Small Smiles Dental Centers of Denver

Patient #019		
Question	**Monitor's Findings**	**CSHM's Findings**
	odontogram was not updated. Also, the following forms were not included in the requested materials: Point System for Determining Appropriateness of Care Under General Anesthesia form, Dictated Operation (or Operative) Note, and Radiographs and Photographs taken in the OR as required by CSHM's policy, titled *Required Documentation for General Anesthesia Cases*, effective June 15, 2011.	
#51	The Consent for Treatment under General Anesthesia form did not note the relationship of the individual signing to the patient and there was not a witness signature documented.	General anesthesia consent form did not have question 7 completed.
#53	The "Crown Options" box was not completed correctly on the Treatment Plan dated January 11, 2012.	Crown type was not initialed in the Crown Options box.
#55	The Hygiene form dated January 11, 2012, did not document the occlusal X-ray that was taken on that date of service. This X-ray was included with the requested materials.	
#68	The patient's weight was recorded as "3" on the OR Procedures form dated March 8, 2012, and the error was not corrected.	.

Patient #020		
Question	**Monitor's Findings**	**CSHM's Findings**
#1	The Monitor was unable to determine the diagnostic quality of the panoramic X-ray taken during the hygiene appointment on August 23, 2011, because the panoramic X-ray was not included in the requested materials. CSHM's auditor scored the question "yes" but only reviewed the bitewing X-rays dated August 23, 2011, and did not request the missing	

Patient #020		
Question	**Monitor's Findings**	**CSHM's Findings**
	panoramic X-ray.	
#6	Decay was not documented on the upper odontogram of the Tooth Chart for teeth #3, #14, #19, and #30. According to the Guidelines for scoring this question, decay must be documented on the upper odontogram of the Tooth Chart and the Tooth Chart should have been updated to reflect the new disease diagnosed during treatment, or a new Tooth Chart should have been completed. The Monitor was also provided an incomplete copy of the Tooth Chart which did not show the sections for radiographic rationale and findings. CSHM did not report this finding because of the consultation response from the DCQIT. In an e-mail dated June 20, 2012, the DCQIT noted that these teeth were initially planned for sealants and did not require any form of documentation on the upper odontogram. He then stated: "However, during the GA procedure the decision was made to place composite fillings. Since this was a GA case, no additional treatment plan is required."	
#10	The Monitor's pediatric dentist noted the occlusal lingual surfaces of teeth #3 and #14, the occlusal buccal surfaces of tooth #19, and the occlusal surface of tooth #30 did not have decay documented on the upper odontogram of the Tooth Chart dated August 23, 2011, and there was not radiographic evidence of decay; therefore, there was no documentation to support the medical necessity for the fillings performed.	
#26	The question "is the patient allergic to anything else?" was answered as "yes" and "no." The error was not properly corrected thus the Monitor was unable to	One question did not have yes or no response. (both marked and then marked out.)

[redacted] Small Smiles Dental Centers of Denver

Patient #020		
Question	**Monitor's Findings**	**CSHM's Findings**
	determine which response was accurate.	
#27	There was no follow-up documentation to the patient's "yes" response to the question on speech/hearing problems on the Health History form dated August 23, 2011.	No response for Speech/Hearing Problems
#28	Since there was no additional narrative in regard to the patient's speech/hearing problems, the follow-up was inadequate.	Further explanation is needed for Speech/Hearing Problems.
#46	It appeared CSHM's auditor scored this question "n/a" because of the rationale from the VP of Training and Education; however, the Monitor scored the question "no" because there was no evidence to show that a new odontogram was completed and the existing upper odontogram was not updated. Also, the following forms were not included in the requested materials: Point System for Determining Appropriateness of Care Under General Anesthesia form, Dictated Operation (or Operative) Note, and Radiographs and Photographs taken in the OR as required by CSHM's policy, titled *Required Documentation for General Anesthesia Cases*, effective June 15, 2011.	Per VP, Training and Education. OR doctors and staff were not informed appropriately in regard to OR procedures forms
#51	The Consent for Treatment under General Anesthesia form did not note the relationship of the individual signing to the patient and there was not a witness signature documented.	General anesthesia consent form did not have question 7 completed.
#53	The "Crown Options" box was not completed correctly on the Treatment Plan dated January 20, 2012.	Crown type was not initialed in the Crown Options box.
#61	The individual completing the Acknowledgment form did not indicate their relationship to the patient.	Parent/guardian relationship to patient was not documented.
#68	The error on the Health History form	Error on Health History dated

Patient #020		
Question	**Monitor's Findings**	**CSHM's Findings**
	related to "other patient allergies" was not properly corrected.	8/23/2011 did not have error notation.
#70	The Hygiene form dated August 23, 2011, documented topical application of bubble-gum varnish, but failed to note "brush on." However, the audit question asks, "If a patient received a prophylaxis, did they also receive fluoride?" Therefore, the Monitor scored the question "yes" per the Guidelines because the documentation showed the patient received a fluoride treatment following a prophylaxis.	Fluoride delivery method was not documented.
#71	The lower odontogram of the Tooth Chart dated August 23, 2011, did not document the extraction of teeth #E, #K, and #Q.	Completed extraction for tooth #E was not charted on the lower odontogram.

Summary

Below is a summary of the Monitor's findings from the record review:

Consents and Acknowledgments

Four records (patients #007, #018, #019, and #020) had findings related to the Acknowledgment form and the Consent for Treatment under General Anesthesia form.

- Patient #007 – The Acknowledgment form was not included in the requested materials.
- Patients #018, #019, and #020 – CSHM's auditor noted "general anesthesia consent form did not have question #7 completed" and the Monitor found the individual signing the Consent for Treatment under General Anesthesia form did not document their relationship to the patient, and there was no witness signature.
- Patients #016 and #17 – The Consent for Treatment under General Anesthesia form was not included in the requested materials; therefore, the Monitor was unable to confirm that proper consent was obtained for all treatment provided in the OR. CSHM did not require this form to complete their review of these records and reported no findings with respect to consent for treatment.

Health History

Twelve records (patients #002, #005, #006, #008, #009, #013, #014, #016, #017, #018, #019, and #020) had findings related to the Health History form. Eleven of the twelve

records (patients #002, #006, #008, # 009, #013, #014, #016, #017, #018, #019, and #020) had incomplete documentation related to varying patient demographics at the top of the Health History form. One record (patient #020) showed an error in regard to the question "is the patient allergic to anything else" with both "yes" and "no" selected. Also, four records (patients #005, #008, #016, and #020) did not show documentation of adequate follow-up for reported health conditions.

Tooth Chart

Sixteen records (patients #001, #003, #004, #005, #006, #007, #008, #010, #011, #013, #014, #016, #017, #018, #019, and #020) had insufficient documentation related to existing conditions, decay, restorations, and completed treatment on the designated odontogram of the Tooth Chart. Following is a summary of each:

- Patients #001, #010, and #019, – There was incomplete documentation of decay. In addition, for patient #001, there was an insufficient description of the condition of three teeth, and incomplete documentation of existing lower anterior teeth. For patient #010, the upper odontogram did not document existing pulpotomies on teeth #L and #S, and a failing pulpotomy on tooth #S. The upper odontogram for patient #019 did not document existing teeth.
- Patient #003 – The failing pulpotomies on teeth #I, #L, and #S were not documented on the Tooth Chart.
- Patients #004, #005, #007, #008, #013, and #018 – The upper odontogram for these patients had incomplete documentation related to existing teeth. In addition, for patient #004, the existing fillings on teeth #K and #R, the missing filling on tooth #I, and the pulpotomy on tooth #T were not documented. Also, for patient #005, the decay on tooth #11 was not clearly documented; for patient #007, there was insufficient documentation of the remineralization plan for tooth #13; and for patient #013, the crown on tooth #G was not documented.
- Patient #006 – There was an existing filling documented for tooth #5 which was not present, and the decay on tooth #29 was not documented.
- Patients #011 and #014 – No documentation indicated the panoramic X-rays were reviewed and interpreted. In addition, for patient #011, the existing teeth were not circled on the upper odontogram.
- Patient #016 – The mesial decay on tooth #K and the existing filling on tooth #S were not documented on the upper odontogram.
- Patient #017 – The lower odontogram had treatment planned on teeth #A, #B, #C, #H, #I, and #J without decay documented on the upper odontogram.
- Patient #020 – The decay on teeth #3, #14, #19, and #30 was not documented on the upper odontogram and the lower odontogram did not have documentation of the extraction of teeth #E, #K, and #Q. The copy of the Tooth Chart included in the requested materials was incomplete and did not contain the sections related to radiographic findings.

Chief Complaint

One record (patient #006) did not show the chief complaint was appropriately addressed. The patient's chief complaint was documented as "molar hurts"; however, there was no evidence noting assessment of the symptomatic tooth or periapical X-ray taken to evaluate for the possibility of an abscess to support the need for a referral to a root canal specialist.

X-rays

Four records (patients #004, #007, #012, and #020) had findings related to X-rays. The following provides a summary of each:

- Two records (patients #004 and #007) contained panoramic X-rays that were non-diagnostic because they were dark with poor contrast. One record (patient #012) contained a non-diagnostic anterior X-ray and two premolar bitewing X-rays. The Monitor's pediatric dentist noted the mandibular anterior X-ray was non-diagnostic because it was too dark to evaluate the fracture of tooth #23 and the apices of the teeth were not visible. Also, the two pre-molar bitewing X-rays were non-diagnostic because the distal surface of the canines and mesial of most first premolars were not visible on either film.
- The Monitor was unable to evaluate the diagnostic quality of the panoramic X-ray related to the audited date of service for patient #020 because it was not included with the requested materials.

Hygiene Procedures Form

Five records (patients #006, #009, #012, #015, and #019) had errors in documentation on the Hygiene form. Following is a summary of each:

- Patients #006, #009, and #015 – Left to right lines were not drawn through the unused sections of the Hygiene form as required.
- Patient #012 – The Hygiene form had an error related to the patient's date of birth that was not properly corrected.
- Patient #019 – There was no documentation on the Hygiene form noting an occlusal X-ray was taken as billed on the Account History Report.

Op Sheet

Five records (patients #001, #007, #010, #012, and #013) had incomplete documentation on the Op Sheet. Following is a summary of each:

- Patient #001 – Neither the "yes" nor "no" response was selected for the statement on complications.
- Patients #007, #010, #012, and #013 – The existing restorations were not documented on the PRSA line of the Op Sheet. Also, for patient #010, the Op Sheet contained a corrected error without documentation of the date and for

patient #012, the left to right lines were not fully drawn across the unused "sealant" section.

OR Procedures Form

For one record (patient #019) there was a documentation error on the OR Procedures form related to the patient's weight which was not corrected.

Treatment under General Anesthesia

For five records (patients #016, #017, #018, #019, and #020), there was incomplete documentation related to treatment in the OR setting. The Point System for Determining Appropriateness of Care under General Anesthesia form, Dictated Operation (or Operative) Note, and Radiographs and Photographs taken in the OR were not included in the requested materials for these patients. Also, for patients #016 and #017, the Consent for Treatment under General Anesthesia form was not a part of the record. CSHM's auditor noted the VP, Training and Education, indicated the Clinic staff were not informed appropriately in regard to OR forms; however, the Monitor noted the missing forms are required by CSHM's policy entitled *Required Documentation for General Anesthesia Cases*. The Monitor's pediatric dentist was concerned that without the appropriate forms there was no documented rationale for the necessity of general anesthesia for these patients. Also, CSHM completed the review of OR records without requiring the OR odontogram, X-rays taken in the OR, or other documentation relevant to the audited date of service.

Treatment Plan

In one record (patient #002), the Monitor was unable to determine if all disease documented on the Tooth Chart had been adequately addressed because there was no updated Treatment Plan and no evidence to show CSHM's auditor contacted the Clinic to determine if there was an updated Treatment Plan. The Monitor's pediatric dentist noted radiographically demonstrable mesial decay on tooth #K that was recorded on the upper odontogram of the Tooth Chart but had not received treatment.

Ten records (patients #002, #005, #006, #007, #008, #010, #013, #017, #019, and #020) did not contain accurate documentation related to the Treatment Plan form. The following provides a summary of each:

- Patients #002, #019 and #020 – The "Crown" selection box on the Treatment Plan was documented as "n/a"; however the patient's treatment did include crowns.
- Patients #005, #006, #007, #008, #010, #013 – Lines were not fully drawn across the unused sections of the Treatment Plan. Also, for patient #007, Dentist #3 did not sign the Treatment Plan dated March 20, 2012.
- Patient #017 – The Treatment Plan failed to document certain teeth which received treatment in the OR setting. CSHM's auditor scored this question "yes" noting "treatment covered by the Gen Anesthesia consent form"; however, the

Monitor noted the Consent for Treatment under General Anesthesia form was not included in the requested materials for this patient.

Under-Treatment

Two records (patients #001 and #006) showed planned treatment did not address radiographically demonstrable decay and showed instances of under-treatment with respect to care provided in the Clinic. CSHM's auditor identified an instance of under-treatment for patient #001 and requested the DCQIT review. Although the DCQIT recommended the Clinic review the X-ray for patient #001 and recall the patient for examination, there was no evidence to show CSHM ensured the Clinic completed the recommended follow-up. CSHM's auditor failed to identify any treatment concerns in regard to patient #006.

- Patient #001 – The Monitor's pediatric dentist agreed with the DCQIT's findings noting radiographic evidence of decay on the distal surface of tooth #R which was not planned for treatment.
- Patient #006 – The Treatment Plan did not address the radiographically demonstrable distal decay on tooth #29.

Over-Treatment

One record (patient #017) showed risk of over-treatment because there was no radiographic evidence or documentation of decay on the Tooth Chart for teeth #A, #B, #C, #H, #I, and #J, which received SSCs in the OR.

Medical Necessity

Five records (patients #001, #016, #017, #018, and #020) did not contain documentation supporting the medical necessity for the planned treatment. The Monitor applied the criteria defined in the Guidelines when determining these findings. The details related to each finding follow:

- Patient #001 – There was no radiographic evidence or documentation of decay on the upper odontogram on the occlusal buccal surface of tooth #30; therefore, the documentation did not support the medical necessity for the filling. Because of this finding, the audited Dentist (Dentist #1) was penalized and the Dentist (Dentist #2) who developed the Treatment Plan should be penalized per question #73 in the Guidelines. The Monitor will defer to CSHM to determine the proper point deduction for Dentist #2 because the Guidelines did not provide clear criteria for the discretionary point deduction process.
- Patient #016 – There was no radiographic evidence or documentation of decay on the upper odontogram for the mesial surface of tooth #K; therefore, the documentation did not support the medical necessity for the SSC performed in the OR.
- Patient #017 – There was no radiographic evidence or documentation of decay on the upper odontogram of the Tooth Chart for teeth #A, #B, #C, #H, #I, and #J;

therefore, the documentation did not support the medical necessity for the SSCs performed on these teeth.

- Patient #018 – CSHM's auditor consulted the DCQIT regarding the medical necessity for pulpotomies on teeth #B, #I, and #S. The DCQIT provided the following response to the auditor: "so what we have is the odontogram and trust that the dentist treatment planned appropriately..." The Monitor's pediatric dentist concluded that posterior X-rays were required to evaluate the depth of decay in order to determine the medical necessity for the pulpotomies performed in the OR. Since the X-rays taken in the OR were not provided or required for review of this record, the Monitor's pediatric dentist found the documentation provided did not support the medical necessity for the pulpotomies performed on teeth #B, #I, and #S.
- Patient #020 – There was no radiographic evidence or documentation of decay on the upper odontogram for decay on teeth #3, #14, #19, and #30; therefore, the documentation did not support the medical necessity for the fillings performed in the OR. CSHM's auditor scored this question "yes" after the DCQIT reviewed noting the teeth were "...planned to receive sealants, and I'm not sure that we require any charting for sealants on the upper odontogram. However during the GA procedures the decision was made to place composite fillings. Since this was a GA case, no additional treatment plan is required...."

Account History Report

The Account History Report for three records (patients #004, #007, and #012) showed billing for X-rays that were non-diagnostic. For one record (patient #012), the pulpotomy on tooth #T was completed, but not billed to Medicaid according to the Account History Report. CSHM addressed all of these findings with the exception of the non-diagnostic X-rays found for patient #012.

Other Scoring Differences

Four records (patients #001, #004, #008, #011, and #013) showed scoring differences between the Monitor and CSHM's auditor.

- In records for patients #001, #004, and #008, CSHM's auditor scored question #67 "no" because the number of staff initials documented on the Hygiene form did not correspond to the number of staff signatures. The Monitor scored the question "yes" because the assistant who took X-rays was not required to provide a signature at the bottom of the form and signed the X-ray section as directed in the Chart Documentation Guide.
- Regarding patient #011, CSHM's auditor scored questions #51 and #68 "no" because the witness section was not completed and an error was not properly corrected on the Authorization form. The Monitor noted the Authorization form was completed outside of the Clinic where a Clinic staff member would not have been present to witness or ensure proper correction of an error; therefore, the

Monitor scored both questions #51 and #68 as "yes" and did not penalize the Clinic.

- For patient #013, CSHM's auditor scored question #65 as "no" because post-operative instructions were not documented; however, the Monitor found there was documentation indicating both written and oral instructions were provided.

Observations

Upon review of the 20 records, the Monitor had the following observations:

For record #001, the X-rays provided to the Monitor were dated May 4, 2012; however, the Account History Report and Hygiene form show the X-rays were taken on April 16, 2012. The CSHM auditor did not have this finding and the DCQIT's consultation e-mail indicated he reviewed the original X-rays dated April 16, 2012, because the duplicates were too dark. The Monitor has specifically requested that CSHM provide the exact materials as reviewed by the auditor to perform a fair assessment of CSHM's chart audit process, which were not provided.

Documentation of decay on the upper odontogram was not always clearly marked in red ink, particularly noted for records #002, #004, #005, #008, #010, #015, and #016. The Monitor was unable to determine if this was a result of the quality of the copied Tooth Chart or the actual documentation by Clinic staff members. It is essential that the patient's pathology is clearly documented to avoid an error during patient treatment and to substantiate the medical necessity of treatment rendered for the auditing process.

There was no documentation of nitrous oxide/oxygen analgesia use for 15 of the 20 audited records. The other five patients were treated in the OR setting. The Progress Note dated February 16, 2012, included with the requested materials for record #019 noted "...our N2O is not currently working at this moment" and this patient was referred to the Aurora Center where nitrous oxide was available. The Monitor's pediatric dentist is concerned that nitrous oxide/oxygen analgesia is not being utilized when it could be beneficial for patient comfort during operative treatment.

For patients #016, #017, #018, #019, and #020, local anesthesia was administered in the OR setting, but the OR Procedures form used to document treatment does not require notation of the DCPW. The Monitor was not provided any other documentation that included the DCPW.

Records #016, #017, and #018 documented the use of sodium hypochlorite for the pulpotomies performed in the OR setting. According to CSHM's *Clinical Policies and Guidelines for CSHM Associated Dental Centers*, the long-term clinically successful medicaments for pulpotomies are: Buckley's Solution of formo cresol and ferric sulfate with electro surgery, gluteraldehyde, calcium hydroxide, and mineral trioxide aggregate (MTA) noted as other potential options. CSHM's policy does not approve the use of sodium hypochlorite and the use of this medicament for pulpotomies in primary teeth will likely affect the long-term prognosis for the teeth involved. This finding was not recognized by CSHM.

CSHM's audit question #46 asks: "For any patients treated under general anesthesia, does the permanent medical record include 1) dictated notes, 2) Point System Form, 3) an odontogram completed in the operating room, 4) the consent for treatment under general anesthesia form, and 5) the OR form?" The Guidelines state "yes" is given when "the record includes the dictated notes, the point system form, an odontogram completed in the operating room, the consent for treatment under general anesthesia form, and the OR form." However, the criteria used for "no" is defined as "the record does not include an odontogram completed in the operating room. NOTE: Auditor should place a comment regarding any other missing forms with respect to patients treated under general anesthesia, but only a missing odontogram causes a "no" for medical necessity when the need for any of the treatment provided is not visible on the radiograph taken after the cleaning in the operatory room." Therefore, the criteria given for the "no" response does not require all forms to be present and does not penalize the Clinic for non-compliance with CSHM's *Required Documentation for General Anesthesia Cases* policy, effective June 15, 2011.

Recommendations

The following recommendations are based on the Monitor's findings from the review of the 20 visit records:

- Ensure staff members verify an Acknowledgement form is completed correctly for each patient and stored in the patient's record.
- Ensure staff members verify the Consent for Treatment under General Anesthesia form is completed correctly.
- Ensure staff members verify all questions are answered on the Health History form.
- Ensure staff members provide adequate and appropriate follow-up documentation for all "yes" responses on the Health History form.
- Ensure staff members correctly document existing conditions, pathology, and completed treatment on the designated odontogram of the Tooth Chart as described in the *Chart Documentation Guide*.
- Ensure the patient's chief complaint is properly addressed by staff members and documentation clearly shows assessment and findings.
- Ensure X-rays are of diagnostic quality.
- Ensure staff members are documenting all procedures on the hygiene form, properly correcting errors, and drawing lines through all unused sections.
- Ensure accurate completion of the Op Sheet including documentation related to PRSA, as directed in the *Chart Documentation Guide*.
- Ensure CSHM's auditors confirm that all documentation and X-rays pertaining to the audited date of service is received from the Clinic in order to perform an accurate record review.

- Ensure the dentists and staff members are compliant with CSHM's policy entitled *Required Documentation for General Anesthesia Cases* and understand the documentation requirements for patients who are treated in an OR setting.
- Perform a root cause analysis to determine why the record for patient #002 failed to include an updated Treatment Plan and why this was not requested by the CSHM auditor.
- Ensure staff members obtain initials of the parent/guardian indicating preference for crown type on the Treatment Plan when indicated.
- Ensure the accurate completion of the Treatment Plan including lines drawn completely across unused sections.
- Ensure any documentation errors are corrected properly.
- Ensure recommended follow-up was completed for patient #001.
- Ensure the Chief Dental Officer (CDO) or DCQIT review the record for patient #006 to determine risk of under-treatment and need for follow-up.
- Ensure medical necessity for treatment provided is evident on X-rays and/or sufficiently documented on the Tooth Chart.
- Ensure CSHM's *Guidelines* define the criteria used for question #73 to determine number of points deducted where a provider has not adequately addressed the patient's needs in the Treatment Plan.
- Review the Monitor's findings related to question #73 to determine the proper point deduction for the dentist who developed the Treatment Plan.
- Ensure patient #016 is monitored to ensure the success of the treatment performed on teeth # E, #F, #L, #M, and #R.
- Ensure patient #017 is monitored to ensure the success of the treatment performed on teeth #D, #E, #F, and #G.
- Clarify expectations related to documentation requirements when the Acknowledgment form is completed and notarized outside the Clinic.
- Ensure the Monitor is provided all documentation and X-rays of the same quality as provided to the CSHM auditor and/or the DCQIT.
- Ensure staff members provide clear documentation of decay in red ink on the upper odontogram of the Tooth Chart.
- Ensure copies of documents provided for the audit process are of good quality.
- Conduct a root cause analysis to determine why nitrous oxide/oxygen analgesia is not being used in the Clinic.
- Revise the OR Procedures form to include documentation of the DCPW in order to ensure the maximum dose of local anesthesia is calculated prior to administration in the OR setting.
- Perform a root cause analysis to determine why Dentist #4 opted to use sodium hypochlorite as a medicament for pulpotomies performed for patients #016, #017, and #018.

- Conduct a quality of care review to evaluate the success of pulpotomies performed with the use of sodium hypochlorite.
- Perform a root cause analysis to determine why CSHM's auditor did not consult the DCQIT regarding the use of sodium hypochlorite for pulpotomies or recognize that this agent is not listed as an acceptable medicament for pulpotomies per CSHM guidelines.
- Perform a root cause analysis to determine why OR cases were reviewed without the required documentation and X-rays from the OR.
- Ensure CSHM auditors perform a complete record review and require all documentation and X-rays relevant to the audited date of service be provided by the Clinic.

EXHIBIT 57

Church Street Health Management

[redacted]
SVP and Chief Compliance Officer
(Telephone [redacted]
(Facsimile) [redacted]

CONFIDENTIAL
FOIL Exempt
FOIA Exempt

May 22, 2012

[redacted]
Office of Counsel to Inspector General
DHHS Office of Inspector General
Cohen Building – Room 5527
330 Independence Ave, SW
Washington, D.C. 20201

[redacted]
Office of Counsel to Inspector General
DHHS Office of Inspector General
Cohen Building – Room 5527
330 Independence Ave, SW
Washington, D.C. 20201

[redacted]
Office of Counsel to Inspector General
DHHS Office of Inspector General
Cohen Building – Room 5527
330 Independence Ave, SW
Washington, D.C. 20201

[redacted]
Vice President for Legal Affairs
[redacted]

RE: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill

Dear [redacted], [redacted], [redacted], and [redacted]:

This letter is to notify you of a Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill ("Oxon Hill Center"). Pursuant to Section III (I)(2)(b)(i) of the Church Street Health Management ("CSHM") Corporate Integrity Agreement with the OIG, CSHM is required to "notify the OIG, in writing, within 30 days after making the determination that the Reportable Event exists." Pursuant to Section III (I)(2)(a)(i) of the CIA, a "Substantial Overpayment" is considered to be a Reportable Event.

CSHM has defined a "Substantial Overpayment" as an "overpayment of more than $15,000 resulting from a single billing or coding error in one Center and/or several related billing or coding errors in one or more Centers."

Description of Reportable Event
On May 3, 2012, the OIG directed CSHM to conduct a claims review of a statistically valid random sample of claims for each dentist who has practiced at Small Smiles Dental Centers of Oxon Hill ("Oxon Hill") since the Effective Date of the CIA. This review was to be completed no later than May 22, 2012. This letter is to report the resulting Substantial Overpayment calculated as part of that claims review in accordance with the provisions of the CIA.

The CSHM statistically valid random sample of claims for each dentist who has practiced at the Oxon Hill center since the effective date of the CIA was selected utilizing the random number generator within RAT-STAT software. A statistically valid random sample of all service codes billed at the Oxon Hill Center since the inception of the CIA resulted in a review of 187 individual service codes. After quantifying the number of records to be reviewed, CSHM then determined the allocable number of procedures performed by each dentist and identified the sample size per provider based upon the percentage of the individual dentist's revenue to total Oxon Hill revenue since the inception of the CIA. This methodology did result in 3 providers who had performed patient care services in the Oxon Hill Center who were not included in the review since their respective percent of revenue compared to Oxon Hill total revenue was 0%. These three providers collectively treated only 85 patients since the inception of the CIA.

The review was conducted by CSHM's Chief Dental Officer, Director of Clinical Quality Initiatives and Education, EVP Operations, both SVPs of Operations, the Director, Clinical Audit Review and a CSHM Clinical Auditor. On-site record reviews were conducted on May 9-11, 2012 and May 14-15, 2012. CSHM calibrated reviewers by utilizing a standardized audit template and workpapers were maintained. CSHM believes our methodology provided an appropriate population and representative sample to review and evaluate the propriety of claims submitted for reimbursement.

The error rate from the statistically valid random sample of 187 records was 9.64%. This error rate has been applied to the revenue at the Oxon Hill center from the inception of the CIA through May 3, 2012, resulting in a total overpayment of $852,492.74. CSHM finalized the error rate, completed quantification of the overpayment, and determined that the Reportable Event existed on May 22, 2012. We will allocate the Substantial Overpayment among payors, notify the payors and refund the overpayment within 30 days in accordance with the terms of the CIA. CSHM will provide an updated letter to the OIG that includes:

- the payor's name, address and contact person to whom the overpayment was sent

- the date of the check and identification number by which the overpayment was repaid
- the Overpayment Refund forms

Corrective Actions and Prevention of Future Recurrence

The primary trends giving rise to the overpayment were:

- Lack of rationale provided for supplemental radiographs
- Instances of non-diagnostic radiographs
- Caries not visible on radiographs or charted on the upper odontogram to support the medical necessity of the services provided
- Missing radiographs
- Poor quality restoration (overhang)
- Restoration replacement in an inordinately short amount of time

CSHM representatives were onsite at the Oxon Hill Center from May 9-11, 2012 to implement numerous corrective actions intended to prevent recurrence of the conduct giving rise to the overpayment and other quality of care matters. The Center was closed on May 9 to conduct intensive training, including hands-on training, and separate training sessions for dentists, dental assistants/hygienists, and front office staff. On Thursday, May 10, the patient schedule was restricted to 50% of normal volume to allow additional training and monitoring. The Center returned to its full schedule on Friday, May 11, with the continued oversight by the CSHM team.

Dr. [redacted] Chief Dental Officer, and Dr. [redacted], Director of Clinical Quality Initiatives and Education led a training session with the entire staff on clinical quality matters. This training covered all aspects of patient care, focusing heavily on the areas of concern identified in the Independent Monitor's April 20, 2012 Report, and the obligations of the CIA. The criticality of documenting medical necessity, including the rationale for supplemental radiographs, was trained in several different manners and heavily emphasized. Proper documentation of patient charts and dental records, specifically the documentation of decay on the upper odontogram to support the medical necessity of services provided, was covered in great detail. All Dental Assistants and Hygienists were retrained with respect to proper techniques for taking radiographs to ensure radiographs are diagnostic.

CSHM conducted a training module for all staff detailing legal sanctions for violating federal health care program requirements. Further, staff was trained once more with respect to the personal obligation of each individual involved in the delivery of items or services at CSHM and CSHM facilities, or involved in the monitoring of clinical quality at CSHM facilities, to know the applicable legal requirements, CSHM's policies and procedures, and professionally recognized standards of health care. As the training was held in the lobby of the center, butcher paper was used to cover all windows to avoid distraction. The butcher paper was then used for an interactive activity to stress this personal obligation of each individual. Three separate

windows were used with "legal requirements" written on one window, "CSHM policies and procedures" written on a second window and "professionally recognized standards of care" written on the third window. Staff was asked to write on each window something that they had learned during the training with respect to each specific area. Finally, on the doors of the center was written "I am personally responsible for"; staff was asked to write on the door something that they are personally responsible for and sign their name. The thought was conveyed to the staff that although the butcher paper would come down when the center reopened, our hope was that each day as each staff member comes and goes through those doors their personal obligation would be at the forefront of their minds.

Examples of proper and improper patient care were discussed with all staff by the Chief Dental Officer and Chief Compliance Officer. Additionally, Dr[redacted] presented a session on Medical Necessity-Chart Documentation on May 21, 2012.

Dr. [redacted] will return to the center the week of June 11, 2012 to continue observing care and utilize the records from the record review as case studies to retrain dentists with respect to overhangs and placing quality restorations. During the onsite visit May 9-11, as Dr. [redacted] observed treatment provided in the Center he trained Dr. [redacted] (Oxon Hill's Lead Dentist) on his techniques for observing care, including utilization of observation templates. Dr. [redacted] did not treat many patients during our visit in order to work as closely as possible with Dr. [redacted] Dr. [redacted] and Dr. [redacted]r agreed that Dr. [redacted] would observe patient care for two (2) days per week until the week of June 11, 2012. At that time, Dr. [redacted] will re-evaluate the monitoring plan with Dr. [redacted] CSHM will also continue to monitor the Oxon Hill Center through quarterly chart audit reviews and outlier analysis.

CSHM has revised its processes and procedures for onsite reviews in an effort to ensure a thorough assessment is made with respect to all aspects of patient care. CSHM's Chief Dental Officer and Director of Clinical Quality Initiatives and Education have developed standardized observation review templates (for both hygiene and operatory procedures) for use by the Chief Dental Officer and other clinicians while observing care during site visits. Additionally, clinical interview templates have been created to consistently evaluate and document the staff's knowledge of CSHM clinical policies. Record review templates have been created to ensure that all clinical reviewers follow a consistent methodology for identifying medically unnecessary services or quality of care trends. CSHM also anticipates that the Chief Dental Officer will attend a site visit with the Monitor to observe the Monitor's techniques for observations and record reviews during on-site reviews.

CSHM is also in the process of recruiting Regional Dentists (Regional Dental Directors, or "RDD's") who will conduct at least one onsite review each month to a CSHM facility to evaluate and ensure compliance with all applicable Federal health care program requirements, state dental

board requirements and the obligations of the CIA. CSHM believes that the addition of RDD's will assist in the prompt identification of medically unnecessary services and/or quality of care trends that may need to be addressed and rectified.

Other

To the best of my knowledge, there are no legal or Federal health care program authorities implicated. Certain Federal health care program beneficiaries may have received medically unnecessary services or substandard care.

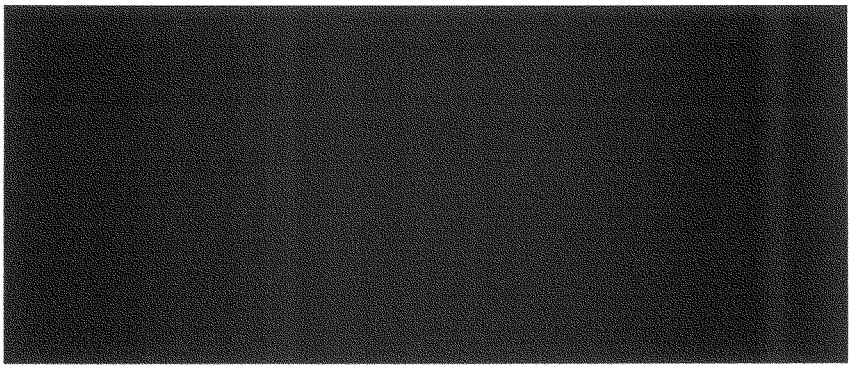
CSHM deeply regrets our failure to adequately oversee the Oxon Hill Center and prevent the conduct causing this substantial overpayment. CSHM will monitor the quality of care closely going forward. If you have any questions or would like additional information, please do not hesitate to contact CSHM.

Respectfully Submitted,

Chief Compliance Officer

Cc: CSHM Board of Directors
CSHM Compliance Committee

EXHIBIT 58



From: [redacted] (OIG/IO) [mailto[redacted]]
Sent: Thursday, March 07, 2013 11:22 AM
To: Law, Christopher (Finance)
Cc: Smith, Erika (Judiciary-Rep)
Subject: RE: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill

Hi Chris,

Per your email below, please find attached the requested document.

You have also separately requested a status update on CSHM's compliance with the March 14, 2012 CIA amendments:

With regard to the March 14, 2012 amendment to the CIA, CSHM satisfied its obligations to implement the Compliance Program Onsite Review requirements, Quality Improvement Initiative requirements, Referral Process requirements and Certifying Employee Certification requirements (items 1 through 4 of the March 14, 2012 amendment). With regard to the Pulp-to-Crown Medical Necessity Review requirement (item 5 of the March 14, 2012 amendment), the OIG has directed CSHM to conduct a new and more expansive review due, in part, to the change in ownership that occurred at CSHM in June 2012. When the review is completed, the results of CSHM's review will be evaluated by the Independent Monitor under the Validation Review as described in the March 14, 2012 amendment.

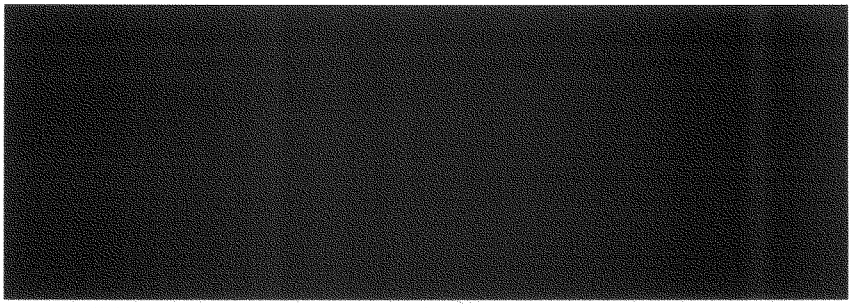
Don't hesitate to let me know if you have any questions.

Regards,
[redacted]

From: Law, Christopher (Finance) [redacted]
Sent: Thursday, March 07, 2013 11:16 AM
To: [redacted] (OIG/IO)
Cc: Smith, Erika (Judiciary-Rep)
Subject: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill

On behalf of Chairman Baucus, I am requesting that you provide my office and Senator Grassley a copy of the May 22, 2012 document "Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill." Thanks.

EXHIBIT 59



From: [redacted] (OIG/IO) [mailto[redacted]]
Sent: Thursday, March 07, 2013 12:56 PM
To: Smith, Erika (Judiciary-Rep); Law, Christopher (Finance)
Subject: RE: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill

Yes

From: Smith, Erika (Judiciary-Rep) [[redacted]]
Sent: Thursday, March 07, 2013 12:23 PM
To: [redacted] (OIG/IO); Law, Christopher (Finance)
Subject: RE: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill

[redacted] –

What about the regional dentists? Has CSHM fulfilled hiring those positions to date??

Thanks!

Erika Smith
Senior Investigator, Republican Staff
Senate Judiciary Committee
[redacted]

From: [redacted] (OIG/IO) [redacted]
Sent: Thursday, March 07, 2013 11:22 AM
To: Law, Christopher (Finance)
Cc: Smith, Erika (Judiciary-Rep)
Subject: RE: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill

Hi Chris,

Per your email below, please find attached the requested document.

You have also separately requested a status update on CSHM's compliance with the March

14, 2012 CIA amendments:

With regard to the March 14, 2012 amendment to the CIA, CSHM satisfied its obligations to implement the Compliance Program Onsite Review requirements, Quality Improvement Initiative requirements, Referral Process requirements and Certifying Employee Certification requirements (items 1 through 4 of the March 14, 2012 amendment). With regard to the Pulp-to-Crown Medical Necessity Review requirement (item 5 of the March 14, 2012 amendment), the OIG has directed CSHM to conduct a new and more expansive review due, in part, to the change in ownership that occurred at CSHM in June 2012. When the review is completed, the results of CSHM's review will be evaluated by the Independent Monitor under the Validation Review as described in the March 14, 2012 amendment.

Don't hesitate to let me know if you have any questions.

Regards,
[redacted]

From: Law, Christopher (Finance) [redacted]
Sent: Thursday, March 07, 2013 11:16 AM
To: [redacted] (OIG/IO)
Cc: Smith, Erika (Judiciary-Rep)
Subject: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill

On behalf of Chairman Baucus, I am requesting that you provide my office and Senator Grassley a copy of the May 22, 2012 document "Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill." Thanks.

EXHIBIT 60

United States Government Accountability Office

GAO

Report to Congressional Committees

November 2010

ORAL HEALTH

Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns

GAO-11-96

GAO
Accountability • Integrity • Reliability

Highlights

Highlights of GAO-11-96, a report to congressional committees

November 2010

ORAL HEALTH

Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns

Why GAO Did This Study

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required GAO to study children's access to dental care. GAO assessed (1) the extent to which dentists participate in Medicaid and the Children's Health Insurance Program (CHIP) and federal efforts to help families find participating dentists; (2) data on access for Medicaid and CHIP children in different states and in managed care; (3) federal efforts to improve access in underserved areas; and (4) how states and other countries have used mid-level dental providers to improve children's access. To do this, GAO (1) examined state reported dentist participation and the Department of Health and Human Services's (HHS) Insure Kids Now Web site for all 50 states and the District of Columbia and called a non-representative sample of dentists in four states; (2) reviewed national data on provision of Medicaid dental services and use of managed care; (3) interviewed HHS officials and assessed certain HHS dental programs; and (4) interviewed officials in eight states and four countries on the use of mid-level and other dental providers.

What GAO Recommends

GAO recommends that HHS take steps to improve its Insure Kids Now Web site and ensure that states gather complete and reliable data on Medicaid and CHIP dental services provided under managed care. HHS agreed with the recommendations, citing specific actions it would take.

View GAO-11-96 or key components. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

Obtaining dental care for children in Medicaid and CHIP remains a challenge, as many states reported that most dentists in their state treat few or no Medicaid or CHIP patients. And, while HHS's Insure Kids Now Web site—which provides information on dentists who serve children enrolled in Medicaid and CHIP—has the potential to help families find dentists to treat their children, GAO found problems, such as incomplete and inaccurate information, that limited the Web site's ability to do so. For example, to test the accuracy of the information posted on the Web site, GAO called 188 dentists listed on the Web site in low-income urban and rural areas in four states representing varied geographic areas and levels of dental managed care and with high numbers of children in Medicaid. Of these 188 contacts, 26 had wrong or disconnected phone numbers listed, 23 were not taking new Medicaid or CHIP patients, and 47 were either not in practice or no longer performing routine exams.

Although improved since 2001, available national data show that in 2008, less than 37 percent of children in Medicaid received any dental services under that program and that several states reported rates of 30 percent or less. Further, although some data indicate that children in Medicaid managed care may receive less dental care than other children, comprehensive and reliable data on dental services under managed care continue to be unavailable despite long-standing concerns. Although HHS has not required states to report information on the provision of dental services under CHIP, CHIPRA requires states to begin reporting this information for fiscal year 2010.

Two programs that provide dental services to children and adults in underserved areas—HHS's Health Center and National Health Service Corps (NHSC) programs—have reported increases in the number of dentists and dental hygienists practicing in underserved areas, but the effect of recent initiatives to increase federal support for these and other oral health programs is not yet known. Despite these increases, both health centers and the NHSC program report continued need for additional dentists and other dental providers to treat children and adults in underserved areas.

Mid-level dental providers—providers who may perform intermediate restorative services, such as drilling and filling teeth, under remote supervision of a dentist—are in limited use in the United States. The only currently practicing mid-level dental providers in the United States serve Alaska Natives. Efforts to supplement the U.S. dental workforce with mid-level and other types of providers are under way. GAO interviewed officials from eight states with varied state laws related to dental providers. Some states have made efforts to increase children's access by reimbursing dental hygienists and primary care physicians for providing certain dental services. Some countries have long-standing programs that use mid-level dental providers, also known as dental therapists, who the countries report have improved children's access to dental services.

Contents

Tables

Figures

Abbreviations

ASTDD	Association of State and Territorial Dental Directors
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FTE	full-time equivalent
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
NHSC	National Health Service Corps
OIG	Office of Inspector General
PPACA	Patient Protection and Affordable Care Act

GAO
Accountability * Integrity * Reliability
United States Government Accountability Office
Washington, DC 20548

November 30, 2010

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

The Honorable Henry A. Waxman
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

Since 2000, our reports as well as reports by the Surgeon General, congressional committees, and oral health researchers have underscored the high rates of dental disease and the challenges of providing dental services to children living in underserved areas and in low-income families. In particular, children with health care coverage under two joint federal-state programs for low-income children—Medicaid and the Children's Health Insurance Program (CHIP)—often have difficulty finding dental care even though dental services are a covered benefit.[1] For example we reported in 2000 that low-income and minority populations—including children in Medicaid and CHIP—had a disproportionately high level of dental disease. In a related report, we found that the major factor contributing to the low use of dental services among low-income persons was finding dentists to treat them, even in areas where dental care for the rest of the population was generally available.[2] We also reported that dentists generally cited low payment rates, administrative requirements,

[1]Children in Medicaid are generally entitled to comprehensive dental services under the program's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. And, beginning in October 2009, states were required to offer a package of dental benefits under their CHIP programs.

[2]See GAO, *Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations*, GAO/HEHS-00-72 (Washington, D.C.: Apr. 12, 2000), GAO, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149 (Washington, D.C.: Sept. 11, 2000), and Related GAO Products at the end of this report.

and patient issues such as frequently missed appointments as reasons why they did not treat Medicaid patients. In 2008, we reported that the situation was largely unchanged. National survey data showed dental disease remained a significant problem for children in Medicaid—we estimated that 6.5 million children had untreated tooth decay and rates of dental disease among children in Medicaid had not decreased over time.[3] National surveys also showed that only one in three children in Medicaid had visited a dentist in the prior year, compared to more than half of privately insured children. In a 2009 survey of state Medicaid programs, we found that identifying a dentist who accepted Medicaid remained the most frequently reported barrier to children seeking dental services. We also found that, of the 21 states that provided Medicaid dental services under managed care arrangements, more than half reported that managed care organizations in their states did not meet any, or only met some, of the state's dental access standards.[4]

Since 2009, a number of actions have been taken to address these challenges. For example, to help families find a dentist to treat children covered by Medicaid and CHIP, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required the Department of Health and Human Services (HHS) to post on its Insure Kids Now Web site a current and accurate list of dentists participating in state Medicaid and CHIP programs.[5] In April 2010, HHS launched a departmentwide oral health initiative to expand oral health services, education, and research, including promoting access to oral health care and the effective delivery of services to underserved populations.

CHIPRA also required that we study and report on various aspects of children's access to dental services.[6] This report discusses (1) the extent

[3]We used national survey data from 1999 through 2004 to estimate the number of Medicaid-enrolled children with untreated tooth decay. We also examined survey data for the 1988 through 1994 and 1999 through 2004 time periods and found that rates of dental disease had not decreased, although the data suggested the trends varied somewhat among different age groups. See GAO, *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*, GAO-08-1121 (Washington, D.C.: Sept. 23, 2008).

[4]GAO, *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain*, GAO-09-723 (Washington, D.C.: Sept. 30, 2009).

[5]Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 501(f), 123 Stat. 8, 88.

[6]Pub. L. No. 111-3, § 501(f), 123 Stat. 88.

to which dentists participate in Medicaid and CHIP, and federal efforts to help families find dentists to treat children in these programs; (2) what is known about access for Medicaid and CHIP children in different states and in managed care; (3) federal efforts under way to improve access to dental services by children in underserved areas; and (4) how states and other countries have used mid-level dental providers to improve children's access to dental services.

To examine the extent to which dentists participate in Medicaid and CHIP, and federal efforts to help families find dentists to treat children in these programs, we (1) analyzed survey responses from states regarding dentists' participation in Medicaid and CHIP, gathered by the Association of State and Territorial Dental Directors (ASTDD), and (2) evaluated information posted on HHS's Insure Kids Now Web site about the dentists participating in Medicaid and CHIP. Specifically, we reviewed the information on the Web site for all 50 states and the District of Columbia to evaluate whether certain data elements specified as required in guidance from the Centers for Medicare & Medicaid Services (CMS)—the HHS agency that administers Medicaid at the federal level—were posted and whether the Web site was usable for a family seeking to identify a dentist for a child covered by Medicaid or CHIP. We also tested the accuracy of information posted to the Web site by calling a nongeneralizeable sample of 188 dentists' offices in low-income urban and rural areas in 4 states.[7] We also reviewed relevant academic and association research on dental services for children with special health care needs.

To evaluate what is known about access for Medicaid and CHIP children in different states and in managed care, we reviewed documents and interviewed officials from CMS. We also (1) analyzed survey responses from states on the use of dental managed care in Medicaid, gathered by the American Dental Association; and (2) examined annual state reports on

[7]We selected 4 states that represented a variation in geography, use of managed care, and the number of children covered by Medicaid. Within each state we called the offices for at least 25 urban and 15 rural dentists in the areas with the largest number of children in poverty.

the provision of dental services under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.[8]

To identify federal efforts to improve children's access to dental services in underserved areas, we focused on two programs administered by HHS's Health Resources and Services Administration (HRSA)—the Health Center program and the National Health Service Corps (NHSC) program—designed, in part, to support the provision of dental services in underserved areas. We also examined information regarding other recent efforts to improve access to care for children in underserved areas, including funding made available by the American Recovery and Reinvestment Act of 2009 (Recovery Act) and the Patient Protection and Affordable Care Act (PPACA).[9]

To determine how states have used mid-level dental providers to improve access to dental services for children, we examined laws, regulations, and practices related to mid-level and other dental providers and interviewed federal officials as well as officials in 8 selected states—Alabama, Alaska, California, Colorado, Minnesota, Mississippi, Oregon, and Washington—that have varying degrees of education, supervision, and scope-of-practice requirements for dental providers.[10] We selected these states based on responses we obtained to a standard set of questions posed to oral health researchers, professional associations, and advocacy groups regarding states that use mid-level and other dental providers to expand access to dental services. We visited Alaska to interview state and tribal officials on efforts to expand access for Alaska Natives through the use of mid-level dental providers. To determine how other countries have used mid-level dental providers to improve access to dental services for children, we examined documents and interviewed officials from four countries—

[8]Annual EPSDT reports contain information on children who are (1) in Medicaid and received EPSDT benefits and (2) in CHIP and received EPSDT benefits because they are part of a Medicaid expansion program.

[9]American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). References to the Patient Protection and Affordable Care Act (PPACA) in this report refer to Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[10]Our interviews with officials from HHS, states, academic institutions, professional associations, and advocacy groups found that there is no commonly-recognized definition of mid-level dental providers.

Australia, Canada, New Zealand, and the United Kingdom. See appendix I for additional information on our scope and methodology.

We conducted this performance audit from August 2009 through November 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

High rates of dental disease and low utilization of dental services by children in low-income families and the challenge of finding dentists to treat them are long-standing concerns. In 2000, the Surgeon General reported that tooth decay is the most common chronic childhood disease and described what the report called the silent epidemic of oral disease affecting the nation's poor children.[11] Left untreated, the pain and infections caused by tooth decay may lead to problems in eating, speaking, and learning. Tooth decay is almost completely preventable and the pain, dysfunction, or on extremely rare occasions, even death, resulting from dental disease can be avoided. The American Academy of Pediatric Dentistry recommends that each child see a dentist when his or her first tooth erupts and no later than the child's first birthday, with subsequent visits occurring at 6-month intervals or more frequently if recommended by a dentist.

Recognizing the importance of good oral health, HHS established oral health goals as part of its Healthy People 2000 and 2010 initiatives.[12] One objective of Healthy People 2010 was to increase the proportion of low-income children and adolescents under the age of 19 who receive any preventive dental service in the past year—including examination, x-ray, fluoride application, cleaning, or sealant application (a plastic material

[11]U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, *Oral Health in America: A Report of the Surgeon General* (Rockville, Md.: 2000).

[12]HHS established Healthy People 2010 as a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. See http://www.healthypeople.gov/About/ (accessed Aug. 3, 2010).

placed on molars to reduce the risk of tooth decay)—from 20 percent in 1996 to 66 percent in 2010.

Federal Programs That Promote Dental Services for Children

Medicaid, a joint federal and state program that provides health care coverage for certain low-income individuals and families, provided health coverage for over 30 million children under 21 in fiscal year 2008.[13] States operate their Medicaid programs within broad federal requirements and may contract with managed care organizations to provide Medicaid medical and dental benefits. Under federal law, state Medicaid programs must provide dental services, including diagnostic, preventive, and related treatment services for all eligible Medicaid enrollees under age 21 under the program's EPSDT benefit.

Federal law also requires states to report annually on the provision of EPSDT services, including dental services, for children in Medicaid. The annual EPSDT participation report, Form CMS-416 (hereafter called the CMS 416), is the agency's primary tool for gathering data on the provision of dental services to children in state Medicaid programs. It captures data on the number of children who received any dental services, a preventive dental service, or a dental treatment service each year. Information on the CMS 416 is used to calculate a state's dental utilization rate—the percentage of children eligible for EPSDT who received any dental service in a given year.

CHIP, which is also a joint federal and state program, expanded health coverage to children—approximately 7.7 million children in fiscal year 2009—whose families have incomes that are low, but not low enough to qualify for Medicaid.[14] States can administer their CHIP programs as (1) an expansion of their Medicaid programs, (2) a stand-alone program, or (3) a combination of Medicaid expansion and stand-alone. Although states have flexibility in establishing their CHIP benefit package, all states covered some dental services in 2009, according to CMS officials, though benefits varied. Children in CHIP programs that are administered as expansions of

[13]The 30 million children represent the fiscal year 2008 unduplicated annual enrollment (the total number of children, each child counted once, who were enrolled in Medicaid at any point in federal fiscal year 2008) reported by CMS.

[14]In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 renamed the State Children's Health Insurance Program (SCHIP) to the Children's Health Insurance Program (CHIP).

Medicaid programs are entitled to the same dental services under the EPSDT benefit as children in Medicaid.

CHIPRA expanded federal requirements for state CHIP programs to cover dental services. Specifically, CHIPRA required states to cover dental services in their CHIP programs beginning in October 2009 and gave states authority to use benchmark plans to define the benefit package or to supplement children's private health insurance with a dental coverage plan financed through CHIP.[15] CHIPRA also required states to submit annual reports to CMS on the provision of dental and other services—similar to information provided by state Medicaid programs each year on their CMS 416 reports.[16] States were previously required to submit annual CHIP reports, although these reports did not contain detailed information on the provision of dental services as required for Medicaid on the CMS 416.

To make it easier for families to find dentists to treat children covered by Medicaid and CHIP, CHIPRA also required that HHS post "a current and accurate list of all such dentists and providers within each State that provide dental services to children" under Medicaid or CHIP on its Insure Kids Now Web site. CHIPRA required the Secretary of HHS to post this list on the Web site by August 4, 2009, and ensure that the list is updated at least quarterly.[17] In June 2009, CMS issued guidance specifying certain data elements required for each dentist listed on the Insure Kids Now Web site—including the dentist's name, address, telephone number, and specialty; whether the dentist accepts new Medicaid or CHIP patients; and whether the dentist can accommodate patients with special needs. HHS posts listings on the Insure Kids Now Web site by state and in some cases provides a link to such a list on an individual state's or managed care organization's Web site.

[15]Pub. L. No. 111-3, § 501, 123 Stat. 84. CHIPRA allowed states to provide dental coverage for children in the CHIP income range who have health insurance through an employer, but who lack dental coverage.

[16]Pub. L. No. 111-3, § 501(e), 123 Stat. 87.

[17]Pub. L. No. 111-3, § 501(f), 123 Stat. 88. HHS's Insure Kids Now Web site was established in 1999 to help parents and guardians find state Medicaid and CHIP program eligibility information. To improve access to information on dental providers participating in Medicaid and CHIP, in February 2009, CHIPRA required HHS to post a list of participating dentists within each state on the Insure Kids Now Web site and also provide such information through its toll-free hotline (1-877-KIDS-NOW).

To address the need for health services in underserved areas of the country, HHS's HRSA administers programs that support the provision of dental and other medical services in underserved areas. For example, under HRSA's Health Center program, health centers—which must be located in federally designated medically underserved areas or serve a federally designated medically underserved population—are required to provide pediatric dental screenings and preventive dental services, as well as emergency medical referrals, which may also result in the provision of dental services.[18] Health centers must accept Medicaid and CHIP patients and treat everyone regardless of their ability to pay. HHS reported that in fiscal year 2009, over 1,100 health center grantees operated over 7,900 service delivery sites in every state and the District of Columbia, and provided health care services, including dental services, to approximately 19 million patients, about one-third of whom were children.

Another HRSA program, NHSC, offers scholarships and educational loan repayment for clinicians who agree to practice in underserved areas.[19] NHSC awards scholarships to students entering certain health professions training programs, including dentistry, who agree to practice in underserved areas when their training is completed. NHSC also provides educational loan repayment for health care providers, including dentists and dental hygienists, who have completed their training and can begin serving in a shortage area. HRSA designates geographic areas, population groups, and facilities as dental health professional shortage areas (HPSAs) for purposes of placing dentists and dental hygienists through the NHSC program. These designations are based, in part, on the number of dentists in an area compared to the area's population.[20] As of July 13, 2010, HRSA

[18]42 U.S.C. § 254b. Health centers are funded in part through grants under the Health Center program—administered by HRSA—and provide comprehensive primary care services for the medically underserved.

[19]42 U.S.C. § 254d. The NHSC scholarship program provides tuition, fees, and living stipends for students in primary care, including dentistry, in exchange for at least 2 years of service. 42 U.S.C. § 254l. The NHSC loan repayment program provides up to $50,000 toward repayment of student loans for providers, including dentists and dental hygienists, in exchange for at least 2 years of service. 42 U.S.C. § 254l-1. HRSA also administers the State Loan Repayment program that provides matching grants to states to run their own loan repayment programs for health providers who agree to practice in underserved areas, which in some states includes awards for dentists and dental hygienists. 42 U.S.C. § 254 q-1.

[20]42 C.F.R. pt. 5, app. B (2009); 42 U.S.C. § 254e(a)(1).

reported that there were 4,377 dental HPSAs in the United States[21] and estimated that it would take 7,008 full-time equivalent (FTE) dentists to remove these designations.[22] To be eligible for a NHSC provider, a site must be located in a HPSA of greatest shortage and meet other requirements, such as accepting Medicaid and CHIP patients and treating everyone regardless of their ability to pay.[23] Providers can then choose where they wish to serve from a list of eligible sites, although providers who have received scholarships are limited to a narrower list of higher priority vacancies.[24] According to HRSA, about half of all NHSC providers, which include dentists and hygienists, practice in health centers.

Dental Services and Dental Providers

Dental services cover a broad array of specialized procedures, from routine exams to complex restorative procedures. For this report, we grouped dental services into five main categories: (1) supportive, (2) preventive, (3) basic restorative, (4) intermediate restorative, and (5) advanced restorative dental procedures (see table 1).

[21]Of the 4,377 dental HPSAs, 790 were for geographic areas, 1,526 were for population groups, and 2,061 were facilities such as health centers that were designated as HPSAs. See http://bhpr.hrsa.gov/shortage/ (accessed July 14, 2010).

[22]HRSA estimates the number of full-time equivalent dentists needed to remove HPSA designations by taking into account the actual level of service provided by a given dentist. For example, a HPSA needing a dentist working half-time to remove its HPSA designation would be estimated to need 0.5 FTE, although adjustments are made for a variety of factors, such as the number of dental hygienists and dental assistants.

[23]To identify HPSAs of greatest shortage, HRSA scores each HPSA based on relative need. Only HPSAs meeting a certain threshold score are considered HPSAs of greatest need. This threshold may differ for scholarship recipients and loan repayment recipients in a given year.

[24]The number of choices available to scholarship recipients is provided for in statute: no more than twice the number of scholarship recipients who will be available for assignment during the year. For example, if there were 25 dentists who received NHSC scholarships available for service, NHSC would provide a list of no more than 50 vacancies for them. See 42 U.S.C. § 254f-1(d)(2).

Table 1: Categories of Dental Services and Examples of Dental Procedures

Supportive	Preventive	Basic restorative	Intermediate restorative	Advanced restorative
• Preparing a patient to be examined by a dentist • Passing instruments to a dentist	• Examination and assessment • Counseling • Cleaning above and below gum line • Fluoride application • Sealant placement[a]	• Temporary fillings • Smoothing an existing restoration • Administration of local anesthetic	• Tooth preparation (drilling) • Tooth restoration (filling) • Tooth extractions	• Periodontal treatment (gums) • Endodontic treatment (root canals)

Source: GAO.

[a]Dental sealants are plastic material that are commonly applied to the chewing surfaces of back teeth to reduce the risk of decay.

While a provider's specific scope of practice may vary by state, types of dental providers who may provide some or all of these services include:

- **Dentists**, who may perform the full range of dental procedures.[25]
- **Mid-level dental providers**, often dental therapists, who may perform preventive, basic restorative, and intermediate restorative dental procedures under remote supervision of a licensed dentist.
- **Dental hygienists**, who generally perform preventive procedures, such as tooth cleaning, oral health education, and fluoride applications, as well as basic restorative procedures in certain states, under various supervisory agreements with a dentist.
- **Dental assistants**, who may provide supportive services and in some states certain preventive and basic restorative procedures under on-site supervision of a dentist.
- **Primary health care providers** (such as physicians and nurse practitioners) who may also perform certain preventive dental procedures, such as applying fluoride varnish, to children in some states.

[25]In the United States, dentists are licensed to practice by the states and states are generally responsible for establishing education requirements and determining scope of practice of dental providers. They can obtain additional training in a dental specialty, such as pediatric dentistry or orthodontics.

Dental therapists, dental hygienists, and dental assistants work under various supervisory arrangements with a dentist. The type of supervision required for these providers may vary depending upon the state and the type of service provided. For this report, we categorized dental supervision as on-site, remote with prior knowledge and consent, remote with consultative agreement, or no supervision (see table 2).

Table 2: Types of Supervision for Other Dental Providers

Supervision type	Description
On-site supervision	The dentist must be on-site when the dental provider performs services and examines the patient at any point before, during, or after the dental services are provided.
Remote supervision with prior knowledge and consent	The dentist may be off-site but must have prior knowledge of and consent to the procedures, in some cases through a treatment plan.
Remote supervision with consultative agreement	The dentist may be off-site but maintain a consultative role, for example through a signed collaborative agreement with another type of dental provider.
No supervision	Dental provider may perform services without dentists' supervision.

Source: GAO.

Note: This table presents examples of the type of supervisory arrangements that may exist between dentists and other dental providers, such as dental therapists and dental hygienists.

For Children in Medicaid and CHIP, Finding a Dentist Remains a Challenge, and HHS's Web Site to Help Locate Participating Dentists Was Not Always Complete or Accurate

States continue to report low participation by dentists in Medicaid and CHIP. While HHS's Insure Kids Now Web site—which provides information on dentists who serve children enrolled in Medicaid and CHIP—has potential to help families find a dentist to treat children in these programs, we found problems such as incomplete or inaccurate information that limit its ability to do so.

States Report Low Dentist Participation in Medicaid and CHIP, and Children with Special Health Care Needs Face Particular Difficulties

While comprehensive nationwide data do not exist, available data suggest that problems with low dentist participation in Medicaid and CHIP persist. Additionally, among dentists who do participate in Medicaid, many may place limits on the number of Medicaid patients that they will treat. Most states responding to a 2009 ASTDD survey[26] reported low participation among dentists, although not all states responded completely. Our analysis shows that 25 of 39 states reported that fewer than half of the dentists in their states treated any Medicaid patients during the previous year.[27] Only one of 41 states reported that more than half of the state's dentists saw 100 or more Medicaid patients during the previous year (see table 3). Fewer states responding to the 2009 ASTDD survey provided data on dentists' participation in CHIP separately from data on participation in Medicaid and CHIP expansions, but the data reported separately for CHIP indicates that dentists' participation in CHIP is also low.

Table 3: State Reported Data on Dentists' Participation in Medicaid and CHIP

	State officials' responses to 2009 Association of State and Territorial Dental Directors (ASTDD) survey	
Level of Dentist Participation in Medicaid or CHIP	**Medicaid or CHIP expansion***	**CHIP only**
States reporting more than half of the dentists in the state treat any patients	14 of 39 states (36%)	4 of 11 states (36%)
States reporting more than half of the dentists in the state treat 100 or more patients	1 of 41 states (2%)	0 of 12 states (0%)

Source: GAO analysis of ASTDD survey data.

Note: This table presents data collected by ASTDD in 2009. ASTDD sent its survey to dental directors in all states and the District of Columbia and received 45 responses. Information collected was for fiscal year 2008 (or the most recent available fiscal year).

*States have the option of administering their CHIP programs as expansions of their Medicaid programs.

[26]ASTDD's annual survey, called the Synopses of State and Territorial Dental Public Health Programs, is conducted under a cooperative agreement with HHS's Centers for Disease Control and Prevention.

[27]ASTDD sent the survey to dental directors in all states and the District of Columbia. However, not all states provided responses to the questions on the number of dentists treating children in Medicaid and CHIP. For example, 39 states reported how many dentists treated children in Medicaid (including children in CHIP programs that are Medicaid expansions) and 11 reported the number of dentists who treated children in a CHIP program separate from Medicaid. See http://apps.nccd.cdc.gov/synopses/ (accessed July 21, 2010).

The results of the 2009 ASTDD survey indicating low levels of dentists' participation in Medicaid are consistent with findings we reported in 2000. We reported that 16 of 39 states responding to our inquiry indicated that more than half of the dentists in the state treated any Medicaid patients in 1999, but that none of the states reported that more than half of the dentists treated 100 or more Medicaid patients.[28]

One group of children particularly affected by low levels of dentists' participation in Medicaid and CHIP are children with special health care needs. On its Web site, HRSA's Maternal and Child Health Bureau has defined children with special health care needs as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." According to a March 2009 ASTDD evaluation of 17 state oral health programs, the most common barriers to dental services for children with special health care needs include low rates of dentists' participation in Medicaid and CHIP, difficulty locating dentists who accept children with special health care needs who have behavioral challenges, and the high cost of specialized care.[29] Studies have also cited the lack of training for dentists to accommodate children who have special treatment needs.[30] In response to the 2005–2006 National Survey of Children with Special Health Care Needs—a periodic survey sponsored by HRSA's Maternal and Child Health Bureau and carried out by the Centers for Disease Control and Prevention—parents (or guardians) of children with special health care needs reported that unmet dental care was the greatest health care need for these children and reported problems getting dental care at levels that exceeded those of healthy children. Unmet dental care for children with special heath care needs can also vary by diagnosis. For example, a study based on the 2005–2006 National Survey of Children with Special Health Care Needs found that children with Down's Syndrome were about twice

[28]GAO/HEHS-00-149.

[29]Association of State and Territorial Dental Directors, *ASTDD Support for State CSHCN Oral Health Forums, Action Plans And Follow-Up Activities; Interim Evaluation Summary* (March 2009).

[30]Burton L. Edelstein, "Conceptual Frameworks for Understanding System Capacity in the Care of People with Special Health Care Needs," *Pediatric Dentistry*, Vol. 29, No. 2 (March/April 2007).

as likely to have unmet dental needs as children with asthma.[31] The study also reported that the odds of having unmet dental care needs were 13 times greater for low-income children with more severe special health care needs compared with higher-income children without special health care needs.[32]

Information on HHS's Web Site to Help Locate Participating Dentists Was Not Always Complete or Accurate

To help families locate dentists near them to treat children in Medicaid or CHIP, CHIPRA required HHS to post information on participating dentists on its Insure Kids Now Web site. However, we found problems with the data available through the Web site—specifically that the listings available on the Web site or through links available from the Web site were not always complete and accurate. CHIPRA required HHS to post a current and accurate list of dentists participating in Medicaid or CHIP on the Web site by August 2009 and to ensure that the list is updated at least quarterly. In August 2010, officials from CMS—the agency within HHS responsible for implementation and that established the data elements that states should provide—described the Web site as a "work in progress" and reported that they are continually improving the site. Although we found that improvements were evident over a 6-month period, problems remained. Specifically, we found cases in which information posted on the Web site was not complete, not usable, or not accurate.

- **Completeness.** Our review of dentist listings for all 50 states and the District of Columbia in November 2009, 3 months after CHIPRA required HHS to post the list of participating dentists, found a variety of problems, including missing or incomplete information on dentists' telephone numbers and addresses, whether dentists accepted new Medicaid or CHIP patients, and whether dentists could accommodate children with special needs. Our second review of dentist listings in April 2010 for these data found some improvements had been made, but that problems with missing or incomplete information continued for some states (see table 4).

[31]The study found that overall, 8.9 percent of children with special health care needs who needed any dental care were unable to obtain it. Children with Down's Syndrome had the highest proportion of unmet dental care needs at 17.4 percent, and children with asthma the lowest at 8.6 percent. C.W. Lewis, "Dental Care and Children with Special Health Care Needs: A Population-Based Perspective," *Academic Pediatrics*. Vol. 9, No. 6: 420-426 (2009).

[32]Specifically, the study noted that the adjusted odds of unmet dental care needs for severely affected, poor/low-income children with special health care needs were 13.4 times that of unaffected, higher-income children.

Table 4: Number of States Providing Missing or Incomplete Dentist Information through HHS's Insure Kids Now Web Site in November 2009 and April 2010

Required data element missing or incomplete		Number of states	
		November 2009	April 2010
Medicaid	Missing or incomplete contact information (i.e., name, address, telephone number) for some or all dentists	10	10
	Did not indicate for all dentists whether dentist accepts new patients	34	29
	Did not indicate for all dentists whether dentist can accommodate patients with special needs	40	37
CHIP	Missing or incomplete contact information (i.e., name, address, telephone number) for some or all dentists	17	14
	Did not indicate for all dentists whether dentist accepts new patients	34	29
	Did not indicate for all dentists whether dentist can accommodate patients with special needs	38	36

Source: GAO analysis of HHS's Insure Kids Now Web site for 50 states and the District of Columbia.

Note: This table presents the results of our review of the information posted on HHS's Insure Kids Now Web site in November 2009 and April 2010. Specifically, we examined each state's listing of dentists to determine if certain data elements, specified in CMS guidance as required, were present for all dentists in all Medicaid and CHIP programs operated by the state and recorded instances in which data were missing or incomplete for all or some dentists.

- **Usability**. In May 2010, we reviewed all state dentist listings on the Insure Kids Now Web site to determine whether families of a child in Medicaid or CHIP could reasonably use the site to find potential dentists near them and found that listings from 25 states and the District of Columbia had usability problems that prevented or hampered the search for a dentist participating in Medicaid or CHIP. For example, menu or search functions for 14 states did not work for a program or entire state—with no indication of when functions would be restored or how the user could obtain alternate assistance while it was unavailable. Other problems we encountered included broken or incorrect links (for example, one state link that took the user to an unrelated agency in another state) and confusing menus that could hinder the search. For example, seven states listed multiple health plans with similar names, some containing typographical errors and some that produced different provider listings, increasing the likelihood of selecting the wrong plan and generating an incorrect list of dentists.

- **Accuracy**. To check the accuracy of information on dentists posted on the Insure Kids Now Web site, in May 2010 we called the telephone number listed for 188 general dentists shown on HHS's Web site as practicing in

selected low-income urban and rural areas in four states[33] and found problems in about half (96) of the listings we checked, including dentists who were not accepting children in Medicaid or CHIP and wrong or disconnected telephone numbers (see table 5). We also asked respondents to tell us what the typical wait time would be for an appointment with the dentists. Of 92 dentists we called that reported that they accepted new Medicaid or CHIP patients under age 19, all but one reported that the wait time was the same for Medicaid or CHIP patients and privately insured patients.[34]

Table 5: Errors in Dentist Listings on HHS's Insure Kids Now Web Site, May 2010

State (number of dentists whose offices we called)	Wrong or disconnected telephone number, percentage (number of errors)	Errors in other posted information,* percentage (number of errors)	Not accepting new Medicaid or CHIP children, percentage (number of errors)
California (40)	5% (2)	8% (3)	30% (12)
Georgia (45)	4% (2)	38% (17)	11% (5)
Illinois (56)	36% (20)	36% (20)	4% (2)
Vermont (47)	4% (2)	38% (18)	9% (4)

Source: GAO analysis.

Note: In May 2010, we called the telephone number listed on HHS's Insure Kids Now Web site for 188 dentists in California, Georgia, Illinois, and Vermont—states we selected because they provided variation in geography, use of Medicaid dental managed care, and the number of children covered by Medicaid. Within each state we identified 25 urban dentists and 15 rural dentists to call in the areas with the largest number of children in poverty. For a dentist in a group practice, a single telephone call could yield additional dentists; thus more dentists were called in some states. We accounted for each dentist separately, so an error such as a wrong telephone number for a dental clinic with multiple dentists would account for multiple errors.

*Other errors included incorrect addresses (11) or dentists no longer in practice or not providing routine examinations (47).

In addition, while CMS issued guidance requiring states to indicate on the Web site whether a dentist could treat children with special needs, as of August 2010, CMS had not defined what capabilities dentists who serve children with special needs should have, and we found some confusion among dentists' offices regarding their ability to treat these children. For

[33]The dentists were listed on the Insure Kids Now Web site as practicing in California, Georgia, Illinois, and Vermont. Our case study approach did not yield results that could be projected to entire states or managed care organizations.

[34]One dentist reported that the wait time for a new Medicaid or CHIP child was 6 months, compared to 2 months for other new patients with private insurance. Twenty-three of the dentists we called who were otherwise treating children were not accepting any new Medicaid or CHIP patients.

example, several of the dentist offices we called indicated they were unsure whether they could serve children with special needs, while others indicated that they would try to serve them. Of the dentist offices that responded to questions about specific capabilities, nearly all (89 of 95) reported that their offices were wheelchair accessible, but few (6 of 74) reported that they could treat children requiring sedation—although a small number indicated that they would refer the patient to another dentist who could provide sedation.

Finally, we identified one dentist shown on a state's Insure Kids Now listing of dentists treating children enrolled in Medicaid or CHIP who was on HHS's register of excluded providers and should not have been allowed to receive reimbursement from either program.[35] We contacted the dentist's office on May 5, 2010 as part of our review of the accuracy of the information posted on the Web site and the dentist's office confirmed that the dentist was accepting new Medicaid patients. We also contacted the HHS Office of Inspector General (OIG), which administers the HHS exclusion program and HHS-OIG officials confirmed that the dentist had been excluded from participation in the Medicaid program and that the dentist had been reinstated effective May 13, 2010.[36]

[35]HHS may exclude providers from receiving payment from federally funded health care programs, including Medicare and Medicaid, for incidents such as conviction for program-related fraud and patient abuse, license revocation or suspension, and default on Health Education Assistance Loans. See http://oig.hhs.gov/fraud/exclusions.asp (accessed July 20, 2010).

[36]HHS-OIG officials told us that the dentist has been excluded from Medicaid in 1986 after pleading guilty to Medicaid fraud.

States Report Improvement in the Provision of Dental Services to Children in Medicaid, but Data to Monitor Service Provision under CHIP or Managed Care are Limited

Although annual state reports on the CMS 416 indicate that the provision of dental services to children in Medicaid nationwide had improved between 2001 and 2008 (the most recent data available at the time of our review), overall utilization rates remained low. In addition, data to measure provision of dental services for some children, such as those in managed care programs or in CHIP, are limited.

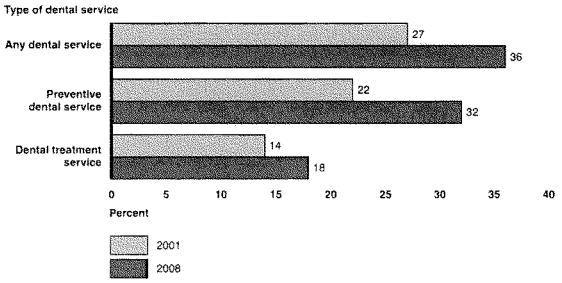
States Report Improvement in the Provision of Dental Services to Children in Medicaid between 2001 and 2008, but Utilization Remains Low

According to data provided by states on annual CMS 416 reports, utilization of dental services among children in Medicaid had improved, but reported utilization rates still varied among states.[37] Nationwide, reported utilization of any Medicaid dental service increased—from 27 percent of children in federal fiscal year 2001 to 36 percent of children in federal fiscal year 2008—but despite this increase, no dental service utilization was reported for nearly two-thirds of Medicaid-enrolled children.[38] Overall, states also reported a higher proportion of children receiving preventive dental services than dental treatment services in both years (see fig. 1).

[37]Children enrolled in CHIP programs that are expansions of the states' Medicaid programs are entitled to the Medicaid EPSDT benefit package and are included in the states CMS 416 reports, but are not identified separately as CHIP enrollees in the CMS 416.

[38]We calculated and report the nationwide Medicaid dental utilization rate—that is, the percentage of total EPSDT-eligible Medicaid enrollees in the nation who received any dental service. CMS reports a national average of 37.7 percent in 2008 that is calculated by averaging the 51 state-utilization rates. We report the national utilization rate rather than the average rate because it accounts for differences in the number of enrollees in each state.

Figure 1: Comparison of Nationwide Medicaid Dental Utilization Rates for Dental Services for Children, Fiscal Years 2001 and 2008

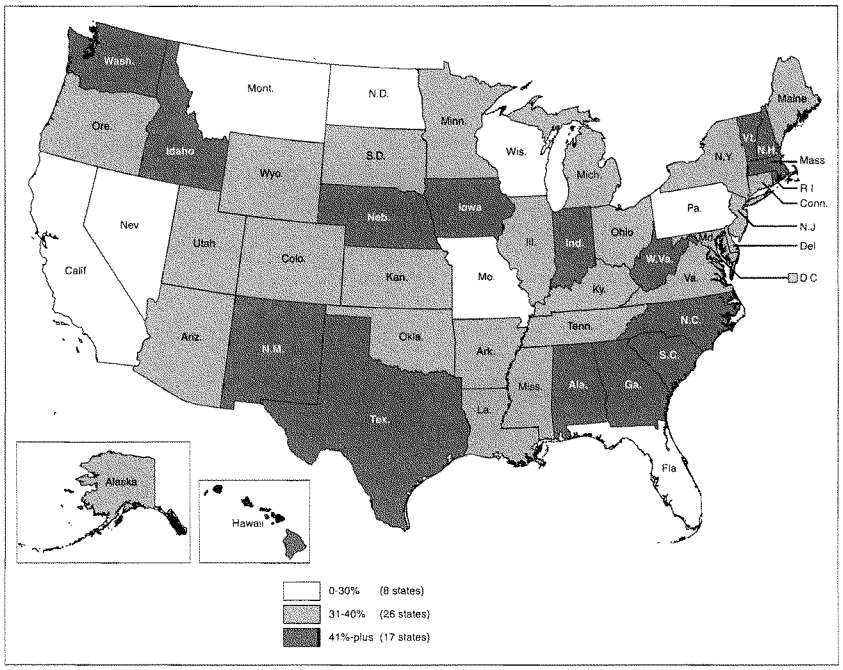


Source: GAO analysis of CMS 416 data.

Note: This figure represents national dental utilization rates calculated from data reported by states in their CMS 416 reports submitted for federal fiscal years 2001 and 2008 on the number of EPSDT-eligible Medicaid-enrolled children who received a dental service during the fiscal year. Children enrolled in CHIP programs that are expansions of the states' Medicaid programs are entitled to the Medicaid EPSDT benefit package and are included in the states CMS 416 reports, but are not identified separately as CHIP enrollees.

Although the percentage of children nationwide in Medicaid who received any dental service increased, there continued to be wide variation among states in the percentage of children reported to have received any dental service, including eight states that reported dental utilization rates at 30 percent or less in fiscal year 2008 (see fig. 2). There was also wide variation among states in utilization rates for preventive and dental treatment services—see appendix II for a complete list of the utilization rates for any dental service, preventive dental services, and dental treatment services reported by states in their fiscal year 2008 CMS 416 reports.

Figure 2: Percentage of Children in Medicaid Receiving Any Dental Service, Fiscal Year 2008



Source: GAO analysis of CMS Form 416 data; Map Resources (map).

Note: This figure represents dental utilization rates calculated from data reported by states in their fiscal year 2008 CMS 416 reports (the most recent available at the time of our review) on the number of EPSDT-eligible Medicaid-enrolled children who received any dental service during the fiscal year. Nationwide, 36 percent of children in Medicaid received any dental service in fiscal year 2008. Children enrolled in CHIP programs that are expansions of the states' Medicaid programs are entitled to the Medicaid EPSDT benefit package and are included in the states' CMS 416 reports, but are not identified separately as CHIP enrollees. Dental utilization rates are rounded to the nearest whole percentage.

For Children in Managed Care and Children in CHIP, Data on the Provision of Dental Services Are Limited

Comprehensive and reliable data on dental utilization by children in Medicaid managed care programs and children in CHIP are not available. States do not distinguish between fee-for-service and managed care programs when reporting annual Medicaid data to CMS (using CMS 416).[39] A comparison of fiscal year 2008 CMS 416 data with available data on the proportion of children in Medicaid managed care in a given state suggests that children in Medicaid managed care plans may have lower dental utilization rates than children in fee-for-service programs. Our analysis of 2008 data on Medicaid managed care penetration rates from the American Dental Association found that 10 states provided dental services predominantly through dental managed care programs.[40] These 10 states reported that 34 percent of children covered by Medicaid received any dental service, compared to 41 percent of children reported by the 33 states that reimbursed exclusively under fee-for-service.

Questions about the provision of Medicaid dental services under managed care compared to fee-for-service payment arrangements are long-standing. In 2007, we reported that CMS had taken steps to improve the CMS 416 data, but that concerns remained about the completeness and sufficiency of the data for purposes of overseeing Medicaid dental services.[41] In particular, we noted that the information could not be used to identify problems with specific delivery methods. Following our report, CMS officials had considered revising the CMS 416 to capture services delivered through managed care; however, as of August 2010, CMS officials did not have any plans to do so.

In addition, national data were not available on the provision of CHIP dental services, although CMS will require improved reporting per CHIPRA in 2011 for dental services provided in 2010. Although states must

[39]In prior work, we found concerns that data on the provision of Medicaid services by managed care programs reported by states on their CMS 416s were not complete or reliable. See GAO, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001). According to CMS officials, states have improved the quality of data gathered and reported on their CMS 416 reports.

[40]See American Dental Association's *Medicaid Compendium Update* http://www.ada.org/2123.aspx (accessed Feb. 12, 2010). We considered states with 75 percent or more Medicaid-enrolled children in dental managed care as predominantly dental managed care states.

[41]GAO, *Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services*, GAO-07-826T (Washington, D.C.: May 2, 2007).

assess the operation of their CHIP programs each federal fiscal year and report on the results of this assessment,[42] CMS had not required states to include specific information on the provision of CHIP dental services, such as required for Medicaid dental services in the CMS 416. However, beginning in fiscal year 2010, CHIPRA requires states to include information on CHIP dental services of the type contained in the CMS 416 in their annual CHIP reports and further requires the inclusion of information on the provision of CHIP dental services in managed care programs.[43] According to CMS officials, a CMS work group is developing specific reporting requirements for CHIP dental services provided by states in fiscal year 2010, with the first reports due to CMS in 2011.

Federal Efforts to Improve Access to Dental Services for Children in Underserved Areas Are Under Way, but Effect Is Not Yet Known

Two HHS programs that provide dental services to children as well as adults in underserved areas—HRSA's Health Center and NHSC programs—have reported increases in the number of dentists and dental hygienists practicing in underserved areas, but the effect of recent initiatives to increase federal support for these and other oral health programs is not yet known. And despite these increases, some gaps may remain. For example, even with recent increases, both health centers and the NHSC program report continued need for additional dentists and dental hygienists to treat children and adults in underserved areas.

Health Center and NHSC Programs Report Recent Increases in the Number of Dentists and Dental Hygienists, but Full Effect of Federal Efforts Is Unknown

One federal effort to improve access to dental services in underserved areas is the Health Center program. To support the expansion of dental services in health centers, HRSA reported that it provided grant opportunities for health centers to expand oral health services, making 312 awards between 2002 and 2009 totaling $56.4 million. The number of patients, including children, that HRSA reported as receiving dental services in health centers, the number of FTE dentists, and the number of FTE dental hygienists providing those services all increased by more than one-third between calendar years 2006 and 2009 (see fig. 3).[44] In addition

[42]Social Security Act § 2108(a) (codified at 42 U.S.C. § 1397hh(a)).

[43]Pub. L. No. 111-3, § 501(e), 123 Stat. 87.

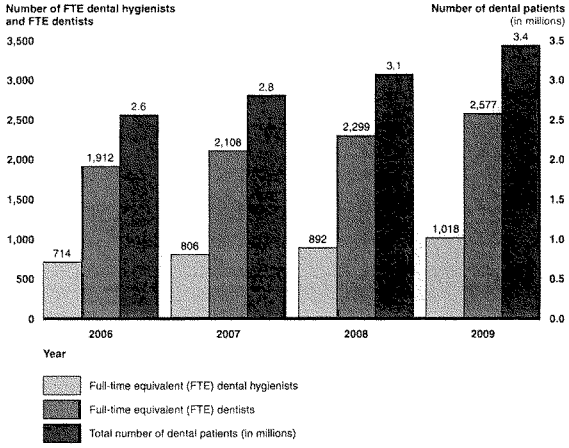
[44]In addition to dentists, health centers employed 1,018 dental hygienist FTEs and over 4,800 FTEs for dental assistants, aides, and technicians in calendar year 2009.

to dental services required of health centers, such as pediatric dental screenings and preventive dental services, HRSA reported a 40 percent increase in the number of patients receiving restorative dental services over this period.[45] Despite these increases, an official with the National Association of Community Health Centers reported continued need for additional health centers and dental providers to practice in them to meet the needs of underserved areas.[46]

[45]HRSA reported that 942 health center grantees offered restorative dental services—either directly, through contracts, or through formal referral arrangements—as of June 2010.

[46]We previously reported that 43 percent of medically underserved areas lacked a health center as of 2007. GAO, *Health Resources and Services Administration: Many Underserved Areas Lack a Health Center Site, and the Health Center Program Needs More Oversight*, GAO-08-723 (Washington, D.C.: Aug. 8, 2008). In August 2010, an official with the National Association of Community Health Centers told us that, although the number of underserved areas with a health center site increased since 2007, the change has not been significant and many underserved areas still lacked a health center to provide dental and other medical services.

Figure 3: Number of Dental Hygienists, Dentists, and Dental Patients at Health Centers, Calendar Years 2006 through 2009



Source: GAO analysis of HRSA data.

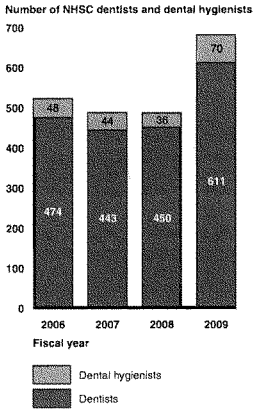
Note: This figure presents information HRSA reported on the number of FTE dental hygienists and dentists practicing in health centers for each calendar year and the total number of dental patients. HRSA reported the exact number of patients receiving dental services as follows: 2,577,003 in 2006, 2,808,418 in 2007, 3,071,085 in 2008, and 3,438,340 in 2009.

Another HHS program reporting an increase in the number of dentists and dental hygienists practicing in underserved areas is the NHSC. HRSA reported that 611 dentists and 70 dental hygienists were practicing in HPSAs through the NHSC scholarship and loan repayment programs at the end of fiscal year 2009.[47] This was at least 30 percent higher than the number of NHSC dentists and dental hygienists HRSA reported as practicing in HPSAs through the program at the end of the three preceding fiscal years (see fig. 4). Despite this increase, the NHSC reported vacancies

[47]Of the 611 dentists and 70 dental hygienists in NHSC at the end of fiscal year 2009, 112 dentists and 13 hygienists were funded through the State Loan Repayment Program.

for 673 dentists and 192 dental hygienists to practice in dental HPSAs in August 2010.

Figure 4: Number of NHSC Dentists and Dental Hygienists Practicing in Shortage Areas, Fiscal Years 2006 through 2009



Source: GAO analysis of HRSA data.

Notes: This figure presents information HRSA reported on the number of dentists and dental hygienists practicing in shortage areas through the NHSC as of the end of each fiscal year.

In 2009, the Recovery Act provided appropriations for both the Health Center and NHSC programs, funding activities to improve access to services, including dental services for children, in underserved areas. For example, according to HRSA, Recovery Act funds were used to support NHSC loan repayment awards for 96 of the dentists and 20 of the dental hygienists practicing in HPSAs through the NHSC at the end of fiscal year 2009[48] as well as an additional 382 dentists and 105 dental hygienists who received NHSC loan repayment awards in fiscal year 2010. HHS also

[48]These loan repayment awards made in fiscal year 2009 represent 16 percent of the 611 dentists and 29 percent of the 70 dental hygienists practicing in HPSAs through the NHSC at the end of fiscal year 2009.

indicated that it used funds made available through the Recovery Act to award more than 1,100 grants totaling approximately $338 million to health centers to support efforts to increase the number of patients served.[49]

Another recent statute—PPACA—authorized and in some cases appropriated funding for both the Health Center and NHSC programs. For example, in August 2010, HHS announced the availability of $250 million in grants—from funds made available in PPACA—for new full-time service delivery sites that provide comprehensive primary and preventive health care services, including pediatric dental screenings and preventive dental services, for underserved and vulnerable populations under the Health Center program. The full effect of PPACA funding on children's access to dental services in underserved areas, however, remains to be seen. See appendix III for additional information on the funding made available to the NHSC and Health Center programs through the Recovery Act and PPACA.

HHS's Oral Health Initiative 2010 and Other HHS Programs May Improve Access to Dental Services for Children in Underserved Areas

In an effort to increase support for and expand the department's emphasis on access to oral health care, including access for underserved populations, HHS launched a departmentwide Oral Health Initiative in April 2010 to improve the nation's oral health by better coordinating federal programs. According to HHS, the initiative is intended to improve the effective delivery of services to underserved populations by creating and financing programs to emphasize oral health promotion and disease prevention, increase access to care, enhance the oral health workforce, and eliminate oral health disparities.[50] The initiative includes two new HHS efforts targeted at specific groups of children that, although too early to tell, may lead to improved access for children in underserved areas:

- HHS's Administration for Children and Families has started the Head Start Dental Homes Initiative, to establish a national network of dental homes for children in Head Start and Early Head Start. The Administration for

[49]These grants for increased demand for services from health centers were awarded to fund activities such as adding new providers, expanding hours, or expanding existing health center services.

[50]See *Promoting and Enhancing the Oral Health of the Public: HHS Oral Health Initiative 2010* for a description of the agency's efforts under this initiative: http://www.hrsa.gov/publichealth/clinical/oralhealth/hhsinitiative.pdf (accessed June 16, 2010).

Children and Families Office of Head Start and the American Academy of Pediatric Dentistry define a dental home as comprehensive, continuously accessible, coordinated, and family-centered oral health care delivered to children by a licensed dentist.

- HHS's Indian Health Service has started the Early Childhood Caries Initiative to promote the prevention and early intervention of dental caries (tooth decay) for young American Indian and Alaska Native children—a population that experiences dental caries at a higher rate than the general U.S. population.[61]

In addition to the NHSC and Health Center programs, HHS administers, or has authority to administer, a number of other oral health programs. Although not all of these programs are targeted specifically to children in underserved areas, they may improve their access to dental services. Examples of such programs include: (1) the School-Based Dental Sealant Program, which was authorized by PPACA to expand grants for school-based dental sealant programs to all 50 states, territories, and Indian tribes and organizations;[62] and (2) the State Oral Health Workforce Grant program which awards grants to states to address workforce issues, including those associated with dental HPSAs. See appendix IV for a list of these and other HHS programs that may improve access to dental services in underserved areas.

[61]The Early Childhood Caries Initiative activities include early oral health assessment by community partners such as Head Start, nurses, and physicians; fluoride varnish application by these community partners and dental teams; and the application of dental sealants on primary teeth for young children.

[62]*See* Pub. L. No. 111-148, § 4102(b), 124 Stat. 551.

Use of Mid-Level Dental Providers Is Not Widespread in the United States, and Other Countries Have Used Them to Improve Children's Access to Dental Services

Mid-level dental providers—providers who can perform intermediate restorative procedures, such as drilling and filling a tooth, under remote supervision of a licensed dentist—are not widely licensed or certified to practice in the United States. Other countries, which have used mid-level dental providers for many years, reported that these providers deliver quality care and increase children's access to dental services.

Efforts Are Under Way to Use Mid-Level and Other Dental Providers to Improve Children's Access to Dental Services

Within the United States, experience with mid-level dental providers is limited to the Dental Health Aide Therapist program for Alaska Natives and the advanced dental therapy program in Minnesota.[53] Efforts are under way to increase access to dental services through the use of dental therapists, dental hygienists, physicians, and other new dental provider models.

Dental Health Aide Therapist Program for Alaska Natives

The Dental Health Aide Therapist program in Alaska, the only mid-level dental provider program with providers practicing in the United States as of July 2010, began in 2003 in response to the extensive dental health needs of Alaska Natives and high dentist vacancy rates in rural Alaska.[54] Dental health aide therapists (dental therapists) in Alaska are not licensed by the state; rather the program is authorized under the federal Community Health Aide Program for Alaska Natives. The 2-year training program is based on a long-standing dental therapy program in New Zealand. After completion of their training and preceptorship, dental therapists become certified and practice in their assigned villages under

[53]For the purposes of this report, in the United States, mid-level providers are known as dental therapists in Alaska under the Dental Health Aide Therapist program and advanced dental therapists in Minnesota.

[54]Alaska Native children had rates of dental caries (cavities) that were 2.5 times the U.S. average and Alaska tribes experienced dentist vacancy rates of 25 percent.

the remote consultative supervision of a dentist.[55] Services performed by dental therapists may include assessments and basic and intermediate restorative procedures. As of June 2010, 19 dental therapists were serving in rural Alaska native villages or completing their preceptorship with a supervising dentist.

Children are an important focus of the Dental Health Aide Therapist program. According to an official from the Alaska Native Tribal Health Consortium, about half of the patients seen by dental therapists under this program are children. For example, between 2006 and 2009, approximately 59 percent of encounters for one dental therapist were with children under 18 years old. Consortium officials also noted that Medicaid is a major payer for dental therapist services, indicating that dental therapists provide a substantial portion of their services to children under Medicaid.[56] Although limited research regarding the impact of this program has been completed, a 2008 study examining the quality of restorative procedures performed by dental therapists found that procedures provided by dental therapists do not differ from similar procedures performed by dentists.[57] In addition, in October 2010, a study of the Dental Health Aide Therapist program found that the five dental therapists who were included in the study performed well, operated safely, and were technically competent to perform procedures within their defined scope of practice. The study also noted that the patients of the dental therapists were generally very satisfied with the care they received from those therapists. The study assessed the quality of services and procedures provided by dental therapists using various methods including patient and oral health surveys, observations of clinical technical performance, medical chart audits, and facility evaluations.[58] See appendix V for more information on the Dental Health Aide Therapist program in Alaska.

[55]Under standards of the Community Health Aide Program Certification Board, prior to certification, each dental therapist is required to complete a clinical preceptorship under the direct supervision of a dentist for a minimum of three months or 400 hours, whichever is longer.

[56]Alaska Medicaid reimburses dental therapist services at the same encounter rate as services provided by a dentist.

[57]K.A. Bolin, "Assessment of treatment provided by dental health aide therapists in Alaska; a pilot study," *Journal of the American Dental Association*, Vol. 139 (2008).

[58]Scott Wetterhall MD, et al., *Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska* (Research Triangle Park, N.C.: RTI International, October 2010).

Minnesota's Advanced Dental Therapist Program

In 2009, Minnesota authorized the certification of the advanced dental therapist and dental therapist positions to provide dental services to low-income, uninsured, and underserved patients.[59] Advanced dental therapists are licensed dental therapists who, upon completion of additional education and experience, may become certified to perform a range of preventive, and basic and intermediate restorative procedures—including drilling and filling and non-surgical extractions of permanent teeth—under the remote consultative supervision of a dentist. They may also develop patient treatment plans with authorization by a consulting dentist.[60]

Advanced dental therapy training is offered by Metropolitan State University as a master's degree program which prepares students with an existing dental hygiene license for licensure as a dental therapist and certification as an advanced dental therapist upon completion of 2,000 hours of dental therapy practice.[61] As of June 2010, certification requirements for advanced dental therapists had not yet been finalized, and there were no practicing advanced dental therapists. State officials anticipated that the first advanced dental therapists will graduate in 2011. Once licensed, advanced dental therapists are required to enter into consultative agreements—which outline any restrictions to their scope of practice—with licensed dentists to whom they will refer patients for services beyond their scope of practice.[62] Minnesota health officials anticipated that advanced dental therapists will be eligible to receive direct Medicaid and CHIP reimbursement, but payment arrangements had not been finalized as of June 2010.

Use of Dental Hygienists and Physicians in Selected States

Certain states have made efforts to increase children's access to dental services by allowing dental hygienists and primary care physicians to provide certain dental services without the on-site supervision of a dentist. In seven of the eight states we examined—Alaska, California, Colorado,

[59]2009 Minn. Laws Ch. 95, Art. 3.

[60]In Minnesota, a dental therapist may perform a range of preventive and basic restorative procedures under remote consultative supervision of a dentist and intermediate restorative procedures under the on-site supervision of a dentist. Because of the on-site supervision requirement for intermediate restorative procedures, we do not consider Minnesota dental therapists as mid-level providers in this report.

[61]The University of Minnesota School of Dentistry also offers a bachelor of science and a master's degree program which prepare students for licensure as dental therapists, but does not include the training required for advanced dental therapist certification.

[62]Licensed dental therapists are also required to enter into consultative agreements.

Minnesota, Mississippi, Oregon, and Washington—dental hygienists may perform certain procedures, such as fluoride application, under remote or no supervision of a dentist; in some cases specifically to increase access for underserved populations.[63] For example, dental hygienists in California, Minnesota, Mississippi, Oregon, and Washington may practice in limited settings outside the private dental office under remote or no supervision of a dentist, increasing access to dental services for underserved populations, including children. Such practices are generally limited to settings such as schools or residential facilities and, in most cases, allow hygienists to provide only preventive services upon completion of additional training or clinical experience. Dental hygienists in these states increase the available locations for individuals to access certain preventive dental procedures. In addition, five of the eight states we studied—California, Colorado, Minnesota, Oregon, and Washington—reported that they allow direct Medicaid and in some cases CHIP reimbursement to certain dental hygienists for providing some preventive dental services.[64] See appendix VI for additional information on the scope of practice and requirements for dental therapists, dental hygienists, and dental assistants in the eight states we examined.

In addition, many states have also engaged primary care medical providers—such as physicians—in the provision of children's dental services. A survey conducted in 2009 indicated that 34 state Medicaid programs reimburse primary care medical providers for providing preventive dental procedures, such as fluoride application, and this represents an increase of nine states from a similar study conducted in 2008.[65] To track the provision of dental services by physicians and dental hygienists to children covered by Medicaid, CMS officials reported that

[63]Dental hygienists in Alabama may only perform dental procedures under the on-site supervision of a dentist. In addition to dental hygienists, dental assistants may provide a variety of services—depending on the state—including preventive and basic restorative procedures, however in general they require on-site supervision by a dentist.

[64]In the remaining three states—Alabama, Alaska, and Mississippi—Medicaid covered services provided by dental hygienists are reimbursed through their supervising dentist.

[65]Chris Cantrell, *Engaging Primary Care Medical Providers in Children's Oral Health* (Portland, Me.: National Academy for State Health Policy, September 2009). This study did not include a separate review of state CHIP reimbursement. According to officials from the Pew Center on the States, Children's Dental Campaign—the organization that funded the 2009 survey and monitors state Medicaid reimbursement policies—as of November 2010, 40 state Medicaid programs reimburse primary care medical providers for providing preventive dental procedures. Seven of the eight states we examined provided such reimbursement.

they are in the process of revising the CMS 416 to collect information on the number of children receiving dental services—such as sealants and oral assessments—from these providers and expect states will use the revised forms in 2011.

Efforts to Train or Employ New Dental Providers

In addition to state initiatives, PPACA authorized demonstration projects to train or employ certain dental providers. In March 2010, PPACA authorized $60 million to fund 15 demonstration projects to train or to employ "alternative dental health care providers" to increase access to dental services in rural and other underserved communities. PPACA defines alternative dental health care providers to include dental therapists, independent dental hygienists, advanced practice dental hygienists, primary care physicians, and any other health professionals that HHS determines appropriate.[66] Entities eligible to apply for the demonstration grants include colleges, public-private partnerships, federally qualified health centers, Indian Health Service facilities, state or county public health clinics, and public hospital or health systems.

Two professional organizations have also proposed new dental provider models to increase children's access to dental services.

- The American Dental Association developed the position of a community dental health coordinator as a new type of dental provider who may provide oral health education as well as some preventive services (depending on the state dental practice laws) under the supervision of a dentist in communities with little access to dental care. The association has begun a community dental health coordinator pilot training program, and as of July 2010, there were 27 students in three locations in California, Oklahoma, and Pennsylvania. The training includes a 12-month online training program through Rio Salado College and a 6-month clinical internship.[67] Officials from the American Dental Association told us they plan to train 18 additional community dental health coordinators by September 2012, and they anticipated all of these providers will serve in their home communities after the training program. The American Dental Association is currently designing an evaluation of the program to be completed in 2013, one year after the pilot training program ends in 2012.

[66]Pub. L. No. 111-148, § 5304, 124 Stat. 621. According to HRSA officials, as of June 2010, no funds had been appropriated specifically for these demonstration projects.

[67]Rio Salado College is based in Tempe, Arizona.

- The American Dental Hygienists' Association developed and proposed the advanced dental hygiene practitioner as a mid-level dental provider to work independently in a variety of settings to provide preventive and certain basic and intermediate restorative services—including procedures such as drilling and filling a tooth—to underserved populations. The model is similar to the advanced dental therapist position in Minnesota and proposes a master's degree curriculum that builds upon existing dental hygiene education programs.[68]

Other Countries Have Used Mid-Level Dental Providers to Improve Access to Dental Services

Mid-level dental providers—dental therapists—have been used by many countries to improve access to preventive and restorative dental services. In particular, New Zealand, the United Kingdom, Australia, and Canada have long-standing dental therapist programs.[69] These countries have used dental therapists to staff school- and community-based dental programs aimed at improving access to dental services for children and other underserved populations, such as those in rural areas (see table 6).[70] Since the mid-1990s, three of the four countries—New Zealand, the United Kingdom, and Australia—have combined their dental therapy and dental hygiene training programs.[71]

[68]The model proposed by the American Dental Hygienists' Association describes the supervisory arrangement for the advanced dental hygiene practitioner as a collaborative partnership with dentists for referral and consultations.

[69]The countries are presented in chronological order by the date that their dental therapy programs started; New Zealand has the oldest dental therapy program. The United Kingdom consists of the countries of England, Northern Ireland, Scotland, and Wales.

[70]These countries have other types of dental providers; however dental therapists are the only providers practicing in these countries who provide preventive, basic restorative and intermediate restorative dental procedures under remote supervision of a dentist. For example, Australia has a provider called a dental prosthesist who diagnoses and creates denture prosthesis, but does not provide primary (preventive and restorative) dental services.

[71]Graduates of the combined programs are generally known as oral health therapists and are trained to provide dental hygiene services such as preventive teeth cleaning in addition to dental therapy services such as intermediate restorative tooth drilling.

Table 6: Characteristics of Mid-Level Dental Providers in New Zealand, the United Kingdom, Australia, and Canada

Country (year program started) *Type of mid-level dental provider*[a]	Scope of practice	Supervision	Years of post secondary education[a]	Number licensed or practicing (year)
New Zealand (1921)				
Dental therapist/ Oral health therapist	• Preventive • Restorative (basic and intermediate)	Remote: consultative	3	730 (2009)
United Kingdom (1959)				
Dental therapist/ Oral health therapist	• Preventive • Restorative (basic and intermediate)	Remote: prior knowledge and consent	3	1,480 (2010)
Australia[b] (1966)				
Dental therapist/ Oral health therapist	• Preventive • Restorative (basic and intermediate)	Remote: consultative	3	1,760 (2005)
Canada (1972)				
Dental therapist	• Preventive • Restorative (basic and intermediate)	Remote: prior knowledge and consent	2	310[c] (2010)

Source: GAO analysis.

Note: In these countries, most dental therapists are paid through the government as salaried employees. However, some work in private practice and are then paid by their employers. The information in this table was obtained from interviews with health officials in the four countries, professional organizations, government reports, and published research. We did not conduct an independent review of the legal authorities for this information.

[a]Since the mid-1990s, Australia, the United Kingdom, and New Zealand have combined their dental therapy and dental hygiene programs with many offered as a bachelor's degree. The required education for the combined degree is between 2 and 3 years and graduates are trained in both scopes of practice.

[b]Until July 2010, dental therapy registration differed among Australia's states with three states allowing dental therapists to provide services to adults. Australia implemented a national registration scheme in July 2010 that will require all states to have the same scope of practice.

[c]Approximately three-quarters of dental therapists (230 of 310) in Canada practice in Saskatchewan, the only province where they are registered providers and able to work in private practice.

Dental therapists in the four countries, including those trained in combined oral health therapy programs, can perform preventive and basic and intermediate restorative procedures for children and adults without the on-site supervision of a dentist in both the public and private sectors. New Zealand, Australia, and Canada also permit dental therapists to determine patient treatment plans providing they maintain a relationship with a dentist where they can refer patients for services beyond their

scope of practice. See appendix VII for more information on the use of dental therapists in these countries.

Health officials from the four countries expressed no reservations about the quality of care provided by dental therapists. Although recent data on the quality of services provided by dental therapists in these countries are limited, a study published in 2009 on Australian dental therapists reported that the standard of restorative procedures performed by dental therapists was comparable to the standard expected of newly graduated dentists in that country.[72]

Health officials from New Zealand, Australia, and Canada reported that the majority of dental therapists' patients are children and available research found that dental therapists providing care in school- or community-based programs were an important part of improving dental outcomes for children.[73] For example, a health official from New Zealand—where dental therapists provide dental services in school-based clinics—told us that nearly all children aged 5 to 12 (96 percent) were enrolled in the nation's publicly funded school-based dental program in 2009. The program aims to see all enrolled children annually (or more frequently in high-risk cases) and the official told us that available data indicated that decay rates are reduced for these children. A New Zealand national oral health survey, planned for publication in December 2010, was expected to provide a clearer picture of children's oral health status across the population. In addition, one academic dental therapy official told us that in 2010 between 40 and 70 percent of Australian children, depending on the state, obtained dental services through publicly funded school-based dental programs primarily staffed by dental therapists. A 2008 study in Australia found that, from 1977 to 2002, the number of decayed, missing, and filled teeth declined 37 percent for primary teeth in 6-year old children and 79 percent for permanent teeth in 12-year old children enrolled in school-based

[72]The study examined 258 restorations on 80 adult patients six months after treatment. H. Calache, et. al, "The capacity of dental therapists to provide direct restorative care to adults," *Australian and New Zealand Journal of Public Health*, Vol. 33 (2009). An Australian official noted that the use of dental therapists is widely accepted and that because the programs are long-standing, few recent studies have been conducted. However, available research on the dental therapists in New Zealand (1951) and Canada (1974) showed that they provided restorative procedures that were similar in quality to restorative procedures provided by dentists.

[73]Health officials from the United Kingdom reported that dental therapists have not had a major impact on children's access in the United Kingdom because patients must first see a dentist before being referred to a dental therapist.

programs.[74] A Canadian health official reported that dental therapists serving aboriginal children in rural provinces and territories since the 1970s have often been the only reliable source of dental care for those children, in part because dentists are difficult to retain in rural areas. In the Canadian province of Saskatchewan, research on the impact of the province's school-based dental program estimated that the program served over 80 percent of non-aboriginal children in the province from 1976 to 1980 and that lower incidence of dental caries could be demonstrated with increased exposure to the program.[75] An official from the Saskatchewan Dental Therapists Association—the dental therapy regulating authority in the province—also reported that dental therapists working in private practice in the province increase children's access to dental services because they can provide restorative services and free time for dentists to see more patients. Since 2004, Canada has piloted and expanded the use of dental therapists to provide preventive and restorative services to aboriginal children in a community-based dental program. As of May 2010, Canadian health officials were completing an evaluation of the program, which they expected to show improved dental outcomes.

Conclusions

In the decade that has passed since the Surgeon General described the silent epidemic of oral disease affecting children in low-income families, dental disease and access to dental services have remained a significant problem for these children—including those in Medicaid and CHIP. States report that nationwide, only 36 percent of children in Medicaid received any dental service in fiscal year 2008, far below HHS's Healthy People 2010 target of 66 percent for low-income children. States also continue to report low participation by dentists in Medicaid and CHIP. Recognizing this challenge, HHS has taken a number of steps to strengthen its dental programs, including its HHS Oral Health Initiative 2010, and recent legislation has authorized and in some cases appropriated funding specifically for programs that may help increase access to dental services

[74]The number of decayed, missing, or filled teeth calculated for both primary (baby) and permanent (adult) teeth is a common measure for dental disease experience. See J.M. Armfield and A.J. Spencer, "Quarter of a century of change: caries experience in Australian children, 1977-2002," *Australian Dental Journal*, Vol. 53 (2008).

[75]The Saskatchewan school-based dental program was staffed by dental therapists and in existence from 1974 to 1993. D.W. Lewis, *Performance of the Saskatchewan Health Dental Plan, 1974-1980*, (University of Toronto, Toronto, Ontario, 1981). Although enrollment in the program by aboriginal children was much lower, enrollment of and access for these children increased over the period of study.

in underserved areas; but results of these efforts are yet to be seen. And while states report some improvement in the provision of Medicaid dental services between 2001 and 2008, CMS has not yet collected comprehensive data on utilization of dental services for children in Medicaid managed care programs and covered by CHIP. We have reported in the past that such gaps limit CMS's oversight of the provision of dental services for children, such as its ability to identify problems with specific service delivery methods.

Providing complete and accurate information to help families with children in the Medicaid and CHIP programs find dental care is an important tool in improving access. The information that HHS is required to post on its Insure Kids Now Web site could provide a useful tool for connecting these children and their families with dentists who will treat them. However, we found problems that limit its ability to do so, such as incorrect, outdated, or incomplete information; links to state Web sites that were not working; and even a dentist taking Medicaid patients who had been excluded by HHS from participation in the program. Addressing these problems—such as providing alternative sources of information to assist users when the Web site is not functioning or taken offline for maintenance, or providing additional guidance on dentists' ability to serve children with special needs—could help make the site more useful to beneficiaries.

Recommendations for Executive Action

We are making several recommendations to enhance the provision of dental care to children covered by Medicaid and CHIP.

First, to help ensure that HHS's Insure Kids Now Web site is a useful tool to help connect children covered by Medicaid and CHIP with participating dentists who will treat them, we recommend that the Secretary of HHS take the following actions:

- Establish a process to periodically verify that the dentist lists posted by states on the Insure Kids Now Web site are complete, usable, and accurate, and ensure that states and participating dentists have a common understanding of what it means for a dentist to indicate he or she can treat children with special needs.
- Provide alternate sources of information, such as HHS's toll-free 1-877-KIDS-NOW telephone number, on the Insure Kids Now Web site when a page or link from the Web site is not functioning or taken offline for maintenance.

- Require states to verify that dentists listed on the Insure Kids Now Web site have not been excluded from Medicaid and CHIP by the HHS-OIG, and periodically verify that excluded providers are not included on the lists posted by the states.

Second, to strengthen CMS oversight of Medicaid and CHIP dental services provided by dental managed care programs, we recommend that the Administrator of CMS take steps to ensure that states gather comprehensive and reliable data on the provision of Medicaid and CHIP dental services by managed care programs.

Agency Comments

We provided a draft of this report for comment to HHS. HHS agreed with our recommendations and provided written comments, which we summarize below. The text of HHS's letter—which included comments from CMS, HRSA, and CDC—is reprinted in appendix VIII. HHS also provided technical comments, which we incorporated as appropriate.

In commenting on our recommendation that steps should be taken to improve the Insure Kids Now Web site, CMS and HRSA concurred that more attention needs to be devoted to improve the accuracy of information submitted by the states. To that end, CMS and HRSA commented that they will undertake several actions:

- To address errors on the site, CMS stated that the agency will increase the type and frequency of checks performed and work with states to ensure that they submit data that are free of the types of problems we identified. HRSA commented that it will work with CMS to develop a plan to periodically analyze a sample of data provided by states to assess its accuracy.
- To ensure that providers that HHS has excluded from Medicaid and CHIP are not listed on the site, CMS commented that it will ensure states are aware that such providers must not be included in the data, and HRSA reported that it plans to cross-check listed providers against the HHS-OIG's database of excluded parties.
- CMS commented that it will ensure that there is a consistent understanding of what it means to be identified on the site as a dentist serving children with special needs.

CMS agreed with our recommendation that the agency take steps to ensure that states gather comprehensive and reliable data on the provision of Medicaid and CHIP dental services by managed care programs, noting that the agency is in the process of revising the CMS 416 to include more information about dental services provided to children in state Medicaid programs, including under managed care payment arrangements. CMS's comments do not specify whether the agency will require states to separately report utilization under managed care for children in Medicaid or CHIP, a step that we believe is necessary for effective oversight.

In addition, CDC commented that a statement in the introduction of our report regarding the prevalence of tooth decay and dental disease in children may be misleading. Although our statement accurately reflects information that we previously reported, we revised the language to clarify that the results of our analysis specifically refer to children enrolled in Medicaid.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IX.

Katherine Iritani
Acting Director, Health Care

Appendix I: Scope and Methodology

To address the objectives in our review—to examine (1) the extent to which dentists participate in Medicaid and the Children's Health Insurance Program (CHIP) and federal efforts to help families find dentists to treat children in these programs, (2) what is known about access for Medicaid and CHIP children in different states and in managed care, (3) federal efforts under way to improve access to dental services by children in underserved areas, and (4) how states and other countries have used mid-level dental providers to improve children's access to dental services—we interviewed appropriate officials from the Department of Health and Human Services (HHS), academic institutions, professional associations, states, and dental and children's advocacy groups; reviewed federal and state laws and regulations; obtained, reviewed, and determined the reliability of data; and reviewed relevant literature.

Specifically, to determine the extent to which dentists participate in Medicaid and CHIP and federal efforts to help families find dentists to treat children in these programs, we:

- Analyzed state reported data on the number of dentists in a state treating Medicaid and CHIP patients, including data from the 2009 Association of State and Territorial Dental Directors (ASTDD) survey[1] and one of our prior reports.[2]
- Reviewed articles in peer-reviewed journals and reports on access to dental services by children with special health care needs.
- Examined states' dentist listings on HHS's Insure Kids Now Web site, including whether listings were complete, usable, and accurate:

Completeness: To examine the completeness of the information on the Web site, we conducted two reviews—in November 2009 and in April 2010—to determine whether information CMS guidance had identified as required elements were present. We examined each state's listing of dentists to determine if certain elements listed as required in the Centers for Medicare & Medicaid Services' (CMS) June 2009 guidance were present

[1]ASTDD surveyed dental directors in all states and the District of Columbia. Respondents were asked to provide the most recent data available or data for the most recently completed fiscal year—generally 2008 data for the 2009 survey. See http://apps.nccd.cdc.gov/synopses/AboutV.asp (accessed July 21, 2010).

[2]GAO/HEHS-00-149.

for all dentists in all Medicaid and CHIP programs operated by the state (states can have multiple dental plans within Medicaid and CHIP) and recorded instances in which data were missing or incomplete for all or some dentists. Specifically, we examined each state's listing for the presence of dentists' names, addresses, phone numbers, and specialties; whether they accepted new Medicaid or CHIP patients; and whether they could accommodate children with special needs.[3]

Usability: In May 2010, we conducted a review of the information available on the Insure Kids Now Web site for each of the 50 states and the District of Columbia. The purpose of this review was to determine whether families seeking a dentist to treat a child covered by Medicaid or CHIP could reasonably complete the task and, if not, what types of errors prevented the site from being usable, such as whether hyperlinks functioned as expected and linked pages contained appropriate information. We tested the drop-down menus on the Web site for the Medicaid and CHIP programs in each state, conducted a general search of dentists for each program, and searched for dentists in each state's capital city and in the District of Columbia.

Accuracy: To check the accuracy of information on dentists posted on the Insure Kids Now Web site, we selected a nongeneralizable sample of dentists listed on the Web site for four states (California, Georgia, Illinois, and Vermont) that provided variation in geography, managed care penetration for Medicaid (as reported by the American Dental Association), and number of children covered by Medicaid. We selected 25 urban dentists and 15 rural dentists listed on the Insure Kids Now Web site in each state. For urban dentists, we identified the urban county with the most children in poverty, the largest city in that county, and then the zip code within that city with the most children in poverty. We then searched for general dentists nearest to the selected zip code.[4] For rural dentists, we selected general dentists in the rural counties with the most children in poverty, excluding rural counties adjacent to major metropolitan areas.

[3]CHIPRA required that HHS post a complete and accurate list of dentists participating in state Medicaid and CHIP programs on the Insure Kids Now Web site by August 4, 2009. In June 2009, CMS issued guidance specifying certain data elements required for each dentist listed on the Insure Kids Now Web site, including the dentists' name, address, telephone number, and specialty; whether the dentist accepts new Medicaid or CHIP patients; and whether the dentist can accommodate patients with special needs.

[4]For all 4 states, HHS's Insure Kids Now Web site allowed the user to enter a zip code to identify dentists nearest to the selected zip code.

We limited our searches to dentists listed as accepting new Medicaid and CHIP patients. We used U.S. Census data and an urban/rural classification system developed by the U.S. Department of Agriculture (called Rural-Urban Continuum Codes) to identify the areas from which we selected dentists. In May 2010, we called the telephone number listed for the selected dentists and asked the person scheduling appointments if the listed dentist currently accepted new patients, including new patients enrolled in the state's Medicaid and CHIP programs. We also asked whether the dentist accommodated children with special health care needs—generally, and specifically with regard to wheelchair access and ability to treat children requiring sedation. Finally, we asked if the listed address was accurate and inquired about the next available appointment time. In the course of making calls we contacted more than 40 dentists in some states because some offices had multiple dentists listed on the Web site, resulting in a total of 188 dentists included in our calls.

- Reviewed the literature, including our past reports and peer-reviewed journals, on factors that impact dentists' decisions to participate in Medicaid and states' efforts to address barriers to dentists' participation.

To examine what is known about access for children in Medicaid and CHIP in different states, including for children in managed care, we examined dental utilization data on children covered by Medicaid, including those covered under Medicaid expansion programs, reported by states to CMS through the annual CMS 416 form. For each state and nationally, we calculated utilization rates reported for any dental service, preventive dental services, and dental treatment services. We calculated utilization rates for federal fiscal year 2001, the year after our first report on oral health, and federal fiscal year 2008, the most recent year for which data were available. In addition, we compared children's utilization of any dental service to data reported by the American Dental Association on the proportion of children in each state who receive their Medicaid dental benefits through managed care.

To identify federal efforts under way to improve access to dental services by children in underserved areas we interviewed cognizant HHS officials, including those from CMS and the Health Resources and Services Administration (HRSA), and obtained written responses from agency officials to specific questions about relevant programs. We obtained data on health center and National Health Service Corps (NHSC) dental provider numbers and HHS program funding levels from HHS officials and documents such as annual HRSA budget justifications. We also reviewed provisions in the Recovery Act and the Patient Protection and Affordable

Care Act (PPACA) legislation and interviewed HHS officials to discuss legislative changes and funding authorized and in some cases appropriated for programs that promote dental services in underserved areas.

To determine how states and other countries have used mid-level dental providers to improve dental access for children, we examined laws, regulations, and practices in eight states and interviewed or obtained written responses from relevant officials in those eight states and four countries. To select those eight states for review, we used a standard set of questions posed to relevant officials from academic institutions, professional associations, and advocacy groups regarding states' dental practice laws, including practice of mid-level dental providers. Using the standard set of questions, we obtained responses on those states considered "expansive" and those considered "restrictive" in their laws governing the practice of dental providers. We assessed the responses and, to demonstrate the variation in state laws, selected eight states—Alabama, Alaska, California, Colorado, Minnesota, Mississippi, Oregon, and Washington. To obtain information on the selected states' use of dental providers other than dentists, we conducted interviews and obtained information from Medicaid and CHIP officials and dental boards in the selected states. Our interviews with officials revealed that there is no commonly recognized definition of mid-level dental providers, therefore we defined mid-level dental providers as providers who may perform intermediate restorative procedures, such as drilling and filling a tooth, under the remote supervision of a dentist. In addition, we defined scope of practice for the purposes of this report based on interviews and review of literature and state laws. To gather information on the only practicing mid-level dental providers in the United States, we conducted a site visit to Alaska. We interviewed state and tribal officials on the Alaska Dental Health Aide Therapist program administered by the Alaska Native Tribal Health Consortium and visited two clinics where dental therapists were training and practicing. To identify efforts related to new dental provider models, we reviewed policies and proposals by professional associations and interviewed officials from academic institutions, professional associations, HHS, and our selected states. To select countries for further review, we identified four countries that use mid-level providers, specifically dental therapists, and are comparable to the United States (identified as developed countries by the CIA World Factbook[5] and with a

[5]*The World Factbook 2009*. Washington, D.C.: Central Intelligence Agency (2009). See https://www.cia.gov/library/publications/the-world-factbook/appendix/appendix-b.html#D (accessed Nov. 20, 2009).

similar percentage of children living in households with incomes below 50 percent of their country's median income). The four countries examined were Australia, Canada, New Zealand, and the United Kingdom. To obtain information on the selected countries' use of mid-level dental providers, we conducted a literature review and interviewed oral health experts and government health officials in each country.[6]

To verify the reliability of the data we used for all four objectives, including HRSA's health center data, ASTDD survey data, the American Dental Association's Medicaid managed care data, U.S. Census data, the U.S. Department of Agriculture's Rural-Urban Continuum Codes, the CMS 416 annual reports, and Alaska Dental Health Aide Therapist encounter data, we interviewed knowledgeable officials, reviewed relevant documentation, and compared the results of our analysis to published data, as appropriate. We determined that the data were sufficiently reliable for the purposes of our engagement.

We conducted this performance audit from August 2009 through November 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[6]We did not perform an independent review of laws and regulations of foreign jurisdictions, but relied on information provided by officials, government reports, and peer-reviewed research.

Appendix II: Medicaid Dental Utilization Rates for Fiscal Year 2008

States report annually to the Centers for Medicare & Medicaid Services (CMS) on the provision of certain covered services, including dental services. Specifically, services covered under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit are reported by states on an annual participation report, CMS 416. It captures data on the number of children who received any dental service, preventive dental service, or dental treatment service each year. We used this information to calculate state and national dental utilization rates—that is, the percentage of children eligible for EPSDT that received services in a given year (see table 7).

Table 7: Utilization of Any Dental Service, Preventive Dental Service, and Dental Treatment Service by Children in Medicaid, Ranked in Order, Fiscal Year 2008

State	Any dental service utilization	State	Preventive dental services utilization	State	Dental treatment services utilization
Idaho	56.1%	Vermont	49.9%	New Mexico	42.1%
Vermont	51.1%	Idaho	46.0%	West Virginia	41.5%
Texas	48.5%	Rhode Island	43.1%	Idaho	30.4%
New Hampshire	46.6%	New Hampshire	42.5%	Arkansas	29.9%
Nebraska	45.9%	South Carolina	42.4%	Hawaii	26.1%
Rhode Island	45.8%	Nebraska	41.6%	Massachusetts	25.1%
Iowa	45.8%	Texas	41.6%	Maine	25.1%
South Carolina	45.0%	Washington	41.4%	Texas	25.0%
Washington	45.0%	Massachusetts	40.3%	South Carolina	22.1%
Massachusetts	44.0%	North Carolina	39.9%	Nebraska	21.8%
North Carolina	43.8%	Iowa	39.4%	Vermont	21.5%
New Mexico	42.9%	Georgia	38.5%	Kentucky	21.2%
Hawaii	42.1%	Alabama	38.4%	New Hampshire	21.1%
West Virginia	41.7%	New Mexico	38.2%	Rhode Island	20.7%
Georgia	41.7%	Indiana	37.1%	Virginia	20.5%
Alabama	41.6%	Hawaii	36.9%	Arizona	20.4%
Indiana	40.8%	Oklahoma	36.5%	Washington	20.4%
Oklahoma	39.2%	West Virginia	36.0%	Alaska	20.2%
Kansas	38.9%	Kansas	35.9%	Indiana	20.0%
Arizona	38.8%	Illinois	35.4%	Georgia	19.6%
Colorado	38.5%	Virginia	35.2%	North Carolina	19.2%
Mississippi	38.5%	South Dakota	34.6%	Colorado	19.1%
Virginia	38.4%	Utah	34.1%	Tennessee	19.0%

State	Any dental service utilization	State	Preventive dental services utilization	State	Dental treatment services utilization
South Dakota	38.4%	Maine	33.9%	Iowa	19.0%
Illinois	38.4%	Tennessee	33.7%	Wyoming	18.9%
Kentucky	38.1%	Colorado	33.5%	Oklahoma	18.4%
Alaska	38.0%	Arizona	33.5%	New Jersey	18.0%
Tennessee	37.6%	Minnesota	32.7%	Kansas	17.9%
Maryland	37.2%	Wyoming	32.0%	Utah	17.7%
Connecticut	36.7%	Ohio	31.7%	Alabama	17.7%
Minnesota	36.7%	Mississippi	31.7%	Louisiana	17.2%
Wyoming	36.5%	Kentucky	31.6%	Minnesota	17.0%
Ohio	36.4%	Michigan	31.6%	Mississippi	16.6%
Maine	36.2%	Maryland	31.6%	Maryland	16.4%
Utah	35.0%	Arkansas	31.4%	Ohio	16.1%
District of Columbia	34.0%	Alaska	31.4%	Delaware	16.1%
Arkansas	33.6%	Connecticut	30.3%	California	16.0%
Delaware	33.4%	Delaware	30.1%	Oregon	15.8%
New Jersey	32.9%	District of Columbia	29.0%	Connecticut	15.4%
Oregon	32.8%	Louisiana	28.0%	New York	15.1%
Louisiana	32.5%	New Jersey	27.8%	South Dakota	14.8%
Michigan	32.4%	New York	27.6%	Illinois	14.7%
New York	32.1%	Oregon	27.6%	Michigan	13.6%
California	30.2%	Nevada	25.0%	District of Columbia	13.6%
Nevada	29.8%	California	24.5%	Montana	13.3%
North Dakota	29.1%	North Dakota	23.8%	Missouri	13.3%
Pennsylvania	26.9%	Pennsylvania	22.3%	Pennsylvania	12.9%
Montana	25.6%	Montana	22.1%	Nevada	11.7%
Missouri	24.7%	Missouri	21.9%	North Dakota	11.7%
Wisconsin	24.1%	Wisconsin	21.0%	Wisconsin	10.4%
Florida	20.9%	Florida	13.8%	Florida	7.8%
Nationwide	**36.2%**	**Nationwide**	**31.5%**	**Nationwide**	**18.0%**

Source: CMS Form 416 data for fiscal year 2008.

Note: This table represents dental utilization rates calculated from data reported by states in their fiscal year 2008 CMS 416 reports (the most recent available at the time of our review) on the number of EPSDT-eligible Medicaid-enrolled children who received any dental service during the fiscal year. Children enrolled in CHIP programs that are expansions of the states' Medicaid programs are entitled to the Medicaid EPSDT benefit package and are included in the states' CMS 416 reports, but are not identified separately as CHIP enrollees.

Appendix III: NHSC and Health Center Funding in the Recovery Act, PPACA, and Fiscal Year 2010 Appropriation

The Recovery Act appropriated $500 million to address health professions workforce shortages through means such as scholarships and loan repayment awards, of which the Conference Committee directed $300 million be provided to NHSC for recruitment and field activities.[1] HRSA plans to use these funds in fiscal years 2009 through 2011.[2] For the Health Center program, the Recovery Act appropriated $2 billion for grants to benefit health centers—$500 million for grants to support the delivery of patient services and $1.5 billion for grants to support and improve health center infrastructure. According to HRSA, as of December 31, 2009, Recovery Act funds for health centers had provided support to over 550 full-time equivalent dental positions, including dentists, dental hygienists, and dental assistants, as well as dental aides, and dental technicians. HRSA reported that these positions have led to more than 575,000 dental visits to over 264,000 patients, including children, in underserved areas.

PPACA authorized and appropriated a total of $1.5 billion for NHSC for fiscal years 2011 through 2015. According to HRSA, this funding will increase the number of dentists and dental hygienists participating in NHSC. However, the agency reported that the exact number of scholarship and loan repayment awards made using these funds will depend on the number of qualified applications the program receives.[3] Additionally, PPACA authorized and appropriated $9.5 billion for health centers through the Community Health Center Fund established by the Act as well as $1.5 billion for construction and renovation of community health centers for fiscal years 2011 through 2015.[4]

[1]H. R. Rep. No. 111-16, at 451 (2009) (Conf. Rep.).

[2]Seventy-five-million dollars of the amount appropriated for NHSC is to remain available through September 30, 2011.

[3]PPACA also authorized a total of approximately $31 billion for health centers for fiscal years 2011 through 2015, with authorization for funding in subsequent years to reflect the growth in costs and the number of patients served. However, these amounts remain unavailable for expenditure until appropriated.

[4]PPACA established and authorized and appropriated funding to the Community Health Center Fund and directed amounts from this fund to be transferred to HHS to provide $9.5 billion in enhanced funding for health centers and $1.5 billion in enhanced funding for NHSC. It also authorized and appropriated $1.5 billion for construction and renovation of community health centers. Pub. L. No. 111-148, § 10503, 124 Stat. 1004, as amended by Pub. L. No. 111-152, § 2303, 134 Stat. 1083.

Funds specifically provided for these programs in the Recovery Act and PPACA are in addition to the funds that may be specifically or generally available for the NHSC and Health Center programs through HHS's annual appropriations (see table 8).

Table 8: Funding for National Health Service Corps and Health Center Programs Under the Recovery Act and PPACA, and the Fiscal Year 2010 Annual Appropriation

Legislation/Program	Funding (appropriated) (in millions)	Funding time frame (fiscal years)
Recovery Act		
National Health Service Corps	$300[a]	2009-2011
Health Center	$2,000	2009
PPACA		
National Health Service Corps	$1,500	2011-2015
Health Center	$11,000[b]	2011-2015
Fiscal Year 2010 Program Funding		
National Health Service Corps	$142[c]	2010
Health Center	$2,190[c]	2010

Source: GAO analysis.

Note: This table presents data from the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 and H.R. Rep. No. 111-16 (2009) (Conf. Rep.); the Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, Division D., Title II, 123 Stat. 3034 and H. R. Rep. No. 111-220 (2009) and S. Rep. No. 111-66 (2009); the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. Funding time frames represent the fiscal years during which funding detailed in the "Funding (appropriated)" column will be available for obligation. All amounts rounded to the nearest million.

[a]Based on direction provided by the Conference Committee for the Recovery Act for specific use of the Act's appropriation to the Department of Health and Human Services. H.R. Rep. No. 111-16, at 451 (2009).

[b]As amended by the Health Care and Education Reconciliation Act of 2010. Pub. L. No 111-152, § 2303, 111 Stat.1029, 1083.

[c]Based on direction provided by the House and Senate Committees on Appropriations for specific use of the 2010 HRSA appropriation. H. R. Rep. No. 111-220, at 46, 49 (2009); S. Rep. No. 111-66, at 38, 40-41 (2009) (providing direction for HRSA appropriation contained in Consolidated Appropriations Act 2010, Pub. L. No. 111-117, Division D, Title II, 123 Stat. 3034, 3239 (2009)).

Appendix IV: Additional HHS Programs That May Improve Access to Dental Services in Underserved Areas

In addition to the NHSC and Health Center programs, HHS administers a number of programs that, while not targeted specifically to children in underserved areas, may nevertheless improve their access to dental services in underserved areas. These include programs that target the provision of oral health services to specific populations such as schoolchildren, as well as programs that support training of oral health providers or prioritize the training of dentists and dental hygienists that could serve in underserved areas (see table 9).

Table 9: HHS Programs that May Improve Access to Dental Services in Underserved Areas

Program (Authority) *HHS Agency*	Program Type: Supports the Provision of Dental Services	Program Type: Oral Health Workforce Training and Support	Description
Children's Hospitals Graduate Medical Education (42 U.S.C. § 256e) *HRSA*		✓	Provides support to freestanding children's hospitals to train medical residents, including dental residents and fellows.[a]
Grants for Training in General, Pediatric, and Public Health Dentistry (42 U.S.C. § 293k-2) *HRSA*		✓	Awards grants to schools, hospitals, and other entities that plan, develop, operate, or participate in an approved professional training program that emphasizes training in general, pediatric, and public health dentistry.[b]
Health Professionals Student Loan Program (42 U.S.C. § 292q) *HRSA*		✓	Awards loans to financially needy health professions students, including dental students.
Loans for Disadvantaged Students (42 U.S.C. § 292t) *HRSA*		✓	Awards loans to health professions students from disadvantaged backgrounds, including dental students.
Ryan White Community-Based Dental Partnership and Ryan White Dental Reimbursement Programs[c] (42 U.S.C. § 300ff-111) *HRSA*	✓	✓	Awards grants to accredited dental education programs to increase access to oral health services for people with human immunodeficiency virus (HIV) in underserved areas by: (1) increasing the number of dentists and dental hygienists with the capability of managing the oral health needs of HIV positive patients; and (2) defraying their unreimbursed costs associated with providing oral health care to people with HIV (applicable to the Dental Reimbursement program only).
Scholarships for Disadvantaged Students (42 U.S.C. § 293a) *HRSA*		✓	Awards scholarships to health professions students from disadvantaged backgrounds, including dental and dental hygiene students.

Program (Authority) *HHS Agency*	Program Type: Supports the Provision of Dental Services	Program Type: Oral Health Workforce Training and Support	Description
School-Based Dental Sealant Program (42 U.S.C. § 247b-14(c)) *Centers for Disease Control and Prevention*	✓		Expands grants for school-based dental sealant programs to provide dental sealants to target populations of children.[d]
School-Based Health Centers (42 U.S.C. §§ 280h-4, 280h-5) *HRSA*	✓		Authorizes HHS to award grants for the establishment of or for the operation of school-based health centers. Requires or authorizes HHS to give preference to applicants that serve a large population of Medicaid and CHIP children or that serve communities with high numbers of children and adolescents who are uninsured, underinsured, or enrolled in public health insurance programs.[e]
State Oral Health Workforce Grants (42 U.S.C. § 256g) *HRSA*	✓	✓	Awards grants to states to address primarily workforce issues associated with dental HPSAs.[f]

Source: GAO analysis of statutes and HHS information, including grant guidance, summary information from HRSA and CDC Web sites, and information provided by agency officials.

Note: This table presents selected HHS programs that may improve access to dental services in underserved areas. While not targeted specifically to children in underserved areas, these programs may improve their access through support of the provision of dental services to specific populations or through support for oral health workforce training.

[b]HRSA reports that, in fiscal year 2009, 56 hospitals were funded through the Children's Hospitals Graduate Medical Education payment program. According to HRSA, the program enables the hospitals to support graduate medical education, enhance research, and provide care for underserved children.

[c]Statutory priority for awarding grants includes giving priority to applicants that establish formal relationships with health centers as well as applicants that have a high rate of placing residents in underserved areas.

[d]While the Ryan White Act authorizes support for institutions that may provide oral health services, these two grant programs—the Ryan White Community-Based Dental Partnership Program and the Ryan White Dental Reimbursement Program—are specifically focused on funding for dental services.

[e]As of May 2010, 16 states had grants to operate school-based or linked dental sealant programs, which generally target schools with large populations of low-income children using the percentage of children eligible for federal free and reduced-cost lunch programs. The Patient Protection and Affordable Care Act (PPACA) authorized an expansion of the program to all 50 states, territories, and Indian tribes and organizations. Dental sealants are a plastic material applied to the chewing surfaces of back teeth that have been shown to prevent tooth decay.

[f]PPACA provided for the establishment of this program and appropriated $200 million over 4 years for the establishment of school-based health centers. PPACA also authorized such sums as may be necessary for grants for program operations over 5 years, although HRSA officials reported no funding had been appropriated specifically for this purpose as of October 2010.

[1]HRSA reported that, as of October 2010, a total of 30 states had 34 grants, with California, Florida, Kansas and Ohio having two grants each. Twenty-five of these 34 active, three-year, grants were awarded in fiscal year 2009 and nine more were awarded in fiscal year 2010. All 30 states may only use the funds received under these grants for the 13 legislatively-authorized activities including, but not limited to, loan forgiveness and repayment programs for dentists who agree to practice in dental HPSAs, programs to expand or establish oral health services and facilities in dental HPSAs, and community-based prevention services—see Social Security Act 340G(b) (codified at 42 U.S.C. 256g(b)). HRSA reported that it awarded $10 million in grants in fiscal year 2009 and $17.5 million in fiscal year 2010.

Appendix V: Dental Health Aide Therapist Program for Alaska Natives

Based on a 1999 oral health survey, the Indian Health Service issued a report detailing the extensive dental health needs and increasing dental vacancy rates within the Alaska Native population.[1] In order to meet the extensive dental health needs of the Alaska Native population, the Alaska Native Tribal Health Consortium (Consortium), a tribal organization managed by Alaska Native tribes through their respective regional health organizations, in collaboration with others, developed the Dental Health Aide Therapist program in 2003. This program selects individuals from rural Alaska communities to be trained and certified to practice under remote consultative supervision of dentists in the Alaska Tribal Health System. Dental health aide therapists (dental therapists) in this program in Alaska are not licensed by the state; rather the program is authorized under the federal Community Health Aide Program for Alaska Natives.

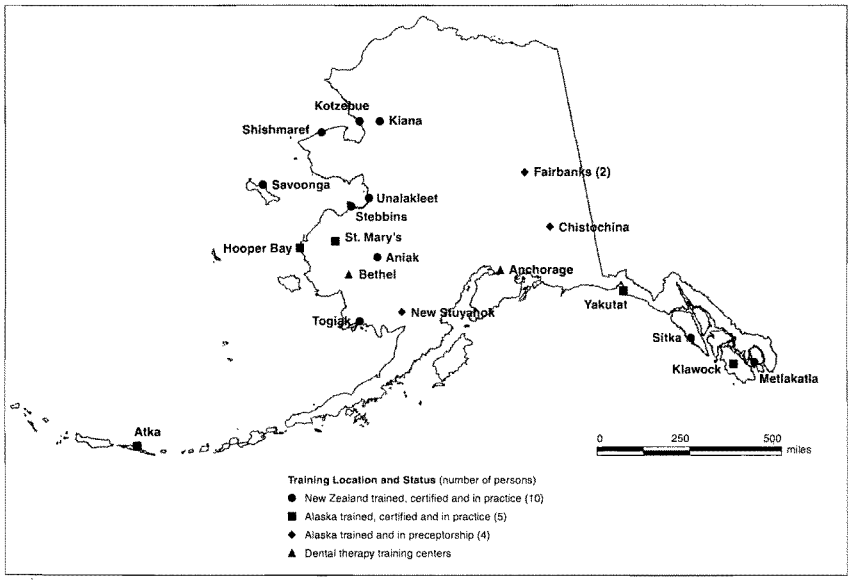
Under standards and procedures developed for this program, dental therapists must complete a 2-year training program, a 400-hour preceptorship under a dentist's supervision, and apply for certification in order to practice. Alaska's first dental therapists received their training from New Zealand's National School of Dentistry in Otago with the first dental therapists graduating in 2004. In 2007, the Consortium in partnership with the University of Washington opened the DENTEX training center and, in 2008, opened the Yuut Elitnaurivat Dental Training Clinic in partnership with the Yuut Elitnaurviat—People's Learning Center. These are the first Dental Health Aide Therapist training centers in the United States. As of March 2010, there were 13 dental therapy students enrolled in the training program.

Since 2005, dental therapists have practiced throughout Alaska. As of June 2010, 19 dental therapists had completed the 2-year training program. Of those 19, 10 dental therapists were trained in New Zealand and were certified and practicing in rural Alaska. Another five completed their preceptorships and were certified to begin practice. The remaining four dental therapists were completing their preceptorships. Figure 5 shows the areas and villages where the dental therapists were practicing or were scheduled to practice upon completion of their preceptorships. According to Consortium officials, the population of the communities where dental

[1]U.S. Department of Health and Human Services, Indian Health Service, *An Oral Health Survey of American Indian and Alaska Native Patients: Findings, Regional Differences and National Comparisons* (Rockville, Md.).

therapists were practicing varies from under 100 to nearly 9,000 individuals.

Figure 5: Dental Therapist Training Locations and Certification Status in Alaska, June 2010



Source: Alaska Native Tribal Health Consortium; MapInfo (map).

In general, dental therapists are based in a sub-regional clinic in an Alaska Native village and travel to surrounding villages to provide services.[2] For example, one dental therapist who has been practicing at a sub-regional clinic since 2006 estimated that he travels approximately two weeks per month to the surrounding villages to provide dental services. Travel for the dental therapists, particularly in the winter, is a challenge as there are limited roads to and from the villages and in many cases air travel is the only possible mode of transport. When traveling, dental therapists often bring their own supplies into the villages and in some cases have to pack a portable dental chair.

Dental therapists treat patients primarily in rural Alaska Native communities. Although these patients are typically Alaska Native or American Indian, services may be provided to other patients, for example when the program has capacity to provide the services to others without denying or diminishing care to Alaska Native or American Indian beneficiaries or there are limited health care resources in the area. Consortium officials stated that all the tribal organizations for regions employing dental therapists generally make services available to non-Native patients, except in larger communities, such as Anchorage, Fairbanks, Juneau, and Sitka.

According to Consortium officials, dental therapists often have an agreement with the schools in their communities to allow for students to receive services during school hours. Dental therapists are trained to focus on expectant mothers and pre-school and school-aged children. Consortium officials estimate that about half of patients treated by dental therapists are children. For example, encounter data for 2006 through 2009 for two practicing dental therapists suggest that, on average, 64 percent and 59 percent of their encounters were children, respectively.[3]

[2]The Alaska Tribal Health System operates using a four-tiered approach: (1) statewide services are provided in Anchorage, (2) regional services are provided at hubs within the various regions, (3) sub-regional clinics operate in some villages, and (4) small village clinics are where individuals obtain their primary health care.

[3]The 2009 encounter data for one dental therapist was only for a portion of that year.

Appendix VI: Types of Dental Providers, Excluding Dentists, in Eight Selected States

In the states we examined—Alabama, Alaska, California, Colorado, Minnesota, Mississippi, Oregon, and Washington—a variety of dental providers other than dentists, such as dental therapists and hygienists, may provide certain services with varying degrees of supervision. Supervision of other dental providers by a dentist may take many forms. For the purposes of this report, we categorized dental supervision as: (1) the dentist must be on-site during the procedure; (2) the dentist may be off-site (remote) but must have prior knowledge of and consent to the procedures, in some cases through a treatment plan; (3) the dentist may be off-site (remote) but maintain a consultative role, for example through a signed collaborative agreement; or (4) the dentist provides no supervision (none). In addition, within each state, there is a basic level of required education and experience for each category of provider, which may increase depending on the scope of practice authorized. For example, dental hygienists in Alaska may perform preventive and basic restorative procedures under a collaborative agreement if—in addition to graduating from dental hygiene school—they have completed 4,000 hours of clinical experience. All required education and experience is listed for each type of provider.

In the eight states we examined scope of practice, required supervision, education and experience, and reimbursement varied by state. Tables 10 through 17 present information on dental providers—other than dentists—authorized to practice in those eight states.

Table 10: Selected Types of Dental Providers in Alabama, June 2010

Type of dental provider	Scope of practice*	Supervision required	Required education and experience	Licensed or certified	Direct Medicaid/CHIP reimbursement
Dental hygienist	• Preventive • Basic restorative	On-site	• Approved dental hygiene school, college or state program	Yes	No
Dental assistant	• Supportive • Preventive • Basic restorative	On-site	• None	No	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state officials.

*Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

Table 11: Selected Types of Dental Providers in Alaska, June 2010

Type of dental provider	Scope of practice[a]	Supervision required	Required education and experience	Licensed or certified	Direct Medicaid/CHIP reimbursement
Dental health aide therapist for Alaska Natives[b]	• Preventive • Basic restorative • Intermediate restorative	Remote: consultative	• Two years post-secondary training program[c] • Specified clinical experience	Yes[d]	Yes
Dental hygienist	• Preventive • Basic restorative	Remote: consultative	• Dental hygiene program • Specified clinical experience	Yes	No
	• Preventive • Basic restorative	Remote: prior knowledge and consent	• Dental hygiene program	Yes	No
	• Preventive • Basic restorative • Intermediate restorative[e]	On-site	• Dental hygiene program • Specific instructional program	Yes	No
Dental assistant	• Supportive • Preventive • Basic restorative • Intermediate restorative[e]	On-site	• Specific instructional program	Yes	No
	• Supportive • Preventive[f]	On-site	• None	No	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state and tribal officials.

[a]Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

[b]The Dental Health Aide Therapist program is authorized under the federal Community Health Aide Program for Alaska Natives, not the state.

[c]Dental health aide therapists are recruited from Alaska communities.

[d]Dental health aide therapists are not licensed by the state; rather they are certified by the Alaska Native Tribal Health Consortium as part of the federal Community Health Aide Program for Alaska Natives.

[e]State regulations establishing specific restorative function requirements have not yet been established.

[f]Dental assistants may perform certain preventive procedures such as coronal polishing, with appropriate certification which would require the completion of a specific instructional program. They may perform other preventive procedures such as the application of sealants with no additional training.

Table 12: Selected Types of Dental Providers in California, June 2010

Type of dental provider	Scope of practice[a]	Supervision required	Required education and experience	Licensed or certified	Direct Medicaid/CHIP reimbursement
Dental hygienist	• Preventive [limited settings][b]	Remote: consultative	• Dental hygiene program/ bachelor's degree • Specified clinical experience • Approved post-licensure training	Yes[c]	Yes[d]
	• Preventive • Basic restorative	On-site	• Dental hygiene program • Approved post-licensure training	Yes[e]	No
	• Preventive • Basic restorative	On-site	• Dental hygiene program • Specific instructional program	Yes[f]	No
	• Preventive	Remote: prior knowledge and consent	• Dental hygiene program	Yes[f]	No
Dental assistant	• Supportive • Preventive • Basic restorative	On-site	• Specific instructional program • Specified clinical experience • Specified post-licensure training	Yes	No
	• Supportive • Preventive	On-site	• Specific instructional program • Specified clinical experience	Yes	No
	• Supportive • Preventive	On-site	• None	No	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state officials.

[a]Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

[b]Certain dental hygienists may provide preventive services in specific settings, such as schools, homebound residences, and residential facilities under remote consultative dentist's supervision.

[c]Dental hygienists with this type of license are known as registered dental hygienists in alternative practice.

[d]California CHIP does not contract with providers directly; the managed care plans reimburse providers. California Medicaid does reimburse certain licensed dental hygienists.

[e]Dental hygienists with this type of license are known as registered dental hygienists in extended function.

[f]Dental hygienists with this type of license are known as registered dental hygienists.

Table 13: Selected Types of Dental Providers in Colorado, June 2010

Type of dental provider	Scope of practice[a]	Supervision required	Required education and experience	Licensed or certified	Direct Medicaid/CHIP reimbursement
Dental hygienist	• Preventive	None	• Dental hygiene program	Yes[b]	Yes[c]
	• Preventive • Basic restorative	Remote: prior knowledge and consent	• Dental hygiene program	Yes	Yes[c]
Dental assistant	• Supportive • Preventive • Basic restorative	On-site[d]	• None	No	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state officials.

[a]Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

[b]Unsupervised dental hygienists are known as independent dental hygienists and operate under the same license as other hygienists in the state.

[c]Dental hygienists may be paid directly for dental services under Medicaid. Under CHIP, only dental hygienists enrolled in a specific state program are paid directly for their services.

[d]Performance of some procedures may require prior knowledge and consent of a dentist, but not on-site supervision.

Table 14: Selected Types of Dental Providers in Minnesota, June 2010

Type of dental provider	Scope of practice[a]	Supervision required	Required education and experience	Licensed or certified	Direct Medicaid/CHIP reimbursement
Advanced dental therapist [limited setting][b]	• Preventive • Basic restorative • Intermediate restorative	Remote: prior knowledge and consent[c]	• Master's level program • Specified clinical experience	Yes[d]	Not yet determined
Dental therapist [limited setting][b]	• Preventive • Basic restorative • Intermediate restorative	On-site[e]	• Bachelor's or Master's level program	Yes[d]	Not yet determined
Dental hygienist	• Preventive • Basic restorative [limited setting]	Remote: consultative[f]	• Dental hygiene program • Specified clinical experience	Yes	Yes[f]
	• Preventive • Basic restorative	On-site[g]	• Dental hygiene program	Yes	No
Dental assistant	• Supportive • Preventive • Basic restorative	On-site[h]	• Specific instructional program	Yes	No
	• Supportive	On-site	• None	No	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state officials.

[a]Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

[b]Advanced dental therapists and dental therapists are limited to practicing in settings that serve low-income, uninsured, and underserved populations or in a dental health professional shortage area.

[c]Pursuant to a collaborative agreement with a dentist, advanced dental therapists may perform all the procedures of a dental therapist—including restorative drilling and filling—under remote supervision of a dentist, as well as develop treatment plans and nonsurgical extractions of permanent teeth under remote supervision.

[d]Licensure for dental therapists and advanced dental therapists is the same. Advanced dental therapists require special certification which includes additional education, but specific requirements had not been finalized as of June 2010. As of June 2010, students were enrolled in advanced dental therapy and dental therapy training programs, but none were yet practicing.

[e]Pursuant to a collaborative agreement with a dentist, dental therapists may perform some preventive and basic restorative procedures off-site with prior knowledge and consent of a dentist, other procedures require on-site supervision.

[f]Pursuant to a collaborative agreement with a dentist, dental hygienists may be authorized to provide services in a health care facility, program, or nonprofit organization. These services may result in direct-to-provider Medicaid reimbursement.

[g]Dental hygienists may perform certain preventive and basic restorative procedures without the dentist being present in the dental office if the procedures being performed are with prior knowledge and consent of a dentist; other procedures require on-site supervision.

[h]Registered dental assistants may perform certain preventive and basic restorative procedures without the dentist being present in the dental office if the procedures being performed are with prior knowledge and consent of a dentist; other procedures require on-site supervision.

Table 15: Selected Types of Dental Providers in Mississippi, June 2010

Type of dental provider	Scope of practice[a]	Supervision required	Required education and experience	Licensed or certified	Direct Medicaid/CHIP reimbursement
Dental hygienist	• Preventive	On-site[b]	• Dental hygiene program	Yes	No
Dental assistant	• Supportive • Preventive[c]	On-site	• None[c]	No	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state officials.

[a]Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

[b]Dental hygienists may provide preventive services outside a dental office under remote supervision through a consultative arrangement with a dentist when employed by the State Board of Health or public school boards. In addition, dental hygienists employed by the State Board of Health may apply fluoride in this context.

[c]Dental assistants must acquire a permit through the state board of dental examiners in order to take radiographs.

Table 16: Selected Types of Dental Providers in Oregon, June 2010

Type of dental provider	Scope of practice[a]	Supervision required	Required education and experience	Licensed or certified	Direct Medicaid/CHIP reimbursement
Dental hygienist	• Preventive [limited setting][b]	None	• Dental hygiene program • Specified clinical experience and coursework or approved course of study including clinical experience	Yes	Yes
	• Preventive • Basic restorative	Remote: prior knowledge and consent	• Dental hygiene program • Specific instructional program	Yes	No
	• Preventive • Basic restorative	On-site	• Dental hygiene program • Specific instructional program	Yes	No
	• Preventive	Remote: prior knowledge and consent	• Dental hygiene program	Yes	No
Dental assistant	• Supportive • Preventive • Basic restorative	On-site[c]	• Specific instructional programs[d]	Yes	No
	• Supportive	On-site	• None	No	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state officials.

[a]Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

[b]Dental hygienists can obtain permits to provide preventive services, including fluoride application, in limited settings such as schools and nursing homes without the supervision of a dentist. These services may result in direct-to-provider Medicaid reimbursement.

[c]Dental assistants may perform certain basic restorative procedures without the dentist being present in the dental office if the procedures being performed are with prior knowledge and consent of a dentist.

[d]Dental assistants in Oregon can obtain certification to perform various preventive and restorative services upon completion of specific instructional programs.

Table 17: Selected Types of Dental Providers in Washington, June 2010

Type of dental provider	Scope of practice[a]	Supervision required	Required education and experience[b]	Licensed or certified	Direct Medicaid/CHIP reimbursement
Dental hygienist	• Preventive [limited setting][c]	None	• Dental hygiene program • Specific instructional program	Yes	Yes
	• Preventive [limited setting][d]	Remote: consultative	• Dental hygiene program • Specified clinical experience	Yes	No
	• Preventive	Remote: prior knowledge and consent	• Dental hygiene program	Yes	No
	• Preventive • Basic restorative • Intermediate restorative[e]	On-site	• Dental hygiene program	Yes	No
Dental assistant	• Supportive • Preventive [limited setting][f]	Remote: prior knowledge and consent	• Program-specific instructional program • Specified clinical experience	Yes[g]	No
	• Supportive • Preventive • Basic restorative	On-site[h]	• Specific instructional program or comparable credential	Yes[g]	No
	• Supportive • Preventive • Basic restorative	On-site	• None	Yes[g]	No

Source: GAO analysis of information from state dental practice acts, state dental boards, and state officials.

[a]Each scope of practice category contains a variety of specified procedures. A provider may not be authorized to perform all procedures in a particular category.

[b]All dental hygienists and dental assistants in Washington must complete AIDS education and training.

[c]Dental hygienists can become endorsed to administer sealants and fluoride varnishes and remove deposits and stains from the surfaces of teeth in school-based settings by completing a specified instructional program (hygienists licensed on or before April 19, 2001 were automatically endorsed). These services may result in direct-to-provider Medicaid reimbursement.

[d]Dental hygienists with at least two years clinical experience may provide preventive services in certain health-care facilities or senior centers under remote dentist's supervision. A consultative agreement with a dentist is required to provide these services in senior centers.

[e]Dental hygienists may place a restoration (filling) in a cavity prepared by a dentist.

[f]Dental assistants can become endorsed to administer sealants and fluoride varnishes in school-based settings by completing a program-specific training program and 200 hours of clinical experience (assistants employed by a licensed Washington dentist on or before April 19, 2001 were not required to obtain an endorsement).

[g]All dental assistants in Washington must be registered or licensed to practice in the state. Dental assistants must meet limited requirements to become registered. Dental assistants must meet additional educational requirements to become licensed or endorsed to perform additional or preventive procedures under remote supervision.

[h]Licensed dental assistants may perform certain preventive procedures without a dentist being present and with prior knowledge and consent of a dentist.

Appendix VII: Summary of Four Selected Countries' Use of Dental Therapists

Dental therapists practice in many countries around the world.[1] In particular, New Zealand, the United Kingdom, Australia, and Canada have long-standing dental therapy training programs originally aimed at improving access to dental services for children and other underserved populations. Below are brief descriptions of the dental therapist programs in these four countries.[2]

New Zealand

New Zealand began training dental therapists in 1921 to provide dental care to children through school-based clinics—known as the school dental service—in response to high rates of dental decay and a shortage of dentists.[3] Since 2006, dental therapy and dental hygiene training have been combined into a single 3-year bachelor's degree granting program offered through two universities.[4] Graduates of the combined programs can register as both a dental therapist and a dental hygienist.[5] Registered dental therapists can work throughout the country to determine treatment plans and provide preventive and basic and intermediate restorative services—including procedures such as drilling and filling a tooth—for children and, in some cases, adults, under remote consultative supervision of a dentist.[6] Dental therapists in New Zealand maintain a consultative relationship with a dentist and refer patients to a dentist for services beyond their scope of practice. Although dental therapists have been able to work in private practice since 2004, according to a 2007 study, the majority of dental therapists in the country work as salaried employees for District Health Boards to provide dental services to children through the

[1]D.A. Nash, J.W. Friedman, T.B. Kardos, et al. "Dental Therapists: a global perspective," *International Dental Journal*, Vol. 58 (2008).

[2]The countries are presented in chronological order by the date their dental therapist program started.

[3]New Zealand pays for dental services for all children up to age 13, with most of the services provided by dental therapists in the school dental service.

[4]Historically, dental therapists were trained in a 2-year non-degree granting program.

[5]Dental therapists must be registered with the Dental Council of New Zealand—a self-regulating body for oral health professionals.

[6]Dental therapists register for general dental therapy scope practice which allows practice for children up to age 18. Dental therapists can register for additional scopes of practice including adult care, radiology, and crowns.

school dental service in school- and community-based dental clinics.[7] An official from the New Zealand Ministry of Health estimated that in 2009, 96 percent of children aged five to 12 in the country were enrolled in the school dental service and therefore received dental care from dental therapists.

The United Kingdom

The United Kingdom established its first dental therapy training program in 1959 to meet a growing need for dental providers to staff school- and community-based dental programs.[8] Students were selected from across the United Kingdom and were expected to return to their home areas after training. The number of dental therapy training programs has expanded in recent years, and most are offered as 3-year combined dental therapy and dental hygiene programs.[9] Dental therapists in the United Kingdom must be registered with the General Dental Council to practice and registered dental therapists may provide preventive and basic and intermediate restorative services—including procedures such as drilling and filling a tooth—for children and adults under a treatment plan developed by a dentist.[10] Until 2002, dental therapists were restricted to salaried employment in the public sector. Since then, they have been able to work in independent practice, and since 2006, dental therapists have been permitted to own their own practice and employ other dental professionals. According to a 2007 survey of registered dental therapists; 50 percent worked in private practice, 31 percent worked in public dental

[7]K.M.S. Ayers, A. Meldrum, W.M. Thomson, J.T. Newton. "The working practices and career satisfaction of dental therapists in New Zealand," *Community Dental Health*, Vol. 24 (2007).

[8]The United Kingdom consists of the countries of England, Northern Ireland, Scotland, and Wales. Each country has a National Health Service administered by Departments of Health that are responsible for administering health care. Countries in the United Kingdom have had subsidized dental services since the 1920s—known as the salaried dental service or community dental service—for which dental therapists were originally trained to serve.

[9]Graduates of the combined programs can register as both a dental therapist and a dental hygienist. Historically, dental therapists were trained in 2-year hospital-based diploma programs, but since the 1990s programs have been offered through bachelor's degree granting programs.

[10]The General Dental Council is the regulating body for oral health professionals.

services, and 10 percent worked in both.[11] Overall, 39 percent of dental therapists reported spending most of their time treating children.[12]

Australia

Dental therapy training programs began in certain Australian states in 1966 and 1967 and expanded to all states and territories to train dental therapists to provide dental services to children through school-based dental programs—known as the school dental service.[13] In 2010, there were nine dental therapy training programs in Australia, eight of which offered a combined 3-year dental therapy and dental hygiene bachelor's degree.[14] In the past, Australia's eight states and territories were responsible for dental therapy registration, but as of July 1, 2010, Australia implemented a national registration and accreditation scheme requiring standard qualification for all dental therapists and oral health therapists registering after that date. Australian health officials reported that prior to national registration, dental therapists could generally provide primary oral health care including treatment planning, preventive and basic and intermediate restorative services—including procedures such as drilling and filling teeth for children under the remote consultative supervision of a dentist. Three Australian states—the Northern Territory, Victoria, and Western Australia—also allowed dental therapists to provide services to adults according to an Australian expert. Until recently, the majority of states and territories restricted employment of dental therapists to the public sector, however according to a 2005 national survey, 78 percent of dental therapists worked in the public sector—mostly as salaried employees of school- and community-based dental programs.[15] In Western

[11]The remaining dental therapists worked in hospitals, were teaching, or in a combination of positions. The National Health Service in each country contracts with independent dental practices—known as the general dental service—to provide services. Independent practices can be reimbursed by the National Health Service for dental services to children up to age 18.

[12]J.H. Godson, J.S. Rowbotham, S.A. Williams, J.L. Csikar, S. Bradley, "Dental therapy in the United Kingdom: Part 2. a survey of reported working practices," *British Dental Journal*, Vol. 207 (2009).

[13]All eight Australian states and territories subsidize dental care for children age 5-12, with certain states also paying for care to younger or older children.

[14]Graduates of the combined programs are known as oral health therapists and can register as both a dental therapist and a dental hygienist. Historically, dental therapists were trained in 2-year non-bachelor degree granting programs.

[15]Australian Institute of Health and Welfare, Dental Statistics and Research Unit, *Dental Therapist Labour Force in Australia 2005* (Adelaide: Australia, July 2008).

Australia, however, which has always permitted dental therapists to work in private practice, about 55 percent of dental therapists worked in the public sector in 2005.

Canada

The first Canadian dental therapy training programs were established in the Northwest Territories and Saskatchewan in 1972 to increase access to dental services for rural and aboriginal populations with a focus on children.[16] Dental therapy practice differs across Canadian provinces and territories.[17] Dental therapy training is offered as a government funded 2-year program through the National School of Dental Therapy at the First Nations University, whose charter is to train dental therapists to treat aboriginal populations. Although the National School of Dental Therapy program is not accredited, graduates either become licensed by and practice in Saskatchewan or work for the federal government or aboriginal tribes. Canadian dental therapists may provide preventive and basic and intermediate restorative services—including procedures such as drilling and filling a tooth—for children and adults under a treatment plan provided by a dentist. As of May 2010, the majority of Canadian dental therapists worked in Saskatchewan where they must be licensed by the Saskatchewan Dental Therapists Association according to an association official.[18] Most of the dental therapists in Saskatchewan work in private dental practices, although some are directly employed by the federal or provincial government or aboriginal tribes.[19] In all other Canadian

[16]Aboriginal populations in Canada are known as First Nations and Inuit. Health Canada—the government department responsible for administering health care—pays for dental services to all aboriginal populations. Private practices and tribes can be reimbursed by Health Canada for services rendered to those populations.

[17]In the 1970s two provinces, Saskatchewan and later Manitoba, established school-based dental programs that utilized dental therapists to provide preventive and restorative dental services for children. The Saskatchewan program had high rates of enrollment and successfully reduced the rates of dental caries in children, and was privatized in 1987 and eliminated in 1993. Dental therapists that previously provided dental services in rural areas either moved to urban areas to work in private practice or lost their jobs according to a Canadian expert. D.W. Lewis, *Performance of the Saskatchewan Health Dental Plan, 1974-1980.* (Toronto: University of Toronto: 1981). The Manitoba program has also since been eliminated.

[18]The Saskatchewan Dental Therapists Association is the self regulating body for dental therapists constituted under Saskatchewan law.

[19]According to a Canadian health official, 52 dental therapists were employed directly by Health Canada and 30 were employed by First Nations tribes which are funded by Health Canada.

provinces and territories except Ontario and Quebec, dental therapists are generally restricted to employment through the federal or territorial government or tribes to provide care to aboriginal populations living on reservations.[20]

[20]Dental therapists are not permitted to practice in Ontario or Quebec. In Manitoba, a number of dental therapists work in the private sector.

Appendix VIII: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 4 2010

Katherine Iritani
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) correspondence entitled: "Oral Health: Efforts Underway to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns" (GAO 11-96).

The Department appreciates the opportunity to review this correspondence before its publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "ORAL HEALTH: EFFORTS UNDERWAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS" (GAO-11-96)

The Department appreciates the opportunity to review and comment on this draft report.

CDC agrees in general with the report. However, based on data from the National Health and Nutrition Examination Survey (NHANES) and citing a previous report, the GAO "estimated that 6.5 million children had untreated tooth decay, and rates of dental disease among younger children in Medicaid had increased." This statement may be misleading in light of more recent analysis of NHANES data by CDC's National Center for Health Statistics.

This 2010 analysis reported that among poor young children (age 2-5 years) there has been no change in rates of dental disease between 1988-94 and 1999-2004. Among poor children age 6-8 years, there has been an increase in caries experience. Among children age 2-5 years, however, the actual increase in caries seems to be significant only among the non-poor boys. Regarding untreated tooth decay, only non-poor boys have shown an increase in untreated caries among all 2-8 year-old children between NHANES 1988-94 and 1999-2004. Rates of untreated tooth decay for poor children age 2-8 years has remained unchanged.

These findings and others are published in: Dye BA, Arevalo O, Vargas CM. Trends in pediatric dental caries by poverty status in the United States, 1988-1994 and 1999-2004. International Journal of Pediatric Dentistry 2010; 20: 132-143.

It should also be noted that when reporting on caries experience or "dental disease" in young children, these constructs include both treated and untreated caries. An increase in caries experience could be driven by an increase in the dental fillings/restorations component while the untreated disease component remained unchanged. An increase in the dental restoration component could indicate an increase in dental utilization, hence improvements in access to dental care, especially for low income children. Healthy People 2010 has shown an increase in utilization of preventive services among low income children age 2-19 years.

CDC appreciates the efforts that went into this report and looks forward to working with GAO on this and other reports.

The GAO issued two recommendations for executive action. CMS concurs with each recommendation with the following comments:

GAO Recommendation

The Department of Health and Human Services should take steps to improve its Insure Kids Now Web site.

CMS Response

We agree with this recommendation and that improvement undertaken by States and the Federal government, such as those identified in this report, is much needed. Under the current process, States submit the information on their participating dental providers to the IKN website through

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "ORAL HEALTH: EFFORTS UNDERWAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS" (GAO-11-96)

a download tool that was developed for this purpose or through another acceptable method. A contractor (working under a Health Resources and Services Administration (HRSA) contract but in collaboration with CMS) then includes the information in a database that links to the dental provider search engine. The data is subject to a screening process in which addresses are matched against public records. However, evaluating the quality of those records has not been part of the scope of the contractor's responsibilities.

The CMS will undertake the following approaches to address this concern:

First, to address the errors found on the Web site, the Department will increase the frequency and type of quality checks performed on State-reported dental provider information, and work with States to ensure they submit data that is complete, accurate and current. Specifically, we will follow up with States identified in the GAO report to ensure that they correct existing information on the Web site. We will also continue the process of requiring States to submit data on providers directly instead of providing links to State Web sites. We will also ensure States are aware of their responsibility to not list providers who have been excluded from participation under section 1128B of the Social Security Act; explore Federal options for cross checking lists of providers with the disenrolled provider database; and create a consistent understanding of what it means to be identified as a dental provider able to serve a child with special needs.

We will consider additional ways, including regulatory guidance, to assure better information in implementing the provisions of CHIPRA, which may include specific requirements, parameters and timeframes for public listings of eligible, enrolled providers who are providing care to Medicaid and CHIP children, including those with special needs.

GAO Recommendation

The Administrator of CMS take steps to ensure that States gather comprehensive and reliable data on the provision of Medicaid and CHIP dental services by managed care programs.

CMS Response

We agree with this recommendation. CMS is in the process of implementing major changes that will improve collection of data related to dental services for children delivered through fee-for-service or managed care payment arrangements. A revised CMS-416 form, which is CMS's primary tool for gathering data on the provision of services to children in State Medicaid programs, is in the final stages of the clearance process and will be released to States, along with written guidance, in the near future. This revised form has been expended to include dental data elements as required by CHIPRA. The instructions for completing the CMS-416 specify that additional data reported on the form must include data for services delivered to individuals in both fee-for-service or managed care arrangements. Several provisions of CHIPRA also establish the foundation for CMS to build an infrastructure for a quality measures program in

2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "ORAL HEALTH: EFFORTS UNDERWAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS" (GAO-11-96)

which data are collected and reported in a uniform way for children in Medicaid and CHIP. The collection of data on dental services will benefit from CMS-wide efforts underway to improve the collection and reporting of data on quality of care measures more broadly.

The CMS is also establishing a workgroup consisting of national and local stakeholders in the field of child health that will focus on improving access to the benefits required under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and will ask the workgroup to identify, among other things, ways to obtain more reliable data on dental services provided for children in managed care plans. This workgroup will be established by early 2011.

Other CMS Activities

The CMS has also undertaken a number of efforts to improve children's access to oral health services. To accelerate our efforts to improve access to oral health services and to provide focus and visibility to our efforts, CMS announced in April 2010 at the National Oral Health conference two national oral health goals. The goals are: 1) to increase the national rate of children and adolescents enrolled in Medicaid or CHIP who receive any preventive dental service by 10 percentage points over 5 years; and 2) to increase the rate of children ages 6-9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over 5 years. The dental sealant goal will be phased in during the next two to three years. Data for monitoring ongoing progress on this goal will be collected through the CMS-416 report and the CHIP State Annual Reports. Data collected for Federal fiscal year 2011 will serve as baseline data for this goal.

The CMS is collaborating with States on how to achieve these goals and we have developed an oral health strategy that identifies the principal barriers to children receiving dental care as well as some recommended approaches to overcoming these barriers. Much of the strategy was developed based on information learned during State dental reviews undertaken by CMS. In 2008, CMS examined the policies and practices of 16 States that had low dental utilization rates. In 2009, CMS began reviews of eight States that had higher than average dental utilization rates or were recommended to CMS as having an innovative practice for increasing dental access. Each State review and a summary of the State reviews will be available on the CMS Web site (http://www.cms.gov/MedicaidDentalCoverage) by the end of December 2010. The results of these State reviews can help other States improve access to dental services.

To support States in improving access to dental care, CMS will provide technical assistance to States to help improve access to children's dental care and to make progress toward achieving these goals, including:

- Identifying promising practices that States have used to increase children's access to oral health care;
- Annual meetings with States and national experts to share experiences;
- Assessing progress toward the goals;
- Identifying barriers to access; and

3

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "ORAL HEALTH: EFFORTS UNDERWAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS" (GAO-11-96)

- Support opportunities for dental providers to receive incentive payments for meaningful use of electronic health record technology.

CMS is holding two technical assistance workshops for States to discuss CMS' dental goals and strategy. The first workshop, held on October 7, 2010 in conjunction with the National Academy for State Health Policy conference in New Orleans, Louisiana, was attended by 20 officials from CHIP or Medicaid programs, including several oral health directors. The second workshop will be held on November 10, 2010 in Arlington, Virginia following the annual conference of the National Association of State Medicaid Directors. CMS will hold a meeting with external stakeholders this year to identify areas where they may wish to support our efforts in improving access to oral health services. CMS will take feedback from all of these meetings into consideration as we finalize our oral health strategy.

The CMS' goals and dental strategy support the larger HHS Oral Health Initiative 2010 and the Department's comprehensive commitment to improved oral health. CMS is coordinating with other components of the Department on this important initiative as a member of the HHS Assistant Secretary for Health's Oral Health Coordinating Committee, which brings together fourteen agencies to direct the Department's oral health activities. In order to further the collaborative efforts on oral health, CMS has entered into a Memorandum of Understanding with HRSA and the Centers for Disease Control and Prevention.

Improving access to children's dental services in Medicaid and CHIP is one of our key priorities. We appreciate the efforts that went into this report and look forward to working with the GAO on this and other issues.

HRSA has offered the following recommendations:

Under the Children's Health Insurance Program Reauthorization Act (CHIPRA), the Department of Health and Human Services (HHS) is required to post a list of oral health providers who provide services to eligible Medicaid and Children's Health Insurance Program (CHIP) children on the Insure Kids Now (IKN) web site. This list is to be updated on a quarterly basis. This initiative was a huge undertaking given that this is the first national list of any type of Medicaid and CHIP health care providers. Despite the challenges, HRSA, under an Interagency Agreement (IAA) with the Centers for Medicare and Medicaid Services (CMS), met all statutory deadlines outlined under CHIPRA and have developed an Oral Health Locator (Locator). This Locator provides information to Medicaid and CHIP enrollees on how to find dentists and other oral health providers that accept Medicaid and CHIP.

HRSA concurs with many of the findings and recommendations from the GAO report. HRSA has spent much effort in the past year working with states to improve the Locators capacity to accept and post data from states. It should be noted that while the law requires that the data on the IKN web site be updated on a quarterly basis, the system allows data to be updated on a daily basis ensuring that the most up-to-date information is available to enrollees.

4

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "ORAL HEALTH: EFFORTS UNDERWAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS" (GAO-11-96)

HRSA has specific comments regarding the following aspects of the report found under Section titled "Information on HHS's Web Site to Help Locate Participating Dentists is Not Always Complete" beginning on page 14, first paragraph:

HRSA concurs that more attention needs to be devoted to improving the accuracy of information submitted by states. Much attention in the past year has been devoted to developing the system to allow for data submissions from states. It should be noted that data are submitted from states that utilize fee-for-service programs, and from health plans that utilize capitated or managed care programs. Given that data are received from multiple sources for one state, it is difficult to ensure the accuracy of all information.

A sampling of the data could be done on a periodic basis. It should be noted that data files are reviewed systematically to ensure that all data fields have acceptable data (e.g., a field that requires a zip code has a 5 or 9 digit numerical value). Data files that do not adhere to the business rules outlined in our technical guidance to the states are returned and not posted.

Completeness: The GAO outlines through their review, cases of missing or incomplete information including "...telephone numbers and addresses, whether dentists accepted new Medicaid or CHIP patients, and whether dentists could accommodate children with special needs." It should be noted that information concerning whether a provider is accepting new patients or accommodates children with special needs is not required under CHIPRA. This is information that CMS and HRSA thought would be important to enrollees trying to identify an oral health provider. We will continue to work with states to improve the quality of this information.

Usability: GAO noted that they found "...7 states listed multiple health plans with similar names, some containing typographical errors and some that produced different provider listings, increasing the likelihood of selecting the wrong plan and generating an incorrect list of dentists." HRSA will continue to work with the Assistant Secretary for Public Affairs (ASPA) to improve the usability of the IKN web site. It should be noted that a widget is currently being developed to make it easier for enrollees to search for an oral health provider. HRSA will also work with ASPA to ensure that all the web links are working. The system was developed bearing in mind that many enrollees may not know if they are in Medicaid or CHIP but rather may more easily associate with the health plan. HRSA has instructed states to utilize the program names identified on their Medicaid or CHIP enrollee cards.

Accuracy: HRSA will work with CMS to develop a plan for periodically analyzing a sampling of the data provided by states.

First paragraph – page 18 : In the first paragraph GAO reported concerns with providers being listed on the IKN web site that were excluded from participating in Medicaid by the HHS Office of Inspector General (OIG). HRSA will cross check the excluded parties list independently and

5

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "ORAL HEALTH: EFFORTS UNDERWAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS" (GAO-11-96)

check with CMS on the currency of the data provided, as the system was not developed to cross check data with OIG.

6

Appendix IX: GAO Contact and Staff Acknowledgments

GAO Contact	Katherine Iritani, (202) 512-7114 or iritanik@gao.gov
Staff Acknowledgments	In addition to the individual named above, Kim Yamane, Assistant Director; Rebecca Abela; Susannah Bloch; George Bogart; Alison Goetsch; Mollie Hertel; Anne Hopewell; Martha Kelly; Perry Parsons; Terry Saiki; Pauline Seretakis; and Suzanne Worth made key contributions to this report.

Related GAO Products

Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement. GAO-10-810. Washington, D.C.: August 4, 2010.

Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but More Can Be Done. GAO-10-112T. Washington, D.C.: October 7, 2009.

Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain. GAO-09-723. Washington, D.C.: September 30, 2009.

Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay. GAO-08-1121. Washington, D.C.: September 23, 2008.

Health Resources and Services Administration: Many Underserved Areas Lack a Health Center Site, and the Health Center Program Needs More Oversight. GAO-08-723. Washington, D.C.: August 8, 2008.

Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services. GAO-07-826T. Washington, D.C.: May 2, 2007.

Medicaid Managed Care: Access and Quality Requirements Specific to Low-Income and Other Special Needs Enrollees. GAO-05-44R. Washington, D.C.: December 8, 2004.

Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care. GAO-03-222. Washington, D.C.: January 14, 2003.

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. GAO-01-749. Washington, D.C.: July 13, 2001.

Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations. GAO/HEHS-00-149. Washington, D.C.: September 11, 2000.

Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations. GAO/HEHS-00-72. Washington, D.C.: April 12, 2000.

EXHIBIT 61

FILED
2011 SEP -6 AM 10:45
RANDOLPH CO., C.S.C.
BY

NORTH CAROLINA RANDOLPH COUNTY	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 11 CVS 2343
NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS, Plaintiff, vs. HEARTLAND DENTAL CARE, INC. d/b/a HEARTLAND MANAGEMENT, INC.; GARY CAMERON AND ASSOCIATES, P.C.; AND GARY L. CAMERON, D.D.S. Defendants.	**CONSENT ORDER GRANTING PERMANENT INJUNCTION**

THIS MATTER came to be heard and was heard on September 6, 2011, before the undersigned Superior Court Judge upon consent of the parties, Plaintiff, North Carolina State Board of Dental Examiners ("the Dental Board"), and Defendants, Heartland Dental Care, Inc. d/b/a Heartland Management, Inc. ("Heartland"); Gary Cameron and Associates, P.C. (the "Existing P.C."); and Gary L. Cameron, D.D.S. ("Dr. Cameron"), by and through their undersigned counsel, and pursuant to N.C. Gen. Stat. §§ 90-40.1(b), 1-485, and 1A-1, Rule 65, on a Complaint for Permanent Injunction against Defendants. The parties consent to and the undersigned Superior Court Judge finds and concludes as follows:

In its Complaint, which is incorporated herein by reference in its entirety, the Dental Board alleges that on or about March 31, 2010, Defendants executed and implemented a series of transactions, contracts, documents and agreements pursuant to which Dr. Cameron unlawfully transferred i) ownership, ii) management, iii) supervision, and/or iv) control of his dental practice to Heartland, an unlicensed individual or entity in violation of the Dental Practice Act codified at

N.C. Gen. Stat. § 90-22 *et seq.* and the Management Arrangements Rule codified at 21 N.C. Admin. Code 16X.0101.

In their Answer, which is incorporated herein by reference in its entirety, Defendants deny that Dr. Cameron transferred ownership, management, supervision, or control to anyone in violation of North Carolina law, and contend that Dr. Cameron lawfully sold certain assets to Heartland and entered into a lawful management agreement with Heartland.

Notwithstanding the allegations of Defendants, Defendants stipulate that for purposes of this matter only and in order to resolve their dispute with the Dental Board, sufficient evidence exists in this matter from which the allegations of the Dental Board could be established.

In accordance with the foregoing, and with the consent of the parties hereto, it is hereby ORDERED, ADJUDGED AND DECREED that:

1. Defendants are perpetually enjoined from individually or jointly engaging in any management agreement, management arrangement, transaction, or other activities that violate the Dental Practice Act codified at N.C. Gen. § 90-22 *et seq.* or the Management Arrangements Rule codified at 21 N.C. Admin. Code 16X.0101. For purposes of this Order, the acts which Heartland is prohibited from engaging in shall also be prohibited for any affiliate or related entity of Heartland, or any successor to Heartland. For purposes of this Order, the acts which Dr. Cameron is prohibited from engaging in shall also be prohibited for any professional entity which is owned or controlled, in whole or in part, by Dr. Cameron.

2. Defendants shall completely and permanently rescind all transactions entered into among them as of the date of this Order. The effective date of the documents evidencing the rescission will be September 30, 2011 in order to permit an orderly transition for employees. As part of the rescission of the transactions:

a. All documents, contracts or other agreements by and among defendants shall be permanently revoked, cancelled, nullified and/or rescinded.

b. All agreements between Heartland or the Existing P.C. and Dr. Peter I. Son, D.M.D. ("Dr. Son") shall be permanently revoked, cancelled, nullified and/or rescinded.

c. Defendants shall not, directly or indirectly, enter into or execute any new transactions, documents, contracts or other agreements among themselves, without prior approval by the Dental Board, except for the i) promissory note described in section 2.e.ii below; ii) the New Management Services

Agreement ("New MSA") described in Section 2.j below; and iii) rescission documents expressly described and permitted herein.

d. All assets and other consideration conveyed to Heartland by Dr. Cameron and/or the Existing P.C. shall be returned to Dr. Cameron. Any assets conveyed by Dr. Cameron to the Existing P.C. may be retained by the Existing P.C. or transferred to the new professional corporation described in section 2.e.i below.

e. All consideration conveyed to Dr. Cameron by Heartland as part of the transactions previously executed by or entered into among them shall be returned to Heartland less a deduction for Dr. Cameron's tax liability incurred in connection with his receipt of said consideration. This deduction shall not exceed the amount paid by Dr. Cameron to state and federal government taxing authorities as a result of his total tax liability from rescinding the prior transaction with Heartland. Dr. Cameron shall provide the Dental Board filed tax returns demonstrating his total tax liability from rescinding the prior transaction with Heartland when such returns are filed.

i. Dr. Cameron shall be permitted to establish a new Professional Entity ("New P.C.") as a Subchapter S Corporation as defined by the statutes and regulations of the Internal Revenue Service for the purposes described herein which shall at all times be owned by Dr. Cameron and/or another dentist or dentists holding a valid license from the Dental Board for the practice of dentistry in North Carolina.

ii. Dr. Cameron shall be permitted to provide a promissory note for the purposes of repaying or reconveying to Heartland all assets he received from Heartland as part of the transactions among Defendants, less Dr. Cameron's tax liability in connection with his receipt of said consideration, with the following conditions and limitations:

1. The promissory note shall be issued by Dr. Cameron individually and shall not be issued in the name of Existing P.C. or New P.C.;

2. A copy of the promissory note, with all terms and conditions included therein, shall be provided to the Dental Board for review, with an amortization schedule showing the schedule of payments and interest due under the promissory note. The promissory note shall not exceed a term of seven (7) years at a commercially-reasonable rate of interest. The loan shall be fully amortized with no balloon payment. The parties to the promissory note shall not amend, revise it, renegotiate it or extend its terms or interest rate without prior approval by the Dental Board;

3. Neither Existing P.C. nor New P.C. shall be a debtor to Heartland under the note or under any other obligation of debt or repayment;

4. Neither the assets of Existing P.C. nor New P.C. shall be used as collateral for the promissory note. No asset that is used in connection with the dental practice owned by the Existing P.C., New P.C. or Dr. Cameron, shall be used as collateral for the promissory note. This prohibition shall apply to any such assets used in connection with the dental practice no matter the form of ownership of such assets;

5. All payments made pursuant to the Promissory Note shall be made in the name of Dr. Cameron individually. Dr. Cameron shall provide verification to the Dental Board in a manner reasonably satisfactory to the Dental Board that all such payments are made by him individually; and

6. The Promissory Note shall not be linked or connected in any manner to the New MSA.

f. The obligation of Existing P.C. to Heartland's creditors issued to secure Heartland's debt will be irrevocably forgiven, rescinded and/or cancelled. Defendant Heartland shall take the steps necessary to cause its creditors, including Fifth Third Bank, to cancel the Uniform Commercial Code filing which was filed with the N.C. Secretary of State's Office on April 2, 2010.

g. Defendants shall provide to the Dental Board documentation sufficient to evidence the rescission of the transactions, agreements, documents and contracts entered into among defendants.

h. The Management Services Employment Agreement between Heartland and Dr. Cameron will be rescinded.

i. The Management Services Employment Agreement between Heartland and Dr. Son will be rescinded.

j. Heartland and Dr. Cameron shall be permitted to enter into an Amended and Restated Management Services Agreement ("New MSA") in the form approved by the Dental Board, a copy of which is attached to this Order under Seal. Heartland and Dr. Cameron, whether individually or through Existing P.C. or New P.C., shall make no revisions or amendments to New MSA unless such amendments or revisions are submitted to the Dental Board for review and are approved in writing by the Dental Board. Heartland and Dr. Cameron, whether individually or through Existing P.C. or New P.C., will comply in all respects with the terms of the New MSA.

k. All employees of Dr. Cameron's dental practice, whether current employees or future employees, will be employed by Dr. Cameron individually, by Existing P.C. or by New P.C. and no employees of Dr. Cameron's dental practice will be employed by Heartland.

3. Heartland and its affiliates, and successors are hereby enjoined from entering any new management arrangements or agreements, or any other similarly purposed agreement by whatever name designated, with North Carolina licensed dentists practicing within the State of North Carolina for a period of five (5) years from the date of the Consent Order Granting Permanent Injunction ("Expansion Limitation"), except those agreements expressly allowed by an Order of this Court in connection with i) the execution of the New MSA with Dr. Gary Cameron, Existing PC or New PC, or ii) the rescission of the transactions entered into among Defendants. Notwithstanding the foregoing, nothing in this Consent Order shall prohibit Heartland, its affiliates and successors from selling to or acquiring any dental management company or dental service organization (collectively, "DSO") that has approved management arrangements in North Carolina and operates on a multi-state basis. The parties acknowledge and agree that the foregoing Expansion Limitation will be applicable to a Heartland successor, regardless of the surviving DSO entity in any such transaction, but that it will not operate to disrupt existing lawful arrangements in North Carolina entered into by Heartland or by the other DSO which have been approved by the Dental Board. Sale of the Existing P.C. or New P.C. would require Dental Board review of any management arrangement or agreement between Heartland and any new owner. Sale of the practice shall not be connected in any way to the promissory note to Heartland referenced in Section 2.e.ii above in the Order.

4. Heartland is enjoined from being named or identified as a third-party beneficiary of any employment agreement between Dr. Cameron, Dr. Son, Existing P.C. or New P.C., and/or any other licensed dentist employed by any of them.

5. Heartland will pay to the Dental Board the sum of Thirty-Six Thousand Eight Hundred Seventeen Dollars and Fifty Cents ($36,817.50) as partial reimbursement of the investigation costs incurred by the Dental Board in connection with this matter.

6. All pending Superior Court and/or administrative actions involving the Dental Board and Defendants shall be dismissed with prejudice, with no rights of appeal from any such dismissals, specifically including but not limited to 1) Defendants' Petition for Judicial Review filed in Wake County Superior Court, 11 CVS 002283; and 2) In re Heartland Dental Care, Inc. d/b/a Heartland Management, Inc., Dr. Gary L. Cameron, D.D.S. and Gary Cameron and Associates, P.C., Petitioners, the Request for Administrative Hearing filed by Defendants with the Dental Board on October 1, 2010.

7. The parties agree to bear the respective costs of this action.

8. This Order resolves all issues among the Parties and there is nothing further to be heard by this Court; however, the Court shall retain jurisdiction of this matter for further proceedings to enforce this Order, if necessary.

Issued this the 6th day of September, 2011.

Superior Court Judge

Consented to by and on behalf of Heartland Dental Care, Inc. d/b/a Heartland Management, Inc., Gary Cameron and Associates, P.C., and Gary L. Cameron, D.D.S.

K & L GATES LLP

By: Michael R. Gordon Date: 8/30/11

Michael R. Gordon
N.C. State Bar No. 26196
Susan K. Hackney
N.C. State Bar No. 32252
430 Davis Drive, Suite 400
Morrisville, NC 27560
Telephone: 919.466.1190
Facsimile: 919.516.2112
Attorneys for Heartland Dental Care, Inc. d/b/a Heartland Management, Inc., Gary L. Cameron, D.D.S and Gary Cameron and Associates, P.C.

And

HEARTLAND DENTAL CARE, INC. d/b/a
HEARTLAND MANAGEMENT, INC.

By: _____ Date: _____
[Name]
[Title]

And

GARY CAMERON AND ASSOCIATES, P.C.

By: _____ Date: _____
Gary L. Cameron
Owner

And

GARY L. CAMERON D.D.S., Individually

Consented to by and on behalf of Heartland Dental Care, Inc. d/b/a Heartland Management, Inc., Gary Cameron and Associates, P.C., and Gary L. Cameron, D.D.S.

K & L GATES LLP

By: Michael R. Gordon Date: 8/30/11

Michael R. Gordon
N.C. State Bar No. 26196
Susan K. Hackney
N.C. State Bar No. 32252
430 Davis Drive, Suite 400
Morrisville, NC 27560
Telephone: 919.466.1190
Facsimile: 919.516.2112
Attorneys for Heartland Dental Care, Inc. d/b/a Heartland Management, Inc., Gary L. Cameron, D.D.S and Gary Cameron and Associates, P.C.

And

HEARTLAND DENTAL CARE, INC. d/b/a
HEARTLAND MANAGEMENT, INC.

By: _____ Date: August 30, 2011

[Name]
[Title]

And

GARY CAMERON AND ASSOCIATES, P.C.

By: _____ Date: _____

Gary L. Cameron
Owner

And

GARY L. CAMERON D.D.S., Individually

Consented to by and on behalf of Heartland Dental Care, Inc. d/b/a Heartland Management, Inc., Gary Cameron and Associates, P.C., and Gary L. Cameron, D.D.S.

K & L GATES LLP

By: Michael R. Gordon Date: 8/30/11

Michael R. Gordon
N.C. State Bar No. 26196
Susan K. Hackney
N.C. State Bar No. 32252
430 Davis Drive, Suite 400
Morrisville, NC 27560
Telephone: 919.466.1190
Facsimile: 919.516.2112
Attorneys for Heartland Dental Care, Inc. d/b/a Heartland Management, Inc., Gary L. Cameron, D.D.S and Gary Cameron and Associates, P.C.

And

HEARTLAND DENTAL CARE, INC. d/b/a
HEARTLAND MANAGEMENT, INC.

By: _____ Date: _____

[Name]
[Title]

And

GARY CAMERON AND ASSOCIATES, P.C.

By: Cameron pres Date: 8-30-2011

Gary L. Cameron
Owner

And

GARY L. CAMERON D.D.S., Individually

By: _____ Date: 8/30/2011
Gary L. Cameron

Consented to by and on behalf of the North Carolina State Board of Dental Examiners.

POYNER SPRUILL LLP

By: _____ Date: _____

Kenneth L. Burgess
N.C. State Bar No. 12340
kburgess@poyners.com
William R. Shenton, Esq.
N.C. State Bar No. 8973
wshenton@poyners.com
301 Fayetteville Street, Suite 1900
Raleigh, NC 27601
Telephone: 919.783.6400
Facsimile: 919.783.1075
Attorneys for the North Carolina State Board of Dental Examiners

And

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

By: _____ Date: _____
[Name]

_____
[Title]

Consented to by and on behalf of the North Carolina State Board of Dental Examiners.

POYNER SPRUILL LLP

By: Kenneth L Burgess Date: 9/6/2014

Kenneth L. Burgess
N.C. State Bar No. 12340
kburgess@poyners.com
William R. Shenton, Esq.
N.C. State Bar No. 8973
wshenton@poyners.com
301 Fayetteville Street, Suite 1900
Raleigh, NC 27601
Telephone: 919.783.6400
Facsimile: 919.783.1075
Attorneys for the North Carolina State Board of Dental Examiners

And

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

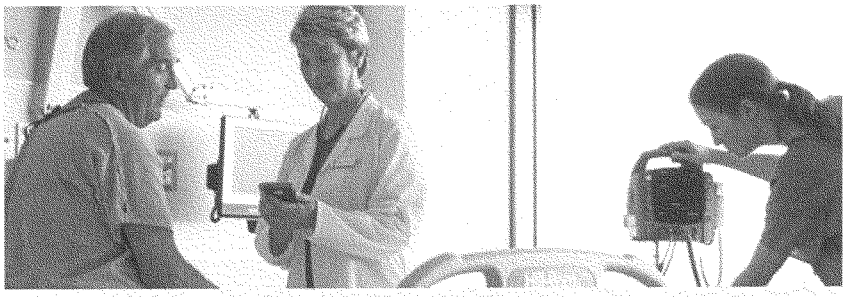
By: C. W. Holland DDS/KLO Date: 9/6/2014
[Name]

Chair, Hearing Panel
[Title]

EXHIBIT 62

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010



Revised: Reduction in dental reimbursement

Overview

The Indiana Health Coverage Programs (IHCP) released bulletin *BT201006* on March 9, 2010, that explained the need for rate changes to avoid budgetary shortfalls. HP recently discovered that the rates for four dental procedure codes with associated age ranges were incorrect prior to the rate change. As a result, the revised rates published in the bulletin were also incorrect.

The following codes and rates are impacted. These codes are highlighted in the table below with blue, bold-faced lettering.

- D5110
- D5120
- D5211
- D5212

The rates associated with these codes have been corrected in the IndianaAIM system. HP apologizes for any inconvenience caused by this error. Providers with claims affected by this error will be notified by letter of the reprocessing timeline.

General

Reimbursement for dental services with a "from" date of service on or after April 1, 2010, through June 30, 2011, will be reduced by 5 percent. Table 1 lists all dental codes, the current rate, and the new rate effective

Continue

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Dental reimbursement

April 1, 2010, through June 30, 2011. Table 2 lists dental codes that are currently manually priced that will also be subject to a 5 percent reduction effective with dates of service on or after April 1, 2010. The IHCP intends to establish rates for the services in Table 2, and providers will be given advance notice of the new rates.

Dental providers will be able to access the reduced fee schedule at www.indianamedicaid.com on and after April 1, 2010.

Table 1 – Dental Codes and New Rate Information

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
D0120	Periodic oral exam	$22.58	$21.45		
D0140	Exam – limited, problem focused	$37.08	$35.23		
D0145	Oral evaluation, pt < 3yr	$35.50	$33.73		
D0150	Exam – comprehensive	$35.50	$33.73		
D0160	Exam – detailed, problem	$50.00	$47.50		
D0170	Re-eval, est pt, problem focus	$20.00	$19.00		
D0210	Intraoral – complete series	$72.25	$68.64		
D0220	Intraoral – periapical – first film	$13.25	$12.59		
D0230	Intraoral – periapical – each additional film	$10.00	$9.50		
D0240	Intraoral – occlusal film	$18.50	$17.58		
D0250	Extraoral – first film	$17.75	$16.86		
D0260	Extraoral – each additional film	$11.25	$10.69		
D0270	Bitewing – single film	$17.29	$16.43		
D0272	Bitewings – two films	$24.81	$23.57		
D0273	Bitewings – three films	$27.75	$26.36		
D0274	Bitewings – four films	$35.17	$33.41		
D0290	Postero – anterior and lateral skull and facial bone, survey film	$51.50	$48.93		

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Table 1 – Dental Codes and New Rate Information

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
D0310	Sialography	$61.75	$58.66		
D0330	Panoramic film	$64.52	$61.29		
D0340	Cephalometric film	$34.25	$32.54		
D0486	Accession of brush biopsy	$68.71	$65.27		
D1110	Prophylaxis – adult	$47.75	$45.36		
D1120	Prophylaxis – child	$34.50	$32.78		
D1203	Topical application of fluoride – child	$22.25	$21.14		
D1204	Topical app fluoride – adult	$22.25	$21.14		
D1206	Topical fluoride varnish	$22.25	$21.14		
D1351	Sealant – per tooth	$29.35	$27.88		
D1510	Space maintainer – fixed – unilateral	$194.34	$184.62		
D1515	Space maintainer – fixed-bilateral	$278.54	$264.61		
D1520	Space maintainer – removable-unilateral	$154.75	$147.01		
D1525	Space maintainer – removable-bilateral	$145.75	$138.46		
D1550	Recementation of space maintainer	$36.50	$34.68		
D1555	Removal of fixed space maintainer	$36.50	$34.68		
D2140	Amalgam – one surface, primary or permanent	$56.88	$54.04		A-T
D2140	Amalgam – one surface, primary or permanent	$61.90	$58.81		01-32
D2150	Amalgam – two surfaces, primary or permanent	$71.93	$68.33		A-T
D2150	Amalgam – two surfaces, primary or permanent	$81.14	$77.08		01-32
D2160	Amalgam – three surfaces, primary or permanent	$86.71	$82.37		A-T
D2160	Amalgam – three surfaces, primary or permanent	$96.47	$91.65		01-32

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
D2161	Amalgam – four or more surfaces, primary or permanent	$93.13	$88.47		A-T
D2161	Amalgam – four or more surfaces, primary or permanent	$116.27	$110.46		01-32
D2330	Resin – one surface – anterior	$79.18	$75.22		
D2331	Resin – two surface – anterior	$96.47	$91.65		
D2332	Resin – three surface – anterior	$111.58	$106.00		
D2335	Composite resin crown – anterior-primary	$154.74	$147.00		
D2390	Ant resin-based cmpst crown	$140.00	$133.00		01-32
D2390	Ant resin-based cmpst crown	$138.75	$131.81		A-T
D2391	Resin-based cmp 1 srf posterior	$55.50	$52.73		01-32
D2391	Resin-based cmp 1 srf posterior	$51.00	$48.45		A-T
D2392	Resin-based cmp 2 srf posterior	$72.75	$69.11		01-32
D2392	Resin-based cmp 2 srf posterior	$64.50	$61.28		A-T
D2393	Resin-based cmp 3 srf posterior	$86.50	$82.18		01-32
D2393	Resin-based cmp 3 srf posterior	$77.75	$73.86		A-T
D2394	Resin-based cmp 4 srf posterior	$104.25	$99.04		01-32
D2394	Resin-based cmp 4 srf posterior	$83.50	$79.33		A-T
D2910	Recement inlay, onlay or partial coverage restoration	$56.00	$53.20		
D2920	Recement crowns	$58.27	$55.36		
D2930	Prefabricated stainless steel crown – primary tooth	$155.86	$148.07		
D2931	Prefabricated stainless steel crown – permanent tooth	$185.69	$176.41		
D2932	Prefabricated resin crown	$138.75	$131.81		
D2933	Prefabricated stainless steel crown with resin window	$161.75	$153.66		
D2934	Prefab steel crown primary	$155.86	$148.07		
D2940	Sedative filling	$60.78	$57.74		
D2980	Crown repair, by report	$160.25	$152.24		

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
D3220	Therapeutic pulpotomy (excluding final restoration)	$105.11	$99.85		
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$105.11	$99.85		
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$136.06	$129.26		
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final)	$115.50	$109.72		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$377.52	$358.64		
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$464.23	$441.02		
D3330	Endodontic therapy, molar (excluding final restoration)	$569.32	$540.85		
D3351	Apexification/recalcification	$240.50	$228.48		
D3352	Apexification/recalcification – interim medication replacement	$49.50	$47.03		
D3353	Apexification/recalcification – final visit includes completed root canal	$49.50	$47.03		
D3410	Apicoectomy/periradicular surgery – anterior	$352.00	$334.40		
D3430	Retrograde filling – per root	$108.25	$102.84		
D4210	Gingivectomy/plasty per quad	$371.38	$352.81		
D4211	Gingivectomy/plasty per one to three tooth	$127.42	$121.05		
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$154.74	$147.00		
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	$52.03	$49.43		
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$98.14	$93.23		
D5110	**Complete upper (denture)**	**$782.50**	**$743.38**	**0-20**	
D5110	**Complete upper (denture)**	**$436.35**	**$414.53**	**21-999**	

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
D5120	**Complete lower (denture)**	**$788.25**	**$748.84**	**0-20**	
D5120	**Complete lower (denture)**	**$439.56**	**$417.58**	**21-999**	
D5130	Immediate upper	$391.25	$371.69		
D5140	Immediate lower	$394.13	$374.42		
D5211	**Upper partial – acrylic base**	**$656.00**	**$623.20**	**0-20**	
D5211	**Upper partial – acrylic base**	**$365.81**	**$347.52**	**21-999**	
D5212	**Lower partial – acrylic base**	**$788.25**	**$748.84**	**0-20**	
D5212	**Lower partial – acrylic base**	**$371.38**	**$352.81**	**21-999**	
D5213	Maxillary partial denture – cast metal framework with resin denture bases	$656.00	$623.20	0-20	
D5213	Maxillary partial denture – cast metal framework with resin denture bases	$328.00	$311.60	21-999	
D5214	Lower partial – predominantly base cast base with acrylic saddles	$788.25	$748.84	0-20	
D5214	Lower partial – predominantly base cast base with acrylic saddles	$333.00	$316.35	21-999	
D5225	Maxillary partial denture – flexible base	$656.00	$623.20	0-20	
D5225	Maxillary partial denture – flexible base	$328.00	$311.60	21-999	
D5226	Mandibular partial denture –flexible base	$788.25	$748.84	0-20	
D5226	Mandibular partial denture – flexible base	$333.00	$316.35	21-999	
D5510	Repair broken – complete denture base	$105.50	$100.23		
D5520	Replace missing or broken teeth – complete denture (each tooth)	$83.25	$79.09		
D5610	Repair resin denture base	$100.00	$95.00		
D5620	Repair cast framework	$159.75	$151.76		
D5630	Repair or replace broken clasp	$144.25	$137.04		
D5640	Replace broken teeth – per tooth	$83.25	$79.09		
D5650	Add tooth to existing partial denture	$111.00	$105.45		

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
D5660	Add clasp to existing partial	$155.50	$147.73		
D5730	Reline upper complete denture	$194.25	$184.54		
D5731	Reline lower complete denture (chairside)	$194.25	$184.54		
D5740	Reline upper partial denture (chairside)	$126.25	$119.94		
D5741	Reline lower partial denture (chairside)	$69.50	$66.03		
D5750	Reline complete maxillary denture laboratory	$249.75	$237.26		
D5751	Reline complete mandibular denture (laboratory)	$249.75	$237.26		
D5760	Reline maxillary partial denture (laboratory)	$200.00	$190.00		
D5761	Reline mandibular partial denture (laboratory)	$144.50	$137.28		
D5952	Pediatric speech aid	$1,352.25	$1,284.64		
D7111	Extraction, coronal remnants – deciduous tooth	$72.25	$68.64		
D7140	Extraction, erupted tooth, or exposed root (elevation and/or forceps removal)	$77.24	$73.38		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone	$154.20	$146.49		
D7220	Removal of impacted tooth – soft tissue	$185.69	$176.41		
D7230	Removal of impacted tooth – partially bony	$247.59	$235.21		
D7240	Removal of impacted tooth – completely bony	$321.76	$305.67		
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$333.00	$316.35		
D7250	Surgical removal of residual tooth roots (cutting procedure)	$185.69	$176.41		
D7260	Oroantral fistula closure	$355.75	$337.96		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed	$216.25	$205.44		

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
	or displaced tooth				
D7280	Surgical access of an unerupted tooth	$158.50	$150.58		
D7285	Biopsy of oral tissue – hard	$210.50	$199.98		
D7286	Biopsy of oral tissue – soft	$172.59	$163.96		
D7288	Brush biopsy – transepithelial sample collection	$35.00	$33.25		
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$185.69	$176.41		
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$157.89	$150.00		
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$247.59	$235.21		
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$198.94	$188.99		
D7410	Excision of benign lesion up to 1.25cm	$111.48	$105.91		
D7411	Excision of benign lesion greater than 1.25cm	$477.75	$453.86		
D7440	Excision of malignant tumor, lesion diameter up to 1.2cm	$152.00	$144.40		
D7441	Excision of malignant tumor, lesion diameter over 1.25 cm	$171.00	$162.45		
D7450	Removal of benign odontogenic cyst or tumor –lesion diameter up to1.25cm	$233.00	$221.35		
D7451	Removal of benign odontogenic	$347.75	$330.36		
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25cm	$162.25	$154.14		
D7461	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25cm	$360.50	$342.48		
D7471	Removal of lateral exostosis (maxilla or mandible)	$270.50	$256.98		
D7510	Incision and drainage of abscess –	$87.50	$83.13		

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
	intraoral soft tissue				
D7520	Incision and drainage of abscess – extraoral soft tissue	$96.25	$91.44		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$153.50	$145.83		
D7620	Maxilla – closed reduction (teeth immobilized if present)	$486.00	$461.70		
D7640	Mandible – closed reduction (teeth immobilized if present)	$1,313.25	$1,247.59		
D7660	Malar and/or zygomatic arch – closed reduction	$143.25	$136.09		
D7670	Alveolus – closed reduction, may include stabilization of teeth	$311.25	$295.69		
D7710	Maxilla – open reduction	$542.75	$515.61		
D7720	Maxilla – closed reduction	$435.25	$413.49		
D7730	Mandible – open reduction	$2,522.25	$2,396.14		
D7750	Malar and/or zygomatic arch – open reduction	$744.00	$706.80		
D7760	Malar and/or zygomatic arch – closed reduction	$143.25	$136.09		
D7770	Alveolus – open reduction	$495.00	$470.25		
D7780	Facial bones – complicated reduction	$1,173.00	$1,114.35		
D7810	Open reduction of dislocation	$487.00	$462.65		
D7820	Closed reduction of dislocation	$335.25	$318.49		
D7910	Facial bones – complicated reduction	$117.66	$111.78		
D7911	Suture of recent small wound up to 5cm	$117.75	$111.86		
D7912	Suture – over 5cm	$245.50	$233.23		
D7951	Sinus augmentation with bone or bone substitutes	$259.66	$246.68		
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	$205.25	$194.99		
D7980	Sialolithotomy	$244.75	$232.51		
D7982	Sialodochoplasty	$243.50	$231.33		

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Procedure Code	Description	Current Rate	New Rate Effective April 1, 2010	Age Range	Tooth Range
D7983	Closure of salivary fistula	$238.50	$226.58		
D8210	Removable appliance therapy	$455.00	$432.25		
D9220	Deep sedation/general anesthesia – first 30 minutes	$107.25	$101.89		
D9221	Deep sedation/general anesthesia – first 30 minutes	$25.00	$23.75		
D9230	Analgesia	$30.95	$29.40		
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$107.25	$101.89		
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$25.00	$23.75		
D9248	Non-intravenous conscious sedation	$38.50	$36.58		
D9920	Behavior management, by report	$46.75	$44.41		

Table 2 – Manually Priced Dental Procedure Codes

Dental Code	Description
D3346	Retreatment of previous root canal therapy – anterior
D3347	Retreatment of previous root canal – bicuspid
D3348	Retreatment of previous root canal therapy – molar
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)
D3425	Apicoectomy/periradicular surgery – molar first root
D3426	Apicoectomy/periradicuar surgery each additional root
D4240	Gingival flap proc w/planin
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant
D4260	Osseous surgery, per quadrant
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)
D5951	Feeding aid
D6930	Recement bridge
D6980	Bridge repair, by report
D7261	Primary closure of a sinus perforation

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201012 APRIL 15, 2010

Dental Code	Description
D7282	Mobilization of erupted or malpositioned tooth to aid eruption
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25cm
D7414	Excision of malignant lesion greater than 1.25cm
D7415	Excision of malignant lesion, complicated
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7511	Incision/drain abscess intra
D7521	Incision and drainage of abscess – extraoral soft tissue
D7610	Maxilla – open reduction (teeth immobilized if present)
D7630	Mandible – open reduction (teeth immobilized if present)
D7650	Malar and/or zygomatic arch – open reduction
D7671	Alveolus – open reduction, may include stabilization of teeth
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches
D7740	Mandible – closed reduction
D7771	Alveolus, closed reduction stabilization of teeth
D7972	Surgical reduction of fibrous tuberosity
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8220	Fixed appliance therapy
D9120	Fixed partial denture sectioning

Questions?

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

EXHIBIT 63

MARCH MADNESS

What's the goal?
To improve team work and clinic performance while providing quality dental services in a timely manner for low-income children to enhance their health and self esteem.

How will we measure team work and clinic performance?

- # of patients converted from hygiene to operative over goal.
- # of patients seen per day over goal.
- Broken Appointment rate less than goal.
- Daily Average Production over goal.

What are the rules?
All clinic teams will start MARCH MADNESS with their February FOCUS 'bonus points' as their base. Each week clinics will be awarded 200 points for each performance category that exceeds their goal (# of patient's converted and total # of patients seen goals are based on each clinic's latest four month average, broken appointment goals are based on each clinic's BA rate for February and daily average production is based on each clinics actual March budget). Points will be accumulated each week and at the end of the month all clinics will be ranked from first to last. ONLY the top 13 clinics will be awarded prize money.

The clinic team with the most points will be named **2007 National Champions!**
The next 4 clinics team will be named **2007 Final Four Champions!**
The next 8 clinics teams will be named **2007 Elite Eight Champions!**

Who is eligible for this contest?
Everyone!

What do we win?

2007 National Champions Trophy and all clinic staff will be awarded	$1,000.00 !!!!
2007 Final Four Champions Trophy and all clinic staff will be awarded	$ 400.00 !!!
2007 Elite Eight Champions Trophy and all clinic staff will be awarded	$ 100.00 !!

How will we know how we're doing in the MARCH MADNESS contest?
We will take care of all that! [redacted] will provide everyone with weekly MARCH MADNESS updates every Monday. All you need to do is focus on the game and WIN!!!

Good luck and Have Fun!!!

Elite Eight *Final Four* *National Champions*

FORBA 0236058
CONFIDENTIAL

Although all clinics are competing against one another we have assigned coaches to clinics teams. Coaches are to provide Lead Dentists, Office Managers and Lead Dental Assistants with moral support, performance reporting, positive feedback and share best practices to help each clinic reach their full potential throughout MARCH MADNESS.

Western Region Coaches	**Clinic Teams**	
[redacted]	Denver Broncos	Aurora Drillers
	Tulsa	OKC1
	Oklahoma Canines (OCK2)	Omaha Cavinators
	Colo. Springs Snow Crowns	
[redacted]	Topeka Tooth Fairies	Albuquerque Toothinators
	Phoenix Crowns	Tucson Tooth Warriors
	KCK Dentinators	Wichita Rezainators
[redacted]	Pueblo Crusaders	Santa Fe Molarnators
	Thornton Cavity Terminators	Reno Coronas
	Boise Bicuspids	E. Alb 505 Prophy Anglers
Central Region Coaches	**Clinic Teams**	
[redacted]	Rochester	Lawrence
	Mattapan Maintainers	Cincinnati Extractors
	Ft.Wayne Smilers	Toledo T Town Tacklers
[redacted]	Gary Steelteeth	Indy 2
	Syracuse Teeth Savers	Roselawn Pulpeteers
	Lynn	
[redacted]	Indy 1 Calculus Crushers	Springfield Springboks
	Columbus Royal Crows	Albany Tight Ends in Motion
	Worcester	Dayton Cavity Busters
Eastern Region Coaches	**Clinic Teams**	
[redacted]	Atlanta Plaque Attackers	Augusta Masters
	Richmond Cavity Kickers	Myrtle Beach
	Baltimore Explorers	
[redacted]	Columbia Cavity Catchers	Florence Fluoriders
	Savannah	Roanoke Stars
	Montgomery	
[redacted]	Greenville Molars	Charleston Clamdiggers
	Macon Lidocaines	Spartanburg Smile Makers
	Washington DC Fighting Floss	

Company		Conversions Month Average	BA Month Average	Production Average	Pts Seen Month Average
0	Pueblo, CO	12.50	23.7%	$17,795.45	79.27
1	Colorado Springs, CO	7.59	33.6%	$13,450.00	71.05
2	Denver, CO	12.36	31.8%	$13,954.55	66.14
3	Albuquerque, NM	11.45	40.3%	$16,136.36	78.82
4	Santa Fe, NM	8.55	32.6%	$10,254.55	57.45
5	Aurora, CO	16.05	28.5%	$17,081.82	79.00
6	Phoenix, AZ	8.73	32.6%	$12,122.73	57.91
7	Indy 1, IN	7.82	35.3%	$12,036.36	71.50
8	Gary, IN	9.86	46.0%	$12,940.91	68.23
9	Thornton, CO	18.55	32.2%	$19,054.55	72.09
10	Greenville, SC	9.59	31.5%	$15,086.36	83.50
11	Columbia, SC	3.41	46.4%	$13,327.27	75.64
12	Tucson, AZ	11.18	35.2%	$14,281.82	68.23
13	Charleston, SC	17.23	25.5%	$15,159.09	65.50
14	Indy 2, IN	12.82	32.1%	$13,636.36	63.09
15	KCK, KS	8.86	33.8%	$14,231.82	80.91
16	Atlanta, GA	5.36	39.0%	$9,195.45	53.36
17	Florence, SC	2.86	45.2%	$13,068.18	60.68
18	Wichita, KS	17.91	36.5%	$20,222.73	102.50
19	Macon, GA	5.68	47.7%	$15,677.27	69.95
20	Tulsa, OK	16.18	37.5%	$28,881.82	106.77
21	Augusta, GA	7.73	43.2%	$10,877.27	52.05
22	Syracuse, NY	6.27	45.9%	$11,809.09	71.50
23	Savannah, GA	10.32	47.1%	$11,936.36	49.68
24	OKC 1, OK	10.68	28.5%	$30,431.82	101.41
25	Rochester, NY	7.95	39.4%	$15,163.64	81.91
26	Springfield, MA	9.27	36.0%	$22,818.18	92.00
27	Columbus, OH	14.43	46.7%	$21,090.91	91.73
28	Boise, ID	11.32	36.1%	$10,250.00	63.00
29	Albany, NY	4.91	41.4%	$15,327.27	72.64
30	Lawrence, MA	7.32	37.2%	$12,904.55	46.05
31	Worcester, MA	7.36	36.7%	$22,531.82	77.55
32	Roselawn, OH	15.68	43.6%	$10,127.27	47.27
33	Dayton, OH	10.05	33.6%	$20,759.09	90.59
34	Mattapan, MA	7.45	43.5%	$12,109.09	37.14
35	Lynn, MA	1.50	44.2%	$9,140.91	40.77
36	Cincinnati, OH	8.18	52.4%	$8,559.09	53.82
37	Reno, NV	7.95	30.0%	$12,104.55	67.64
38	East Albuquerque, NM	3.68	40.9%	$12,590.91	52.45
39	Fort Wayne, IN	6.14	29.4%	$16,777.27	69.27
40	Spartanburg, SC	6.64	37.4%	$12,254.55	54.82
41	Richmond, VA	2.82	40.4%	$7,727.27	34.00
42	Toledo, OH	28.05	41.4%	$13,500.00	68.45
43	Myrtle Beach, SC	6.14	29.8%	$7,800.00	32.73
44	Topeka, KS	6.14	41.3%	$12,104.55	62.91
45	Roanoke, VA	3.82	51.5%	$15,740.91	77.32
46	OKC 2, OK	4.18	32.7%	$11,786.36	44.82
47	Baltimore, MD	4.77	41.4%	$17,536.36	83.45
48	Omaha, NE	4.15	39.8%	$10,600.00	35.82
49	Washington, DC	2.36	40.3%	$23,063.64	69.14
50	Montgomery, AL	4.68	40.9%	$12,554.55	69.27
	COMPANY AVERAGE	**8.93**	**38.9%**	**$14,678.61**	**67.11**

FORBA 0236060
CONFIDENTIAL

Company	Clinic	3/1/2007	3/2/2007	3/5/2007	3/6/2007	3/7/2007	3/8/2007	3/9/2007	3/12/2007	3/13/2007	3/14/2007	3/15/2007	3/16/2007	3/19/2007	3/20/2007	3/21/2007	3/22/2007	3/23/2007	3/26/2007	3/27/2007	3/28/2007	3/29/2007	3/30/2007	Conversions Month Average
0	Pueblo, CO	11	4	13	10	15	30	12	15	10	7	15	11	8	10	18	9	12	6	12	14	7	12	12.5
1	Colorado Springs, CO	11	4	6	13	7	6	5	8	10	6	12	8	5	14	8	7	1	6	7	9	14	5	7.590959091
2	Denver, CO	11	12	13	11	11	3	10	6	10	12	14	14	10	16	11	15	3	17	25	14	19	6	12.36363636
3	Albuquerque, NM	13	5	3	21	9	10	6	12	14	5	11	8	13	13	4	20	6	26	17	11	13	8	11.45454545
4	Santa Fe, NM	13	10	9	15	10	11	3	5	10	21	6	6	13	4	20	6	6	26	10	7	7	3	8.545454545
5	Aurora, CO	13	12	10	14	17	18	14	12	15	14	20	15	16	15	21	16	26	20	15	22	20	8	16.04545455
6	Phoenix, AZ	12	8	5	7	8	11	5	7	9	15	7	11	17	9	7	4	2	10	2	2	9	7	8.727272727
7	Gilbert, AZ	3	3	3	7	14	11	9	6	10	14	5	7	9	7	9	4	6	5	12	12	7	7	7.818181818
8	Tempe, AZ	16	7	7	7	10	5	7	9	9	11	16	11	7	14	12	7	14	4	11	18	10	12	9.863636364
9	Thornton, CO	18	19	14	27	12	10	18	16	13	16	12	9	15	15	19	21	21	25	25	22	23	23	16.54545455
10	Greenville, SC	1	0	6	12	10	9	7	14	13	13	12	6	7	15	19	3	3	12	13	12	12	6	9.590909091
11	Columbia, SC	5	2	4	8	3	6	0	3	9	2	1	2	6	5	5	2	1	0	3	3	3	3	3.409090909
12	Tucson, AZ	3	11	13	15	13	16	12	16	15	9	5	12	12	9	11	15	10	10	12	14	7	6	11.18181818
13	Charleston, SC	17	12	18	23	10	10	23	15	5	18	17	19	19	21	20	20	21	17	21	11	24	18	17.22727273
14	Mesa, AZ	12	7	13	7	10	14	12	15	15	11	11	13	13	16	12	7	14	6	5	22	14	17	12.31818182
15	KCK, KS	14	5	5	1	7	20	5	6	13	1	1	3	16	14	12	4	10	10	6	5	3	5	8.863636364
16	Atlanta, GA	6	5	4	3	1	4	3	5	2	3	3	0	7	3	4	6	6	1	3	2	6	0	2.863636364
17	Florence, SC	12	0	4	3	1	4	3	5	2	3	3	0	3	4	0	6	1	3	2	1	7	3	2.863636364
18	Wichita, KS	17	15	15	23	20	13	15	18	20	19	29	17	21	15	23	16	11	15	25	14	19	19	17.09090909
19	Macon, GA	5	7	8	2	12	9	3	8	4	7	10	2	5	2	5	3	4	7	10	4	5	3	5.681818182
20	Vista, CA	16	19	11	16	9	16	21	14	15	20	18	18	17	16	15	17	5	21	20	13	22	15	16.18181818
21	Augusta, GA	6	3	3	7	5	4	21	6	5	9	5	8	19	21	20	13	10	11	9	7	10	4	7.727272727
22	Syracuse, NY	7	10	12	7	5	4	3	6	2	2	8	2	10	6	7	3	5	5	8	6	9	9	6.227272727
23	Savannah, GA	7	7	2	14	14	13	9	15	13	14	7	11	10	8	11	16	11	10	6	5	5	7	10.31818182
24	OKC 1, OK	11	10	14	16	13	15	13	13	13	18	21	14	2	6	12	6	6	5	7	4	3	13	10.68181818
25	Rochester, NY	5	9	7	8	13	14	4	11	6	7	7	10	7	4	5	8	5	8	8	6	17	8	7.954545455
26	Cincinnati, OH	7	15	10	5	14	7	11	7	12	11	8	2	9	11	10	6	8	9	5	8	11	9	9.272727273
27	Columbus, OH	14	15	14	22	23	16	20	15	19	16	14	6	6	15	12	11	11	12	11	14	10	10	14.42857143
28	Boise, ID	5	11	8	13	12	14	10	10	12	10	12	6	16	6	10	15	7	17	11	14	11	11	11.13636364
29	Albany, NY	6	6	4	6	8	3	1	6	6	5	6	8	5	3	4	4	2	7	7	4	4	3	4.909090909
30	Lawrence, MA	6	8	6	5	2	8	6	9	11	10	10	3	9	7	7	6	8	7	9	6	9	9	7.318181818
31	Worcester, MA	3	3	6	11	6	9	6	9	10	13	7	4	10	6	9	7	6	10	9	7	4	4	7.363636364
32	Dayton, OH	20	18	14	19	13	15	17	15	16	14	15	13	14	16	11	18	16	24	19	8	17	13	15.68181818
33	Dayton, OH	11	14	10	16	16	10	8	4	10	6	14	14	3	12	11	7	6	13	14	13	7	13	10.04545455
34	Mattapan, MA	5	6	3	7	2	14	9	9	4	4	7	9	5	8	10	4	5	6	6	14	10	8	7.454545455
35	Lynn, MA	1	0	1	2	1	4	2	3	3	3	0	0	1	1	0	5	0	2	4	1	2	2	1.5
36	Cincinnati, OH	6	4	8	18	6	5	3	6	10	6	6	7	12	9	7	13	12	10	11	7	2	10	8.181818182
37	Reno, NV	11	7	1	13	8	4	3	12	8	12	12	7	11	9	5	4	14	11	3	6	4	10	7.954545455
38	Albuquerque, NM	6	5	1	6	4	3	3	0	8	4	1	1	0	6	4	6	4	7	5	4	3	2	3.681818182
39	Fort Wayne, IN	10	4	6	2	4	2	5	5	5	3	10	3	8	8	5	4	6	13	8	5	4	10	6.136363636
40	Spartanburg, SC	9	8	7	4	2	5	5	4	5	10	13	7	6	6	5	4	6	6	6	3	3	3	5.681818182
41	Richmond, VA	8	3	0	4	0	7	1	6	3	0	1	1	4	1	7	0	2	2	8	4	0	2	2.818181818
42	Toledo, OH	25	26	20	24	36	33	33	40	34	23	21	26	26	13	42	33	29	36	21	29	24	23	28.04545455
43	Myrtle Beach, SC	9	9	11	5	6	3	4	8	6	6	9	4	2	4	4	6	4	9	5	6	8	7	6.136363636
44	Topeka, KS	6	10	10	4	8	5	13	5	7	9	5	9	5	3	7	5	1	4	8	4	3	6	6.136363636
45	Roanoke, VA	6	7	3	5	3	3	2	5	1	7	3	3	2	4	8	1	6	5	1	3	2	2	3.818181818
46	OKC 2, OK	4	4	7	4	5	2	8	4	3	11	6	3	4	4	3	3	1	6	1	1	1	3	4.181818182
47	Baltimore, MD	4	1	5	2	7	10	1	8	3	9	4	2	4	4	2	8	3	3	2	2	11	7	4.772727273
48	Omaha, NE			2	1	3	1	1	8	8	7	3	3	1	3	1	3	4	6	7	6	9	6	4.15
49	Washington, DC, DC	6	0	2	1	4	5	2	1	1	1	0	0	1	3	3	2	4	3	2	4	5	2	2.363636364
50	Hoover, AL	2	2	1	5	6	3	1	1	4	1	1	0	0	1	3	3	7	8	1	3	3	7	4.681818182
	Company Total	445	395	398	527	495	490	432	480	476	510	491	399	469	454	470	457	406	530	493	449	444	423	455.4545455
	Company Daily Average	8.784314	7.745098	7.823529	10.33333	9.137255	9.607843	8.470588	9.411765	9.333333	10	9.431373	7.823824	9.015686	8.843137	9.392157	8.843137	7.960784	9.803922	9.686667	8.803922	8.705882	8.294118	8.930481283

FORBA 0236061
CONFIDENTIAL

	3/1/2007	3/2/2007	3/5/2007	3/6/2007	3/7/2007	3/8/2007	3/9/2007	3/12/2007	3/13/2007	3/14/2007	3/15/2007	3/16/2007	3/19/2007	3/20/2007	3/21/2007	3/22/2007	3/23/2007	3/26/2007	3/27/2007	3/28/2007	3/29/2007	3/30/2007	
Company	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Rate	BA Month Average
0 Pueblo, CO	0.165138	0.301587	0.382114	0.092593	0.165138	0.299145	0.125	40.7%	35.0%	37.5%	26.6%	4.9%	0.325203	0.19469	0.217391	0.190083	0.153846	0.224	0.257813	0.28	0.158333	0.238806	23.7%
1 Colorado Springs, CO	0.466667	0.44	0.324324	0.235849	0.386364	0.324786	0.212121	42.7%	35.9%	31.3%	31.7%	50.0%	0.45	0.320755	0.333333	0.25	0.203704	0.291971	0.416667	0.274074	0.24183	0.302632	33.6%
2 Denver, CO	0.5	0.107143	0.333333	0.319588	0.329114	0.391304	0.075472	36.5%	32.1%	38.5%	27.3%	32.2%	0.288889	0.398438	0.296	0.344444	0.294118	0.331169	0.335484	0.354037	0.358025	0.269231	31.8%
3 Albuquerque, NM	0.47651	0.392405	0.478873	0.51938	0.410959	0.428571	0.203125	40.3%	52.0%	39.2%	52.9%	48.6%	0.416667	0.516129	0.333333	0.335443	0.410256	0.421384	0.347518	0.237805	0.327778	0.283951	40.3%
4 Santa Fe, NM	0.446154	0.246914	0.481818	0.289157	0.269231	0.52	0.35	27.4%	42.7%	41.7%	36.8%	23.4%	0.353535	0.173333	0.35	0.213333	0.315789	0.376344	0.329268	0.273684	0.20202	0.264368	32.6%
5 Aurora, CO	0.354545	0.313559	0.318681	0.351064	0.298969	0.34375	0.178947	15.9%	30.5%	33.0%	40.6%	19.4%	0.333333	0.245283	0.272727	0.321839	0.224299	0.266187	0.277372	0.288889	0.294521	0.190789	28.5%
6 Phoenix, AZ	0.478873	0.472527	0.094118	0.388889	0.383333	0.057143	0.456824	45.7%	39.8%	32.6%	46.3%	32.0%	0.358491	0.313725	0.262626	0.333333	0.252427	0.333333	0.253333	0.2125	0.280488	0.28125	32.6%
7 Indy 1, IN	0.401515	0.482456	0.293651	0.295082	0.452381	0.375887	0.25	36.2%	34.8%	17.8%	28.7%	41.6%	0.349057	0.516393	0.336283	0.228261	0.294118	0.441176	0.410526	0.351648	0.322581	0.377778	35.3%
8 Gary, IN	0.537736	0.81194	0.589041	0.490566	0.452703	0.556522	0.544828	57.7%	39.5%	45.6%	37.3%	50.4%	0.198675	0.262295	0.409091	0.459184	0.540881	0.551948	0.533333	0.469027	0.088889	0.52381	46.0%
9 Thornton, CO	0.424528	0.336066	0.315217	0.315789	0.237113	0.353535	0.422764	37.0%	22.9%	28.4%	43.5%	37.8%	0.327731	0.284483	0.252874	0.340206	0.305556	0.330357	0.31405	0.280702	0.276423	0.262295	32.2%
10 Greenville, SC	0.325	0.381579	0.329193	0.428571	0.301471	0.315385	0.235294	30.2%	35.5%	33.3%	38.6%	26.3%	0.369427	0.198473	0.29771	0.367647	0.179104	0.279221	0.328571	0.34507	0.232143	0.380952	31.5%
11 Columbia, SC	0.561538	0.51145	0.407692	0.434783	0.5125	0.481481	0.414634	44.8%	44.2%	38.5%	42.9%	41.4%	0.482143	0.455782	0.506667	0.468531	0.544118	0.480916	0.444444	0.380165	0.468254	0.544	46.4%
12 Tucson, AZ	0.394231	0.495652	0.378378	0.31068	0.40367	0.428571	0.326316	29.9%	38.9%	35.2%	39.0%	31.6%	0.401786	0.333333	0.309091	0.359649	0.362832	0.271028	0.284211	0.194444	0.285714	0.454545	35.2%
13 Charleston, SC	0.303371	0.329268	0.208791	0.192771	0.26506	0.208333	0.258427	17.6%	51.8%	25.6%	25.9%	25.4%	0.150538	0.086022	0.257143	0.213483	0.2	0.301075	0.256098	0.294737	0.301205	0.32	25.5%
14 Indy 2, IN	0.345679	0.357895	0.382979	0.358491	0.366071	0.37234	0.31	34.6%	25.3%	37.4%	37.8%	39.8%	0.19	0.206522	0.298701	0.191176	0.263736	0.314286	0.43038	0.147368	0.348485	0.43617	32.1%
15 KCK, KS	0.364486	0.394958	0.359649	0.463918	0.425	0.245455	0.366071	35.7%	34.1%	42.5%	26.8%	31.6%	0.255639	0.229167	0.383117	0.354839	0.436709	0.316901	0.304	0.229167	0.40625	0.204545	33.8%
16 Atlanta, GA	0.35	0.2375	0.47619	0.362745	0.467391	0.232558	0.515789	29.0%	37.1%	34.9%	47.8%	24.1%	0.357143	0.5	0.291667	0.547368	0.417582	0.435897	0.363636	0.466667	0.521739	0.30303	39.0%
17 Florence, SC	0.534351	0.646154	0.55	0.416667	0.428571	0.473282	0.435484	61.8%	47.6%	51.1%	46.0%	35.8%	0.380952	0.452381	0.36036	0.491667	0.425532	0.514925	0.380531	0.419355	0.407692	0.213115	45.2%
18 Wichita, KS	0.407643	0.417178	0.375723	0.309859	0.381579	0.377622	0.405714	40.9%	38.6%	30.5%	48.5%	37.0%	0.368421	0.387283	0.41573	0.310734	0.352941	0.310559	0.310559	0.337748	0.348993	0.265306	36.5%
19 Macon, GA	0.57047	0.550336	0.541935	0.489051	0.532895	0.398496	0.364341	49.4%	51.1%	47.0%	50.0%	49.6%	0.422222	0.490066	0.47541	0.541985	0.383838	0.392593	0.473282	0.454545	0.552632	0.4	47.7%
20 Tulsa, OK	0.364198	0.382022	0.393443	0.457317	0.442857	0.309677	0.422857	42.0%	30.7%	39.4%	40.4%	47.4%	0.342697	0.310345	0.484536	0.281437	0.35468	0.333333	0.342657	0.289308	0.310976	0.420455	37.5%
21 Augusta, GA	0.585859	0.473118	0.44186	0.51087	0.48913	0.240506	0.424242	33.3%	33.3%	43.3%	54.5%	38.2%	0.506329	0.337209	0.347826	0.320988	0.398058	0.456311	0.333333	0.482353	0.541284	0.59434	43.2%
22 Syracuse, NY	0.352941	0.616541	0.611111	0.646154	0.461538	0.470149	0.401515	52.0%	44.6%	48.5%	45.7%	39.6%	0.465116	0.410448	0.310078	0.37069	0.414063	0.430769	0.492647	0.435115	0.430894	0.483871	45.9%
23 Savannah, GA	0.607143	0.368421	0.435897	0.488372	0.505376	0.322581	0.531915	50.5%	58.2%	48.9%	53.8%	49.5%	0.490196	0.52	0.421569	0.344086	0.525253	0.346535	0.525773	0.480392	0.515789	0.322917	47.1%
24 OKC 1, OK	0.421875	0.329412	0.315789	0.191304	0.237037	0.40367	0.428571	39.9%	12.1%	3.7%	33.3%	37.8%	0.130719	0.246914	0.375	0.298137	0.257862	0.33758	0.141844	0.214815	0.248	0.414414	28.5%
25 Rochester, NY	0.330935	0.381295	0.451852	0.467153	0.387324	0.401575	0.335938	41.6%	37.1%	38.8%	36.3%	47.8%	0.294574	0.364964	0.411765	0.496241	0.443662	0.408759	0.37594	0.364964	0.416667	0.328244	39.4%
26 Springfield, MA	0.35461	0.478261	0.408451	0.270833	0.388889	0.323741	0.401361	37.8%	27.8%	33.6%	30.5%	45.8%	0.358108	0.377483	0.356643	0.381944	0.496552	0.359477	0.342657	0.268456	0.335664	0.271523	36.0%
27 Columbus, OH	0.594771	0.564706	0.418301	0.416667	0.483871	0.458904	0.531073	46.9%	52.2%	47.4%	46.6%	46.4%	0.393064	0.403226	0.461078	0.401163	0.454054	0.404494	0.528302	0.441718	0.446927	0.455446	46.7%
28 Boise, ID	0.338235	0.475248	0.414141	0.305263	0.43	0.39604	0.228261	45.9%	21.8%	27.6%	39.0%	35.3%	0.352459	0.337349	0.277108	0.384615	0.5	0.344	0.478261	0.338983	0.358491	0.286957	36.1%
29 Albany, NY	0.487395	0.709091	0.4375	0.422764	0.447154	0.381356	0.375	48.9%	41.5%	38.1%	35.4%	49.2%	0.338462	0.372881	0.38806	0.516667	0.310924	0.416	0.395161	0.344262	0.301724	0.336	41.4%
30 Lawrence, MA	0.402778	0.56701	0.461538	0.415385	0.418919	0.314286	0.258621	47.4%	27.4%	34.2%	29.7%	58.8%	0.205882	0.309859	0.434211	0.363636	0.358025	0.421053	0.285714	0.465753	0.248377	0.275	37.2%
31 Worcester, MA	0.342342	0.663366	0.318239	0.336449	0.365217	0.4	0.258065	36.7%	32.5%	39.7%	34.7%	68.6%	0.354839	0.233871	0.324786	0.284404	0.432	0.377049	0.284615	0.338346	0.295775	0.325758	36.7%
32 Roselawn, OH	0.454545	0.509259	0.43	0.412371	0.360465	0.511905	0.369048	53.1%	38.8%	49.3%	52.8%	46.3%	0.443038	0.36	0.621212	0.382716	0.48913	0.337209	0.37931	0.426667	0.225806	0.47191	43.6%
33 Dayton, OH	0.510638	0.347222	0.261194	0.309353	0.217391	0.352113	0.266667	31.5%	31.9%	24.1%	30.6%	34.5%	0.408451	0.351145	0.449275	0.193798	0.441558	0.216	0.419118	0.283784	0.4	0.432624	33.6%
34 Mattapan, MA	0.526316	0.545455	0.561644	0.55	0.522388	0.455696	0.493151	26.8%	39.4%	49.4%	26.9%	61.4%	0.470588	0.396552	0.4375	0.393443	0.385542	0.282051	0.4375	0.467742	0.295455	0.305085	43.5%
35 Lynn, MA	0.5	0.507463	0.552632	0.468354	0.532258	0.395349	0.385714	43.8%	41.2%	41.1%	50.0%	50.0%	0.475	0.289157	0.458333	0.486111	0.360656	0.428571	0.418605	0.428571	0.295775	0.472727	44.2%
36 Cincinnati, OH	0.543103	0.623853	0.605263	0.578125	0.53913	0.398374	0.507576	59.1%	48.1%	53.2%	58.7%	55.0%	0.458015	0.526786	0.455446	0.533333	0.525862	0.561905	0.438095	0.479592	0.444444	0.575221	52.4%
37 Reno, NV	0.360825	0.339806	0.44086	0.206897	0.302083	0.296703	0.302326	32.1%	23.5%	24.8%	32.7%	39.6%	0.136842	0.363636	0.285714	0.202381	0.228571	0.333333	0.38	0.348315	0.3	0.255102	30.0%
38 East Albuquerque, NM	0.402597	0.362637	0.444444	0.358025	0.319149	0.428571	0.275862	45.5%	47.9%	45.8%	50.6%	35.1%	0.495146	0.456522	0.372093	0.233766	0.378788	0.447917	0.395062	0.544554	0.397959	0.444444	40.9%
39 Fort Wayne, IN	0.370787	0.303571	0.378641	0.236559	0.397849	0.367816	0.262626	27.1%	24.2%	26.7%	41.0%	27.1%	0.316327	0.203883	0.117647	0.311828	0.375	0.075472	0.23913	0.217391	0.336957	0.505155	29.4%
40 Spartanburg, SC	0.466667	0.471154	0.428571	0.342593	0.297297	0.338028	0.223404	52.7%	30.8%	33.3%	42.3%	38.6%	0.333333	0.409091	0.253012	0.232558	0.289474	0.558559	0.434211	0.328125	0.38806	0.463768	37.4%
41 Richmond, VA	0.474576	0.528571	0.322581	0.409836	0.326531	0.470588	0.395833	39.7%	43.1%	31.1%	63.6%	44.6%	0.361702	0.3	0.377358	0.384615	0.507463	0.363636	0.301887	0.367347	0.305085	0.462687	40.4%
42 Toledo, OH	0.363636	0.503704	0.451613	0.475728	0.46087	0.392523	0.407692	28.8%	42.3%	43.5%	47.0%	45.5%	0.435897	0.464646	0.356589	0.352	0.359375	0.433071	0.584815	0.311927	0.342857	0.355556	41.4%
43 Myrtle Beach, SC	0.465517	0.326923	0.166667	0.222222	0.254902	0.5	0.333333	18.4%	41.7%	31.5%	14.0%	47.2%	0.369565	0.396226	0.26	0.306122	0.456522	0.025641	0.42	0.255814	0.232558	0.046512	29.8%
44 Topeka, KS	0.56701	0.432624	0.387097	0.532609	0.353535	0.444444	0.357143	46.2%	52.9%	31.1%	32.8%	43.2%	0.387597	0.489051	0.426752	0.459627	0.403846	0.46729	0.308824	0.357143	0.2875	0.361905	41.3%
45 Roanoke, VA	0.496552	0.57764	0.5375	0.514793	0.704819	0.406667	0.512821	42.1%	53.3%	54.6%	50.9%	52.5%	0.521472	0.5	0.544218	0.459259	0.553672	0.561728	0.481928	0.477419	0.474684	0.482143	51.5%
46 OKC 2, OK	0.5	0.3125	0.369863	0.386667	0.447368	0.34375	0.3125	35.8%	35.7%	34.4%	43.3%	24.6%	0.386364	0.333333	0.33871	0.289474	0.264368	0.241379	0.181818	0.189655	0.423077	0.129032	32.7%
47 Baltimore, MD	0.414966	0.38255	0.397351	0.413793	0.590909	0.372093	0.315436	33.1%	40.5%	43.2%	43.7%	49.7%	0.432624	0.458065	0.4	0.445205	0.398496	0.357664	0.416667	0.398496	0.405594	0.406667	41.4%
48 Omaha, NE	1	1	0.512195	0.145161	0.25	0.323077	0.317073	35.1%	38.2%	47.2%	33.9%	31.1%	0.333333	0.413793	0.5	0.263158	0.25	0.44	0.171429	0.326087	0.27027	0.382353	39.8%
49 Washington, DC	0.518868	0.446154	0.358974	0.380531	0.566538	0.340426	0.478992	50.4%	48.2%	40.2%	27.9%	48.8%	0.347826	0.456	0.333333	0.295918	0.363636	0.338843	0.316239	0.312	0.4	0.447619	40.3%
50 Montgomery, AL	0.664516	0.930556	0.326087	0.456376	0.387324	0.514493	0.808824	43.3%	35.8%	42.2%	22.8%	33.3%	0.258065	0.3125	0.243902	0.474138	0.465649	0.365079	0.144737	0.206897	0.364865	0.302632	40.9%
COMPANY TOTAL	0.45	0.468042	0.41094	0.389601	0.410092	0.381997	0.378738	0.404822	0.385122	0.378101	0.403253	0.415799	0.354667	0.350489	0.368141	0.360587	0.38631	0.371955	0.369256	0.368141	0.360587	0.38631	38.9%

FORBA 0236062
CONFIDENTIAL

Company	3/1/2007 Daily Actual	3/2/2007 Daily Actual	3/5/2007 Daily Actual	3/6/2007 Daily Actual	3/7/2007 Daily Actual	3/8/2007 Daily Actual	3/9/2007 Daily Actual	3/12/2007 Daily Actual	3/13/2007 Daily Actual	3/14/2007 Daily Actual	3/15/2007 Daily Actual	3/16/2007 Daily Actual	3/19/2007 Daily Actual	3/20/2007 Daily Actual	3/21/2007 Daily Actual	3/22/2007 Daily Actual	3/23/2007 Daily Actual	3/26/2007 Daily Actual	3/27/2007 Daily Actual	3/28/2007 Daily Actual	3/29/2007 Daily Actual	3/30/2007 Daily Actual	Production Average
0 Pueblo, CO	$ 21,500	$ 11,400	$ 16,000	$ 19,800	$ 18,600	$ 24,900	$ 14,000	$ 14,500	$ 17,700	$ 19,800	$ 18,900	$ 13,500	$ 15,700	$ 19,700	$ 19,700	$ 21,000	$ 13,700	$ 18,800	$ 16,900	$ 22,100	$ 22,200	$ 11,100	$ 17,795
1 Colorado Springs, CO	13,800	6,500	14,200	13,500	17,400	13,400	8,700	15,000	14,300	16,400	14,100	6,000	13,600	13,500	13,600	14,700	7,700	15,500	16,800	17,800	17,900	11,500	$ 13,450
2 Denver, CO	7,900	8,800	12,900	12,900	12,200	11,000	10,300	12,600	14,000	11,100	11,200	9,600	18,100	16,100	20,300	15,900	4,000	21,200	22,100	20,800	22,800	11,200	$ 13,955
3 Albuquerque, NM	19,100	9,000	13,300	14,800	18,500	18,600	10,500	13,200	15,400	16,300	13,700	6,400	17,400	17,900	23,400	20,800	7,900	21,300	21,400	21,600	24,800	9,500	$ 16,136
4 Santa Fe, NM	8,500	11,300	9,700	13,300	10,000	7,500	8,900	10,100	9,100	11,000	11,700	9,800	11,300	13,800	7,300	8,700	9,600	9,200	9,100	11,900	14,300	9,500	$ 10,255
5 Aurora, CO	13,700	15,600	12,600	14,000	15,100	17,600	15,700	16,300	15,900	15,800	14,500	17,200	15,800	17,300	14,200	12,900	18,500	22,500	22,100	20,400	24,400	23,700	$ 17,082
6 Phoenix, AZ	8,700	13,000	9,300	6,700	9,000	14,900	11,300	7,700	16,400	13,700	9,300	11,900	13,900	16,400	15,200	15,300	14,500	8,600	9,600	11,900	15,300	14,100	$ 12,123
7 Indy 1, IN	10,900	8,900	14,800	13,000	12,300	16,600	16,300	13,100	13,300	13,200	9,500	10,200	$ 12,400	$ 11,100	$ 12,000	$ 12,600	$ 12,900	$ 9,100	$ 12,500	$ 11,100	$ 10,500	$ 8,500	$ 12,036
8 Gary, IN	12,100	10,400	11,900	13,600	18,200	8,700	13,200	11,400	14,100	13,500	13,000	11,300	18,500	12,400	11,800	10,800	15,100	13,400	14,200	12,900	13,200	13,000	$ 12,941
9 Thornton, CO	15,700	19,700	16,100	20,300	19,700	17,400	19,700	17,600	19,500	17,600	15,800	19,200	18,800	20,100	18,400	17,800	20,600	20,000	22,000	19,200	23,100	21,100	$ 19,055
10 Greenville, SC	$ 15,800	7,300	17,900	14,800	15,600	16,000	7,100	19,900	16,700	19,300	14,400	8,900	$ 16,500	$ 18,900	$ 19,300	$ 15,000	$ 11,000	$ 20,100	$ 17,800	$ 16,600	$ 15,900	$ 7,100	$ 15,086
11 Columbia, SC	10,700	11,700	13,700	14,900	12,600	12,200	16,400	15,000	14,900	13,200	10,400	11,300	15,500	17,200	15,600	12,800	9,900	12,800	13,500	12,600	13,700	12,400	$ 13,327
12 Tucson, AZ	11,900	11,000	16,500	14,500	15,200	15,900	13,400	16,000	13,800	15,400	11,100	15,800	12,500	12,200	15,500	12,600	13,300	16,400	13,200	17,500	15,900	14,600	$ 14,282
13 Charleston, SC	16,400	14,800	16,500	13,800	14,700	11,900	16,800	18,800	8,000	12,700	16,200	13,300	16,700	18,600	16,900	17,500	18,800	14,200	13,800	12,500	12,600	20,000	$ 15,159
14 Indy 2, IN	8,700	13,700	12,400	16,400	16,900	12,400	14,800	13,400	16,000	14,900	15,700	10,300	16,700	15,900	16,900	10,200	16,900	14,600	8,500	12,900	9,800	10,000	$ 13,636
15 KCK, KS	12,800	11,300	13,000	11,000	13,400	14,900	12,500	12,200	10,700	10,900	11,600	13,500	18,600	18,700	15,900	17,800	15,800	15,800	15,400	16,900	14,500	15,900	$ 14,232
16 Atlanta, GA	9,000	7,400	8,300	8,800	10,300	9,200	6,800	12,400	9,100	7,000	7,400	10,800	9,800	9,000	9,500	10,800	10,500	11,400	10,200	9,300	7,900	7,400	$ 9,195
17 Florence, SC	16,800	5,600	15,900	15,500	17,500	16,900	7,200	10,200	13,100	14,900	13,700	5,400	15,300	17,200	12,700	13,200	7,500	13,700	15,300	15,400	15,000	9,500	$ 13,068
18 Wichita, KS	18,900	18,200	20,800	20,400	24,300	20,500	17,400	20,800	20,000	20,200	20,900	18,000	19,100	20,100	19,000	22,800	19,400	21,100	22,700	20,600	17,700	21,200	$ 20,223
19 Macon, GA	16,100	14,300	17,100	15,800	15,500	19,000	20,900	18,200	14,900	18,900	17,900	11,700	18,300	15,400	14,100	10,700	12,000	17,700	16,600	15,600	11,000	13,200	$ 15,677
20 Tulsa, OK	26,700	27,800	37,200	23,800	19,000	26,700	27,600	28,400	27,700	29,300	33,700	27,100	42,400	29,200	28,500	27,500	28,600	30,200	23,500	27,700	33,800	29,000	$ 28,882
21 Augusta, GA	9,100	10,700	9,000	11,500	10,300	13,000	14,000	14,900	11,400	11,600	7,900	8,800	6,400	11,300	16,000	9,800	11,400	11,000	11,200	14,400	9,400	6,200	$ 10,877
22 Syracuse, NY	15,100	10,000	10,300	8,200	12,500	9,700	11,100	11,900	12,700	12,500	12,700	10,400	12,000	13,400	14,900	11,600	13,200	11,400	12,900	11,800	11,100	10,400	$ 11,809
23 Savannah, GA	7,000	8,200	13,600	12,800	12,000	14,800	10,400	10,400	10,600	14,700	8,900	13,100	12,000	12,900	13,200	10,700	11,500	18,600	10,500	15,600	7,700	13,400	$ 11,936
24 OKC 1, OK	25,600	20,900	25,000	36,000	29,200	16,000	27,800	25,500	28,900	34,800	29,400	20,000	33,400	41,400	31,700	35,000	36,600	30,500	40,200	40,500	29,000	34,100	$ 30,432
25 Rochester, NY	15,800	13,900	13,600	14,800	18,700	15,700	15,100	15,600	15,600	14,500	16,000	13,600	15,700	14,300	15,100	12,800	14,200	16,000	14,300	17,900	15,900	14,700	$ 15,164
26 Springfield, MA	21,700	20,700	21,900	21,500	22,500	24,700	22,600	22,800	23,600	24,000	23,200	15,000	22,900	26,000	23,900	22,500	23,300	21,900	22,200	25,300	24,400	25,400	$ 22,818
27 Columbus, OH	18,100	20,100	25,300	23,000	21,000	21,400	18,500	20,400	22,000	25,100	22,300	19,400	23,000	20,800	18,900	23,500	19,700	21,600	17,000	21,000	18,700	23,200	$ 21,091
28 Boise, ID	8,000	9,300	8,900	9,600	9,000	9,000	10,400	13,400	10,100	9,900	7,000	10,100	12,400	9,800	11,600	9,700	7,600	14,900	10,300	12,100	10,400	12,000	$ 10,250
29 Albany, NY	13,600	5,300	14,700	15,500	15,800	13,600	16,300	18,500	14,000	16,500	14,100	13,700	16,000	19,200	16,900	16,600	12,800	16,600	13,700	17,000	20,600	16,200	$ 15,327
30 Lawrence, MA	12,500	13,500	11,200	11,100	12,400	12,800	11,500	11,100	11,900	14,900	12,200	9,700	14,300	14,800	14,100	12,600	14,500	14,200	14,700	10,700	14,200	15,000	$ 12,905
31 Worcester, MA	20,500	10,400	19,100	24,200	25,300	21,900	28,000	20,700	23,600	26,200	24,700	13,000	24,700	24,600	23,400	21,100	19,300	24,100	24,300	26,500	26,200	23,900	$ 22,532
32 Roselawn, OH	10,600	9,900	9,400	12,000	9,000	8,800	10,900	11,100	12,300	9,100	10,100	10,700	8,100	9,600	5,800	9,400	11,800	13,800	13,400	6,700	10,200	10,100	$ 10,127
33 Dayton, OH	19,700	19,900	24,800	22,400	22,000	21,700	19,600	16,900	17,200	23,900	21,500	19,100	18,900	20,600	19,200	21,100	20,400	22,200	19,000	23,100	19,800	23,700	$ 20,759
34 Mattapan, MA	11,300	10,900	12,200	10,900	8,500	13,500	12,900	14,900	12,400	13,800	11,700	9,600	11,300	12,200	9,200	13,100	16,500	15,000	12,200	11,200	10,900	12,200	$ 12,109
35 Lynn, MA	9,300	9,100	9,300	8,000	6,400	16,100	9,300	9,200	9,300	8,400	8,300	7,600	9,300	11,100	8,800	10,100	6,000	11,000	10,500	8,900	9,100	7,000	$ 9,141
36 Cincinnati, OH	8,400	7,300	8,200	8,400	7,600	10,600	8,900	8,300	10,300	7,400	6,200	9,100	11,500	11,000	7,400	8,000	8,800	6,800	9,400	7,000	10,500	7,200	$ 8,559
37 Reno, NV	11,600	10,300	10,300	15,700	13,100	11,200	9,900	12,100	14,400	12,900	14,100	11,100	12,300	10,400	12,100	13,100	15,000	11,300	10,800	11,200	11,700	11,700	$ 12,105
38 East Albuquerque, NM	12,300	12,200	8,900	17,900	13,900	13,600	18,100	15,000	10,100	13,600	8,900	7,400	9,700	10,100	12,200	12,900	10,600	11,600	17,100	12,100	16,600	12,200	$ 12,591
39 Fort Wayne, IN	15,300	15,300	17,600	14,600	14,900	12,100	17,200	18,800	16,800	18,600	17,600	20,000	18,500	20,400	16,600	16,300	17,000	18,700	15,600	17,000	17,000	13,200	$ 16,777
40 Spartanburg, SC	9,700	15,400	12,600	13,900	13,100	11,300	15,800	13,800	10,300	9,200	11,600	14,200	16,300	14,100	12,200	13,600	14,600	9,300	11,300	8,100	11,100	8,100	$ 12,255
41 Richmond, VA	8,900	6,500	9,300	10,200	8,200	9,200	6,400	11,200	8,800	6,300	4,500	7,400	6,800	6,300	7,100	5,500	8,400	8,000	8,500	6,200	6,800	9,500	$ 7,727
42 Toledo, OH	12,100	15,800	10,600	10,100	14,600	15,000	16,800	17,900	13,700	12,500	12,300	14,900	13,200	9,100	15,500	15,000	16,600	13,400	9,400	14,700	13,200	10,600	$ 13,500
43 Myrtle Beach, SC	9,100	9,300	8,100	8,400	8,200	5,000	8,400	9,100	7,000	9,700	10,300	6,000	5,900	5,200	7,200	8,300	5,100	9,900	7,800	5,900	8,000	7,700	$ 7,800
44 Topeka, KS	9,000	14,200	13,600	8,700	11,200	8,900	17,100	12,400	11,100	13,600	8,500	10,400	13,000	12,000	18,100	15,000	16,100	9,800	10,800	9,300	9,500	14,000	$ 12,105
45 Roanoke, VA	16,300	13,300	16,100	14,800	12,600	16,900	15,100	16,900	16,400	15,900	16,100	14,000	15,500	16,600	16,100	13,800	18,000	16,700	16,900	16,800	14,900	16,600	$ 15,741
46 OKC 2, OK	8,200	10,600	10,500	8,800	10,400	11,800	11,700	11,000	12,100	10,200	9,900	12,600	15,300	14,200	10,300	11,400	14,300	13,300	12,900	13,900	8,300	17,600	$ 11,786
47 Baltimore, MD	16,900	17,700	17,600	18,300	16,700	16,200	20,900	19,100	19,900	17,700	12,900	13,700	15,500	17,600	15,700	18,400	15,800	18,000	18,300	18,500	19,200	21,200	$ 17,536
48 Omaha, NE			5,400	10,200	10,600	10,100	13,200	12,600	12,200	10,500	8,900	10,400	12,500	8,900	6,100	11,600	11,200	10,100	8,000	9,500	18,400	11,400	$ 10,600
49 Washington, DC	19,500	21,400	22,700	22,800	15,300	20,500	21,800	21,100	19,700	39,200	28,200	21,300	25,100	21,700	24,900	20,300	23,000	28,300	22,700	28,400	22,800	18,700	$ 23,064
50 Montgomery, AL	8,000	1,000	17,500	13,700	15,400	12,600	3,800	12,800	16,700	11,900	15,900	12,600	18,100	16,900	16,400	12,300	15,500	15,300	9,200	10,900	8,600	11,000	$ 12,555
COMPANY TOTAL	678,900	620,800	737,200	749,600	746,400	742,900	733,000	766,500	747,700	794,200	720,800	643,100	806,500	805,200	780,600	756,100	737,000	810,900	772,300	797,700	790,500	731,700	$ 748,609
Company Daily Average	13311.76	12172.55	14454.9	14698.04	14635.29	14566.67	14372.55	15029.41	14660.78	15572.55	14129.41	12609.8	15813.73	15788.24	15305.88	14825.49	14450.98	15900	15143.14	15641.18	15500	14347.06	$ 14,679

FORBA 0236063
CONFIDENTIAL

Company	3/1/2007 Daily Patients	3/2/2007 Daily Patients	3/5/2007 Daily Patients	3/6/2007 Daily Patients	3/7/2007 Daily Patients	3/8/2007 Daily Patients	3/9/2007 Daily Patients	3/12/2007 Daily Patients
0 Pueblo, CO	91	44	76	98	91	82	56	67
1 Colorado Springs, CO	72	28	75	81	81	79	52	71
2 Denver, CO	43	50	64	66	53	42	49	61
3 Albuquerque, NM	78	48	74	62	88	80	51	88
4 Santa Fe, NM	36	61	57	59	57	36	52	69
5 Aurora, CO	71	81	62	61	68	63	78	90
6 Phoenix, AZ	37	48	77	33	37	68	48	44
7 Indy 1, IN	79	59	89	86	69	88	99	81
8 Gary, IN	49	52	60	81	81	51	66	60
9 Thornton, CO	61	61	63	65	74	64	71	63
10 Greenville, SC	108	47	108	80	95	89	39	104
11 Columbia, SC	57	64	77	78	78	70	96	95
12 Tucson, AZ	63	58	69	71	65	56	64	75
13 Charleston, SC	62	55	72	67	61	57	66	84
14 Indy 2, IN	53	61	58	68	71	59	89	70
15 KCK, KS	68	72	73	52	69	83	71	74
16 Atlanta, GA	52	61	55	65	49	66	46	76
17 Florence, SC	61	23	63	77	84	69	35	52
18 Wichita, KS	93	95	108	98	94	89	104	97
19 Macon, GA	64	67	71	70	71	80	82	78
20 Tulsa, OK	103	110	111	89	78	107	101	98
21 Augusta, GA	41	49	48	45	47	60	57	66
22 Syracuse, NY	88	51	56	46	77	71	79	71
23 Savannah, GA	33	48	44	44	46	63	44	47
24 OKC 1, OK	74	57	78	93	103	65	78	86
25 Rochester, NY	93	86	74	73	87	76	85	80
26 Springfield, MA	91	72	84	105	88	94	88	89
27 Columbus, OH	62	74	89	98	80	79	83	95
28 Boise, ID	45	53	58	68	57	81	71	59
29 Albany, NY	61	32	72	71	68	73	80	67
30 Lawrence, MA	43	42	42	38	43	48	43	41
31 Worcester, MA	73	34	80	71	73	75	92	73
32 Roselawn, OH	48	53	57	57	55	41	53	38
33 Dayton, OH	69	94	99	96	108	92	110	85
34 Mattapan, MA	27	30	32	27	32	43	37	52
35 Lynn, MA	43	33	34	42	29	52	43	36
36 Cincinnati, OH	53	41	45	54	53	74	65	52
37 Reno, NV	62	68	52	69	67	64	60	72
38 East Albuquerque, NM	46	58	50	52	64	52	63	55
39 Fort Wayne, IN	56	78	64	71	56	55	73	70
40 Spartanburg, SC	40	55	56	71	52	47	73	52
41 Richmond, VA	31	33	42	36	33	38	29	41
42 Toledo, OH	70	67	51	54	62	65	77	99
43 Myrtle Beach, SC	31	35	35	35	38	21	34	31
44 Topeka, KS	42	80	57	43	64	55	81	57
45 Roanoke, VA	73	68	74	82	49	89	76	95
46 OKC 2, OK	29	33	46	46	42	42	55	43
47 Baltimore, MD	88	92	91	85	63	81	102	99
48 Omaha, NE	0	0	20	53	42	44	56	50
49 Washington, DC	51	72	75	70	43	62	62	62
50 Montgomery, AL	52	10	93	81	87	67	26	72
COMPANY TOTAL	3,014	2,863	3,360	3,381	3,320	3,323	3,366	3,530
Company Daily Average	59.09803922	56.1372549	65.88235294	66.29411765	65.09803922	65.15686275	66	69.21569

Company	3/13/2007 Daily Patients	3/14/2007 Daily Patients	3/15/2007 Daily Patients	3/16/2007 Daily Patients	3/19/2007 Daily Patients	3/20/2007 Daily Patients	3/21/2007 Daily Patients	3/22/2007 Daily Patients	3/23/2007 Daily Patients
0 Pueblo, CO	80	70	80	58	83	91	90	98	55
1 Colorado Springs, CO	75	77	71	30	66	72	64	78	43
2 Denver, CO	57	59	56	40	96	77	88	59	24
3 Albuquerque, NM	71	93	72	36	91	75	92	105	46
4 Santa Fe, NM	55	49	60	59	64	62	52	59	52
5 Aurora, CO	66	63	63	87	76	80	64	59	83
6 Phoenix, AZ	59	60	44	68	68	70	73	66	77
7 Indy 1, IN	75	83	62	66	69	59	75	71	72
8 Gary, IN	72	68	69	63	121	90	65	53	73
9 Thornton, CO	74	63	52	69	80	83	65	64	75
10 Greenville, SC	91	92	81	56	99	105	92	86	55
11 Columbia, SC	82	88	60	78	87	80	74	76	62
12 Tucson, AZ	66	68	61	78	67	66	76	73	72
13 Charleston, SC	41	61	63	53	79	85	78	70	68
14 Indy 2, IN	71	62	56	59	81	73	54	62	67
15 KCK, KS	60	69	52	67	99	111	95	100	89
16 Atlanta, GA	56	56	48	85	63	44	51	43	53
17 Florence, SC	66	65	68	34	78	69	71	61	27
18 Wichita, KS	97	114	87	102	108	106	104	122	110
19 Macon, GA	67	71	72	63	78	77	64	60	61
20 Tulsa, OK	113	106	112	113	117	120	100	120	131
21 Augusta, GA	56	55	46	55	39	57	60	55	62
22 Syracuse, NY	72	70	75	81	69	79	89	73	75
23 Savannah, GA	38	47	42	54	52	48	59	61	47
24 OKC 1, OK	131	131	80	56	173	202	105	113	118
25 Rochester, NY	88	82	86	72	91	87	80	67	79
26 Springfield, MA	104	91	98	71	95	94	92	89	73
27 Columbus, OH	87	92	94	94	105	111	90	103	101
28 Boise, ID	68	63	50	66	79	55	60	56	49
29 Albany, NY	72	78	84	88	88	74	82	58	62
30 Lawrence, MA	53	50	45	35	54	49	43	49	52
31 Worcester, MA	85	76	81	44	80	95	79	78	71
32 Roselawn, OH	52	38	42	43	44	48	25	50	47
33 Dayton, OH	77	107	86	91	84	85	76	104	86
34 Mattapan, MA	40	40	38	27	36	35	36	37	51
35 Lynn, MA	40	43	38	35	42	59	39	37	39
36 Cincinnati, OH	54	52	45	54	71	53	55	49	55
37 Reno, NV	78	82	72	64	82	63	65	67	61
38 East Albuquerque, NM	50	58	38	50	52	50	54	59	41
39 Fort Wayne, IN	75	77	62	70	67	82	90	64	65
40 Spartanburg, SC	54	42	45	81	78	65	62	66	54
41 Richmond, VA	37	31	20	36	30	35	33	32	33
42 Toledo, OH	75	61	61	78	66	53	83	81	82
43 Myrtle Beach, SC	28	37	37	28	29	32	37	34	25
44 Topeka, KS	56	62	41	54	79	70	90	87	93
45 Roanoke, VA	71	74	85	76	78	84	67	73	79
46 OKC 2, OK	45	40	34	46	54	52	41	54	64
47 Baltimore, MD	86	75	71	78	80	84	81	81	80
48 Omaha, NE	42	28	41	42	40	34	25	42	45
49 Washington, DC	59	73	88	62	75	68	60	69	77
50 Montgomery, AL	86	67	95	70	92	88	93	61	70
COMPANY TOTAL	3,455	3,459	3,229	3,143	3,872	3,786	3,558	3,534	3,371
Company Daily Average	67.7451	67.82353	63.31373	61.62745	75.92157	74.23529	69.76471	69.29412	66.09804

Company	3/26/2007 Daily Patients	3/27/2007 Daily Patients	3/28/2007 Daily Patients	3/29/2007 Daily Patients	3/30/2007 Daily Patients	Pts Seen Month Aver
0 Pueblo, CO	97	95	90	101	51	79
1 Colorado Springs, CO	97	84	98	116	53	71
2 Denver, CO	103	103	104	104	57	66
3 Albuquerque, NM	92	92	125	121	58	79
4 Santa Fe, NM	58	35	69	79	64	57
5 Aurora, CO	102	99	96	103	123	79
6 Phoenix, AZ	54	56	63	59	69	58
7 Indy 1, IN	57	56	59	63	56	72
8 Gary, IN	69	56	60	82	60	68
9 Thornton, CO	75	83	82	89	90	72
10 Greenville, SC	111	94	93	86	28	84
11 Columbia, SC	68	75	75	67	57	76
12 Tucson, AZ	78	88	87	60	80	68
13 Charleston, SC	65	61	67	58	68	66
14 Indy 2, IN	72	45	81	43	53	63
15 KCK, KS	97	87	111	76	105	81
16 Atlanta, GA	44	42	40	33	46	53
17 Florence, SC	65	70	72	77	48	61
18 Wichita, KS	111	111	100	97	108	103
19 Macon, GA	82	69	78	51	63	70
20 Tulsa, OK	98	94	113	113	102	107
21 Augusta, GA	56	54	44	60	43	52
22 Syracuse, NY	74	69	74	70	64	72
23 Savannah, GA	66	46	53	46	65	50
24 OKC 1, OK	104	121	108	94	65	101
25 Rochester, NY	81	83	87	77	88	82
26 Springfield, MA	98	94	109	95	110	92
27 Columbus, OH	106	75	91	99	110	92
28 Boise, ID	82	60	78	68	82	63
29 Albany, NY	73	75	80	81	83	73
30 Lawrence, MA	44	50	39	52	58	46
31 Worcester, MA	76	93	88	100	89	78
32 Roselawn, OH	57	54	43	46	47	47
33 Dayton, OH	98	79	106	81	80	91
34 Mattapan, MA	56	38	33	31	41	37
35 Lynn, MA	44	50	40	50	29	41
36 Cincinnati, OH	46	59	51	55	46	54
37 Reno, NV	64	62	58	63	73	68
38 East Albuquerque, NM	53	49	46	59	55	52
39 Fort Wayne, IN	98	70	72	81	48	69
40 Spartanburg, SC	49	43	43	41	37	55
41 Richmond, VA	35	37	31	41	36	34
42 Toledo, OH	72	47	75	69	58	68
43 Myrtle Beach, SC	38	29	32	33	41	33
44 Topeka, KS	57	47	45	57	67	63
45 Roanoke, VA	71	88	81	83	87	77
46 OKC 2, OK	44	45	47	39	54	45
47 Baltimore, MD	88	77	80	85	89	83
48 Omaha, NE	28	29	31	54	42	36
49 Washington, DC	80	80	86	69	58	69
50 Montgomery, AL	80	65	69	47	53	69
COMPANY TOTAL	3,713	3,459	3,681	3,567	3,317	3,423
Company Daily Average	72.80392	67.82353	72.17647	69.94118	65.03922	67.11319

March Madness 2007

Company	Clinic	Avg Conversions	BA Goal	Production Goal	Avg Patients per Day	February Focus Points
5	Aurora Drillers	9	33%	$ 14,165.20	66	300
8	Cary [illegible]	7	62%	$ 12,160.42	52	240
33	Dayton Cavity Busters	4	51%	$ 16,749.05	77	220
25	Rochester	4	46%	$ 13,059.66	75	180
26	Springfield Springboks	8	39%	$ 21,826.87	88	120
47	Baltimore Explorers	3	50%	$ 12,899.68	70	100
31	Worcester	6	46%	$ 18,125.74	66	80
14	Indy 2	11	45%	$ 12,292.17	53	80
39	Fort Wayne Smilers	7	41%	$ 14,323.50	43	280
27	Columbus Royal Crowns	11	55%	$ 19,966.09	88	120
34	Mattapan Maintainers	5	48%	$ 30,723.48	33	120
32	[illegible] Pulpotomers	13	64%	$ 10,131.78	38	80
0	Thornton Cavity Terminators	13	33%	$ 14,379.67	71	460
49	Washington, DC Fighting Floss	3	51%	$ 15,299.09	53	200
18	Wichita [illegible]	16	36%	$ 19,715.88	95	120
29	Albany Tight Ends in Motion	5	50%	$ 13,542.22	62	100
37	Reno Coronas	5	34%	$ 12,868.17	62	40
46	Omaha Cavinators	5	40%	$ 8,599.79	34	40
12	Tucson Tooth Warriors	8	34%	$ 12,093.00	65	200
13	Charleston [illegible]	16	27%	$ 14,886.18	62	420
20	Tulsa	17	39%	$ 27,804.44	82	400
30	Lawrence	7	38%	$ 13,787.33	41	280
24	OKC 1	14	31%	$ 20,834.18	83	40
7	Indy 1 Calculus Crushers	7	43%	$ 14,063.87	71	220
48	OKC 2 Oklahoma Canines	3	16%	$ 10,317.72	26	420
6	Phoenix Crowns	9	38%	$ 11,702.05	51	400
35	Lynn	1	45%	$ 10,937.95	38	180
15	KCK Dentinators	11	41%	$ 15,334.57	66	280
50	Montgomery	9	43%	$ 6,727.27	65	240
3	Albuquerque Toothinators	5	36%	$ 14,275.96	83	140
2	Denver Broncos	13	35%	$ 15,295.77	66	320
45	Roanoke Stars	4	48%	$ 15,549.84	55	0
1	Colorado Springs Snow Crowns	6	31%	$ 15,600.54	74	360
23	Savannah	8	43%	$ 13,858.82	39	320
21	Augusta Masters	8	41%	$ 14,773.82	52	480
22	Syracuse Teeth Savers	9	50%	$ 14,764.69	64	280
44	Topeka Tooth Fairies	5	41%	$ 13,797.54	60	280
43	Myrtle Beach	8	35%	$ 10,131.78	27	260
19	Macon Lidocaines	4	46%	$ 17,090.91	65	0
36	Cincinnati Extractors	11	60%	$ 12,124.65	47	0
38	East Albuquerque 505 Prophy Anglers	5	37%	$ 11,931.18	47	160
0	Pueblo Crusaders	9	23%	$ 19,036.85	88	0
4	Santa Fe Molarnators	11	38%	$ 12,370.51	60	360
10	Atlanta Plaque Attackers	7	41%	$ 12,868.17	44	160
11	Columbia Cavity Catchers	9	44%	$ 14,784.10	68	340
17	Florence [illegible]	4	50%	$ 16,345.68	61	120
42	Toledo T Town Tacklers	30	50%	$ 14,731.12	66	180
28	Boise Bicuspids	13	34%	$ 10,417.09	53	240
16	Greenville Molars	14	40%	$ 18,920.00	84	0
40	Spartanburg Smile Makers	10	37%	$ 14,701.38	57	240
41	Richmond Cavity Kickers	5	37%	$ 10,723.48	34	180
	COMPANY TOTAL	435	41%	$ 733,407.44	3065	

Company	Clinic	Week 1 (March 1-9) Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 1 Points	Week 2 (March 12-16) Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 2 Points
5	Aurora Drillers	14.0	31%	$ 14,990.00	69.1	800	15.2	38%	$ 15,940.00	74	800
8	Cary [illegible]	8.9	54%	$ 12,585.71	62.9	800	10.8	46%	$ 12,660.00	66	800
33	Dayton Cavity Busters	11.3	32%	$ 21,442.86	95.4	800	7.6	31%	$ 19,720.00	88	800
25	Rochester	8.4	39%	$ 15,371.43	83.0	800	8.2	40%	$ 15,060.00	82	800
26	Springfield Springboks	9.9	38%	$ 22,228.57	88.9	800	8.9	35%	$ 24,133.33	91	800
47	Baltimore Explorers	4.3	41%	$ 17,757.14	85.7	800	4.3	42%	$ 16,660.00	82	800
31	Worcester	6.3	38%	$ 21,342.86	71.1	800	9.6	43%	$ 24,644.44	72	800
14	Indy 2	12.9	36%	$ 13,814.29	61.7	800	13.2	35%	$ 14,060.00	64	800
39	Fort Wayne Smilers	4.7	33%	$ 15,285.71	64.7	600	5.2	29%	$ 18,560.00	71	600
27	Columbus Royal Crowns	18.0	50%	$ 21,857.14	80.7	600	16.8	48%	$ 21,840.00	92	800
34	Mattapan Maintainers	6.4	53%	$ 11,457.14	32.6	400	6.8	41%	$ 12,480.00	39	800
32	[illegible] Pulpotomers	16.6	44%	$ 10,085.71	52.0	600	14.6	48%	$ 10,660.00	43	800
0	Thornton Cavity Terminators	17.4	34%	$ 18,371.43	68.4	400	15.2	34%	$ 17,940.00	64	400
49	Washington, DC Fighting Floss	2.9	44%	$ 28,571.43	62.1	600	6.6	43%	$ 25,980.00	89	600
18	Wichita [illegible]	16.9	38%	$ 20,042.86	97.3	600	20.6	39%	$ 28,180.00	98	600
29	Albany Tight Ends in Motion	4.9	47%	$ 13,542.86	65.3	600	4.3	43%	$ 15,360.00	73	800
37	Reno Coronas	6.7	52%	$ 11,728.57	63.1	600	10.2	31%	$ 12,920.00	74	800
46	Omaha Cavinators	1.6	31%	$ 9,990.00	30.7	400	5.8	31%	$ 10,960.00	41	800
12	Tucson Tooth Warriors	11.9	39%	$ 14,857.14	61.7	400	11.4	35%	$ 14,420.00	70	600
13	Charleston [illegible]	16.1	25%	$ 14,985.71	62.9	800	14.8	29%	$ 13,800.00	60	-
20	Tulsa	15.7	40%	$ 26,971.43	95.9	200	17.0	40%	$ 29,240.00	108	400
30	Lawrence	5.9	41%	$ 12,142.86	43.7	200	8.6	40%	$ 11,960.00	45	400
24	OKC 1	13.1	33%	$ 25,785.71	78.0	200	15.8	25%	$ 27,320.00	97	800
7	Indy 1 Calculus Crushers	7.1	36%	$ 13,257.14	81.5	600	8.4	32%	$ 13,860.00	73	600
48	OKC 2 Oklahoma Canines	4.9	38%	$ 10,285.71	41.0	400	6.4	33%	$ 11,160.00	42	600
6	Phoenix Crowns	8.0	33%	$ 10,414.29	49.1	0	9.8	39%	$ 11,800.00	55	800
35	Lynn	1.6	47%	$ 9,500.00	36.4	400	1.8	43%	$ 8,560.00	38	400
15	KCK Dentinators	10.4	37%	$ 12,700.00	69.7	400	10.0	34%	$ 11,780.00	84	200
50	Montgomery	3.9	38%	$ 10,285.71	59.4	200	4.4	35%	$ 14,000.00	78.8	600
3	Albuquerque Toothinators	9.6	42%	$ 14,828.57	68.4	400	9.0	47%	$ 13,000.00	72	200
2	Denver Broncos	9.3	29%	$ 16,857.14	52.4	200	12.8	33%	$ 13,700.00	55	200
45	Roanoke Stars	4.1	54%	$ 15,614.29	73.0	400	3.6	51%	$ 15,860.00	80	400
1	Colorado Springs Snow Crowns	7.4	34%	$ 12,500.00	66.9	200	7.8	38%	$ 13,160.00	65	200
23	Savannah	11.6	47%	$ 11,257.14	46.9	400	12.0	52%	$ 11,540.00	48	400
21	Augusta Masters	7.9	45%	$ 11,085.71	49.6	0	6.4	41%	$ 10,920.00	58	400
22	Syracuse Teeth Savers	6.9	51%	$ 10,985.71	66.9	200	5.4	46%	$ 13,040.00	74	400
44	Topeka Tooth Fairies	7.7	44%	$ 11,814.29	60.5	400	7.8	41%	$ 11,200.00	54	400
43	Myrtle Beach	6.7	32%	$ 8,071.43	32.7	400	6.6	31%	$ 8,620.00	32	400
19	Macon Lidocaines	6.6	49%	$ 16,957.14	72.1	400	6.2	49%	$ 16,320.00	70	400
36	Cincinnati Extractors	7.4	54%	$ 8,485.71	55.0	400	7.0	55%	$ 8,260.00	51	400
38	East Albuquerque 505 Prophy Anglers	4.0	37%	$ 13,842.86	55.8	600	2.4	43%	$ 11,000.00	50	200
0	Pueblo Crusaders	13.6	22%	$ 18,028.57	76.9	400	11.8	29%	$ 16,880.00	71	200
4	Santa Fe Molarnators	10.1	37%	$ 9,885.71	51.1	200	10.0	34%	$ 10,340.00	58	200
10	Atlanta Plaque Attackers	4.6	38%	$ 8,542.86	56.3	400	4.0	35%	$ 9,340.00	64	400
11	Columbia Cavity Catchers	4.0	47%	$ 13,171.43	74.3	200	3.4	42%	$ 12,960.00	85	400
17	Florence [illegible]	3.9	50%	$ 13,628.57	58.9	200	2.6	48%	$ 11,460.00	57	200
42	Toledo T Town Tacklers	28.1	44%	$ 13,571.43	63.7	200	28.8	41%	$ 14,260.00	75	400
28	Boise Bicuspids	10.4	37%	$ 9,171.43	58.7	200	11.2	34%	$ 10,300.00	61	200
16	Greenville Molars	6.4	33%	$ 13,500.00	80.9	200	11.6	33%	$ 15,840.00	85	400
40	Spartanburg Smile Makers	8.0	37%	$ 13,114.29	56.3	200	8.0	40%	$ 11,820.00	55	-
41	Richmond Cavity Kickers	3.0	47%	$ 8,385.71	34.3	200	2.2	44%	$ 7,640.00	33	-
	COMPANY TOTAL	434.0	41%	$ 715,542.86	3232.4	400	461.4	40%	$ 734,420.00	3363.2	800

Company	Clinic	Week 3 (March 19-23) Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 3 Points	Week 4 (March 26-30) Avg Conversions	BA Rate	Production	Avg Patients per Day	Week 4 Points	Total Points
5	Aurora Drillers	18.8	27.8%	$ 15,740.00	72.4	600	17.0	26%	$ 22,520.00	104.6	800	3500
8	Cary [illegible]	9.2	37.4%	$ 13,324.00	80.4	800	11.0	43%	$ 13,340.00	65.4	800	3440
33	Dayton Cavity Busters	9.4	36.9%	$ 20,040.00	87	800	12.0	35%	$ 21,560.00	88.8	800	3420
25	Rochester	5.2	40.2%	$ 14,380.00	80.8	600	9.6	38%	$ 15,760.00	83.2	800	3380
26	Springfield Springboks	8.8	36.9%	$ 23,720.00	88.6	800	10.2	32%	$ 23,840.00	101.2	800	3320
47	Baltimore Explorers	3.8	42.7%	$ 16,660.00	81.2	800	7.0	40%	$ 19,040.00	83.8	800	3300
31	Worcester	8.2	32.6%	$ 22,620.00	80.6	600	6.8	32%	$ 21,060.00	89.2	800	3280
14	Indy 2	11.4	23.0%	$ 15,720.00	67.4	800	12.8	34%	$ 11,160.00	58.8	600	3080
39	Fort Wayne Smilers	7.6	28.5%	$ 17,760.00	73.6	600	8.2	27%	$ 16,360.00	69.8	800	3080
27	Columbus Royal Crowns	11.6	42.3%	$ 21,180.00	103	600	11.0	46%	$ 20,360.00	96.2	600	2920
34	Mattapan Maintainers	7.4	41.7%	$ 12,460.00	39	800	9.6	34%	$ 12,300.00	39.4	600	2920
32	[illegible] Pulpotomers	15.0	45.9%	$ 8,540.00	42.8	600	16.2	27%	$ 19,840.00	49.8	800	2880
0	Thornton Cavity Terminators	18.4	30.2%	$ 19,300.00	73.4	400	23.6	29%	$ 21,080.00	83.8	800	2860
49	Washington, DC Fighting Floss	2.6	35.9%	$ 23,000.00	73.6	600	3.2	36%	$ 23,780.00	74.6	800	2800
18	Wichita [illegible]	17.2	36.7%	$ 20,980.00	110	600	17.4	31%	$ 20,660.00	105.4	800	2720
29	Albany Tight Ends in Motion	3.6	38.5%	$ 16,300.00	76.4	600	5.0	36%	$ 16,820.00	78.4	600	2700
37	Reno Coronas	8.6	24.3%	$ 12,580.00	71.6	600	6.8	32%	$ 11,340.00	64	600	2640
46	Omaha Cavinators	2.4	33.3%	$ 10,060.00	37.2	600	6.8	32%	$ 11,480.00	36.8	800	2640
12	Tucson Tooth Warriors	11.4	35.3%	$ 13,220.00	70.8	600	9.8	30%	$ 15,520.00	70.6	800	2600
13	Charleston [illegible]	20.2	18.1%	$ 17,300.00	96	800	18.2	29%	$ 14,620.00	63.8	400	2420
20	Tulsa	14.0	35.5%	$ 31,240.00	117.6	600	18.2	34%	$ 28,640.00	104	600	2400
30	Lawrence	7.4	33.4%	$ 14,060.00	49.4	800	8.0	34%	$ 13,760.00	48.6	600	2280
24	OKC 1	6.4	26.2%	$ 35,624.00	142.2	600	6.4	27%	$ 34,860.00	98	600	2240
7	Indy 1 Calculus Crushers	7.4	34.8%	$ 12,200.00	99.2	400	8.6	38%	$ 10,340.00	58.1	400	2220
48	OKC 2 Oklahoma Canines	2.8	32.2%	$ 13,160.00	53	400	2.4	23%	$ 13,200.00	44	400	2220
6	Phoenix Crowns	11.4	30.4%	$ 15,060.00	70.8	600	6.0	27%	$ 11,900.00	68.2	600	2200
35	Lynn	1.2	41.4%	$ 9,560.00	43.2	600	3.8	41%	$ 9,300.00	42.6	600	2180
15	KCK Dentinators	9.2	33.2%	$ 17,360.00	98.8	600	5.2	29%	$ 15,700.00	95.2	600	2080
50	Montgomery	6.5	35%	$ 15,845.00	80.8	600	4.0	28%	$ 11,000.00	62.8	400	2040
3	Albuquerque Toothinators	13.6	40.2%	$ 17,480.00	81.8	400	15.8	32%	$ 19,760.00	97.6	800	1940
2	Denver Broncos	12.4	32.4%	$ 14,580.00	68.8	400	16.2	33%	$ 19,620.00	94.2	800	1920
45	Roanoke Stars	4.8	31.6%	$ 16,900.00	76.3	600	2.6	30%	$ 18,380.00	81.6	400	1800
1	Colorado Springs Snow Crowns	6.8	31.2%	$ 12,620.00	64.6	200	8.4	31%	$ 15,900.00	89.6	800	1760
23	Savannah	11.2	46.0%	$ 12,060.00	53.4	400	5.6	44%	$ 13,180.00	55.2	200	1720
21	Augusta Masters	8.4	38.2%	$ 10,980.00	54.6	600	8.2	48%	$ 10,440.00	49.4	200	1680
22	Syracuse Teeth Savers	6.4	39.4%	$ 13,020.00	77	400	6.2	45%	$ 11,520.00	70.2	400	1680
44	Topeka Tooth Fairies	4.2	43.3%	$ 14,840.00	83.8	400	5.6	36%	$ 10,680.00	54.6	200	1680
43	Myrtle Beach	4.0	36.8%	$ 6,340.00	31.4	200	7.0	29%	$ 7,860.00	34.6	400	1660
19	Macon Lidocaines	3.8	46.3%	$ 14,100.00	68	200	5.8	46%	$ 14,820.00	68.6	600	1600
36	Cincinnati Extractors	10.6	50.0%	$ 9,340.00	56.6	400	8.0	50%	$ 8,180.00	51.8	400	1600
38	East Albuquerque 505 Prophy Anglers	4.0	38.7%	$ 11,100.00	51.2	200	4.2	45%	$ 13,920.00	51.4	400	1560
0	Pueblo Crusaders	13.4	21.4%	$ 17,960.00	83.4	400	10.8	23%	$ 18,220.00	84.8	400	1,400
4	Santa Fe Molarnators	8.2	28.1%	$ 10,140.00	57.8	200	5.2	29%	$ 10,800.00	66	400	1360
10	Atlanta Plaque Attackers	5.8	42.3%	$ 9,920.00	50.8	200	7.4	42%	$ 9,240.00	41	200	1360
11	Columbia Cavity Catchers	3.2	48.1%	$ 14,240.00	75.8	200	3.8	46%	$ 11,060.00	68.6	200	1340
17	Florence [illegible]	2.8	42.2%	$ 13,180.00	61.2	400	1.8	39%	$ 11,780.00	66.4	400	1320
42	Toledo T Town Tacklers	28.6	38.4%	$ 13,880.00	73	400	26.6	40%	$ 12,360.00	64.2	200	1300
28	Boise Bicuspids	11.2	37.0%	$ 10,220.00	59.8	200	12.8	36%	$ 11,940.00	74	400	1240
16	Greenville Molars	10.6	28.2%	$ 16,140.00	87.4	400	13.0	31%	$ 15,500.00	82	200	1200
40	Spartanburg Smile Makers	3.8	30.3%	$ 14,160.00	65	400	4.2	43%	$ 9,580.00	42.6	-	840
41	Richmond Cavity Kickers	2.8	38.8%	$ 6,820.00	32.6	-	3.2	36%	$ 7,800.00	36	400	780
	COMPANY TOTAL	449.4	38.4%	$ 777,080.00	3624.2	800	463.8	37.1%	$ 780,620.00	3547.4	800	2,800

FORBA 0236065
CONFIDENTIAL

Clinic	Week 1									Week 2								Week 3								Week 4				
	3/1/2007	3/2/2007	3/5/2007	3/6/2007	3/7/2007	3/8/2007	3/9/2007	Average	3/12/2007	3/13/2007	3/14/2007	3/15/2007	3/16/2007	Average	3/19/2007	3/20/2007	3/21/2007	3/22/2007	3/23/2007	Average	3/26/2007	3/27/2007	3/28/2007	3/29/2007	3/30/2007	Average
Pueblo, CO	11	4	13	10	15	30	12	13.57143	15	10	15	11	8	11.8	10	18	18	9	12	13.4	9	12	14	7	12	10.8
Colorado Springs, CO	15	4	8	13	7	8	8	7.857143	8	7	12	6	6	7.8	14	6	7	7	1	6.6	7	6	14	6	6	6.4
Denver, CO	5	12	15	11	11	3	10	9.285714	12	12	14	12	10	12.8	16	11	17	15	3	12.4	6	17	25	17	14	16.2
Albuquerque, NM	13	5	3	21	9	10	8	9.571429	12	14	6	11	2	9	13	4	20	20	8	13	26	17	11	13	8	15
Santa Fe, NM	13	10	9	15	10	11	3	10.14286	5	10	21	8	11	10	6	13	8	16	6	8.2	4	10	2	7	3	5.2
Aurora, CO	13	12	10	14	17	18	14	-------	12	15	14	20	15	15.2	15	15	21	16	26	18.8	20	15	22	20	9	17
Phoenix, AZ	12	8	5	7	14	11	5	7.142857	6	10	9	14	5	8.8	17	12	14	17	6	13.4	10	2	2	2	7	5
Indy 1, IN	3	3	3	7	14	11	5	7.142857	6	10	9	14	5	8.4	9	7	4	4	6	7.4	5	12	12	7	7	8.6
Gary, IN	16	7	7	7	12	10	8	8.857143	9	9	11	11	16	10.8	7	14	4	7	14	9.2	4	11	18	10	12	11
Thornton, CO	18	19	14	27	12	16	16	17.42857	18	19	16	12	9	15.2	15	16	19	21	21	18.4	25	25	22	23	23	23.6
Greenville, SC	1	0	8	12	10	9	7	6.428571	14	13	13	12	6	11.6	15	19	9	3	1	10.6	12	13	12	12	6	11
Columbia, SC	5	2	4	8	3	6	3	4.571429	3	9	9	2	1	5.2	6	5	2	1	1	3.2	0	3	3	3	5	3.8
Tucson, AZ	3	11	13	15	13	16	12	11.85714	15	9	9	5	12	11.4	12	9	11	15	10	11.4	10	12	14	7	6	9.8
Charleston, SC	17	12	18	23	10	10	23	16.14286	15	5	18	17	19	14.8	19	21	20	20	21	20.2	17	21	11	24	18	18.2
Indy 2, IN	12	11	13	18	10	14	12	12.85714	15	15	11	12	13	13.2	18	12	7	14	10	12.4	6	5	22	14	17	12.8
KCK, KS	14	7	5	7	11	20	9	10.42857	6	10	7	11	16	10	12	4	6	9	10	9.2	5	10	5	3	3	5.2
Atlanta, GA	6	5	4	1	7	4	5	4.571429	6	3	3	7	4	4.6	3	7	4	6	6	5.2	10	6	7	6	3	6.4
Florence, SC	12	0	4	3	1	4	3	3.857143	6	2	3	1	3	3	7	4	0	6	1	2.8	3	1	1	3	0	1.8
Wichita, KS	17	15	15	23	20	13	15	16.85714	18	20	19	29	17	20.6	21	15	23	16	11	17.2	15	25	14	14	19	17.4
Macon, GA	5	7	8	2	12	9	3	6.571429	8	4	7	10	2	6.2	5	2	5	3	4	3.8	7	10	4	5	3	5.8
Tulsa, OK	15	19	11	16	9	19	21	15.71429	14	15	20	18	18	17	17	16	15	17	5	14	21	20	13	22	15	18.2
Atlanta, GA	5	3	7	11	5	7	23	7.714286	5	7	5	6	6	5.8	7	10	10	10	10	9.4	11	9	19	9	4	8.2
Syracuse, NY	7	3	12	7	5	4	3	6.857143	6	2	9	8	2	5.4	10	6	8	3	5	6.4	5	8	5	4	9	6.2
Savannah, GA	7	2	14	14	13	19	9	11.14286	15	13	14	7	11	12	10	8	11	16	11	11.2	10	8	3	5	7	6.6
OKC 1, OK	11	10	14	16	13	13	15	13.14286	13	13	18	21	14	15.8	2	6	12	6	6	6.4	5	7	4	3	13	6.4
Rochester, NY	5	9	7	8	13	14	4	8.571429	11	6	11	17	10	8.2	4	11	8	5	4	5.2	6	6	17	8	9	9.6
Springfield, MA	7	15	10	5	14	7	15	9.571429	17	12	11	6	12	11.6	10	5	8	5	6	6.8	9	5	15	18	17	15.2
Columbus, OH	14	15	14	22	23	18	20	18.57143	15	19	16	14	4	13.6	15	9	12	11	12	11.8	7	14	10	10	10	11
Boise, ID	6	5	8	8	6	3	1	4.857143	6	6	5	6	8	6.2	5	3	7	4	2	3.8	7	7	4	4	3	5
Albany, NY	6	6	4	6	8	3	1	4.857143	6	5	6	8	3	5.6	3	7	7	6	2	5	8	7	6	6	4	6.8
Lawrence, MA	3	8	6	5	2	6	6	5.857143	9	11	10	10	3	8.6	10	8	9	7	7	8.2	9	9	7	9	4	7.6
Worcester, MA	3	3	6	11	5	9	6	6.285714	9	10	13	11	7	10	7	9	8	9	7	8	10	9	7	4	4	6.8
Rossiawn, OH	20	14	14	19	13	15	17	16.57143	15	16	14	15	13	14.8	14	16	11	18	16	15	24	19	8	17	13	16.2
Dayton, OH	11	14	10	16	10	10	8	11.28571	4	10	6	6	14	7.4	9	12	11	7	6	9	13	14	13	7	13	12
Mattapan, MA	5	6	3	7	2	5	14	6.428571	9	4	7	9	5	6.8	8	10	4	7	8	7.4	8	4	14	10	8	9.6
Lynn, MA	1	0	1	2	4	5	3	2.285714	3	3	0	0	1	1.4	1	0	0	0	0	0.2	0	4	0	1	2	1.8
Cincinnati, OH	8	4	4	8	6	5	3	5.428571	6	10	6	6	7	7.4	12	9	7	5	13	10.6	10	11	7	2	10	8
Reno, NV	11	7	1	1	8	4	3	5.714286	12	8	12	12	7	10.2	11	9	9	5	14	9.6	11	3	6	4	10	6.8
East Albuquerque, NM	6	5	1	6	4	3	3	4	0	6	4	1	3	2.4	0	8	4	5	4	4	7	5	4	3	2	4.2
Fort Wayne, IN	10	4	0	2	4	2	5	4.714286	4	6	4	3	10	5.2	6	5	4	6	8	5.8	13	6	5	4	10	8.2
Spartanburg, SC	9	3	7	11	9	7	5	7	5	5	10	5	10	7	8	6	5	4	8	6.2	8	2	6	3	3	4.2
Richmond, VA	6	3	0	4	0	1	0	2.142857	5	3	0	1	1	2	4	1	7	0	2	2.8	2	0	8	4	0	3.2
Toledo, OH	25	26	20	24	36	33	33	28.14286	40	34	23	21	26	28.8	26	13	42	33	29	28.6	36	21	29	24	23	26.6
Myrtle Beach, SC	9	9	11	5	6	3	4	5.714286	8	8	6	9	5	6.6	2	4	4	6	4	4	9	5	6	8	7	7
Topeka, KS	6	10	10	4	9	5	13	7.714286	5	7	7	9	5	7	5	3	7	5	1	4.2	4	8	4	3	6	5
Kansas City, KTA	6	7	3	5	3	2	4	4.857143	5	8	7	7	3	6.2	4	3	6	1	8	4.4	5	1	3	2	3	2.8
OKC 2, OK	4	4	7	4	3	2	1	4.857143	4	8	3	11	6	6.4	4	4	4	3	0	3.8	6	1	1	1	1	2.4
Baltimore, MD	4	1	5	2	7	10	1	4.285714	3	3	9	4	2	4.2	4	4	4	8	1	3.8	3	2	12	11	7	7
Omaha, NE			2	1	3	1	1	1.6	8	8	7	3	3	5.8	1	3	1	3	4	2.4	6	7	8	9	5	6.8
Washington, DC, DC	6	0	2	1	4	5	2	2.857143	1	1	1	0	3	1.2	3	1	3	2	4	2.6	3	2	4	5	2	3.2
Bridgeport, CT	2	4	6	5	6	3	2	3.428571	1	4	7	7	3	4.4	14	3	3	2	4	5.2	6	3	3	3	4	3.8
Company Total	446	395	399	527	466	466	400	432	480	476	516	481	360	461.4	460	451	479	491	406	449.4	500	493	449	444	423	461.8

Company		3/26/2007 BA Rate	3/27/2007 BA Rate	3/28/2007 BA Rate	3/29/2007 BA Rate	3/30/2007 BA Rate	Average
0	Pueblo, CO	0.224	0.257813	0.28	0.158333	0.238806	23.2%
1	Colorado Springs, CO	0.291971	0.416667	0.274074	0.24183	0.302632	30.5%
2	Denver, CO	0.331169	0.335484	0.354037	0.358025	0.269231	33.0%
3	Albuquerque, NM	0.421384	0.347518	0.237805	0.327778	0.283951	32.4%
4	Santa Fe, NM	0.376344	0.329268	0.273684	0.20202	0.264368	28.9%
5	Aurora, CO	0.266187	0.277372	0.288889	0.294521	0.190789	26.4%
6	Phoenix, AZ	0.333333	0.253333	0.2125	0.280488	0.28125	27.2%
7	Indy 1, IN	0.441176	0.410526	0.351648	0.322581	0.377778	38.1%
8	Gary, IN	0.551948	0.533333	0.469027	0.088889	0.52381	43.3%
9	Thornton, CO	0.330357	0.31405	0.280702	0.276423	0.262295	29.3%
10	Greenville, SC	0.279221	0.328571	0.34507	0.232143	0.380952	31.3%
11	Columbia, SC	0.480916	0.444444	0.380165	0.468254	0.544	46.4%
12	Tucson, AZ	0.271028	0.284211	0.194444	0.285714	0.454545	29.8%
13	Charleston, SC	0.301075	0.256098	0.294737	0.301205	0.32	29.5%
14	Indy 2, IN	0.314286	0.43038	0.147368	0.348485	0.43617	33.5%
15	KCK, KS	0.316901	0.304	0.229167	0.40625	0.204545	29.2%
16	Atlanta, GA	0.435897	0.363636	0.466667	0.521739	0.30303	41.8%
17	Florence, SC	0.514925	0.380531	0.419355	0.407692	0.213115	38.7%
18	Wichita, KS	0.310559	0.310559	0.337748	0.348993	0.265306	31.5%
19	Macon, GA	0.392593	0.473282	0.454545	0.552632	0.4	45.5%
20	Tulsa, OK	0.333333	0.342657	0.289308	0.310976	0.420455	33.9%
21	Augusta, GA	0.456311	0.333333	0.482353	0.541284	0.59434	48.2%
22	Syracuse, NY	0.430769	0.492647	0.435115	0.430894	0.483871	45.5%
23	Savannah, GA	0.346535	0.525773	0.480392	0.515789	0.322917	43.8%
24	OKC 1, OK	0.33758	0.141844	0.214815	0.248	0.414414	27.1%
25	Rochester, NY	0.408759	0.37594	0.364964	0.416667	0.328244	37.9%
26	Springfield, MA	0.359477	0.342657	0.268456	0.335664	0.271523	31.6%
27	Columbus, OH	0.404494	0.528302	0.441718	0.446927	0.455446	45.5%
28	Boise, ID	0.344	0.478261	0.338983	0.358491	0.286957	36.1%
29	Albany, NY	0.416	0.395161	0.344262	0.301724	0.336	35.9%
30	Lawrence, MA	0.421053	0.285714	0.465753	0.246377	0.275	33.9%
31	Worcester, MA	0.377049	0.284615	0.338346	0.295775	0.325758	32.4%
32	Roselawn, OH	0.337209	0.37931	0.426667	0.225806	0.47191	36.8%
33	Dayton, OH	0.216	0.419118	0.283784	0.4	0.432624	35.0%
34	Mattapan, MA	0.282051	0.4375	0.467742	0.295455	0.305085	35.8%
35	Lynn, MA	0.428571	0.418605	0.428571	0.295775	0.472727	40.9%
36	Cincinnati, OH	0.561905	0.438095	0.479592	0.444444	0.575221	50.0%
37	Reno, NV	0.333333	0.38	0.348315	0.3	0.255102	32.3%
38	East Albuquerque, NM	0.447917	0.395062	0.544554	0.397959	0.444444	44.6%
39	Fort Wayne, IN	0.075472	0.23913	0.217391	0.336957	0.505155	27.5%
40	Spartanburg, SC	0.558559	0.434211	0.328125	0.38806	0.463768	43.5%
41	Richmond, VA	0.363636	0.301887	0.367347	0.305085	0.462687	36.0%
42	Toledo, OH	0.433071	0.564815	0.311927	0.342857	0.355556	40.2%
43	Myrtle Beach, SC	0.025641	0.42	0.255814	0.232558	0.046512	19.6%
44	Topeka, KS	0.46729	0.308824	0.357143	0.2875	0.361905	35.7%
45	Roanoke, VA	0.561728	0.481928	0.477419	0.474684	0.482143	49.6%
46	OKC 2, OK	0.241379	0.181818	0.189655	0.423077	0.129032	23.3%
47	Baltimore, MD	0.357664	0.416667	0.398496	0.405594	0.406667	39.7%
48	Omaha, NE	0.44	0.171429	0.326087	0.27027	0.382353	31.8%
49	Washington, DC	0.338843	0.316239	0.312	0.4	0.447619	36.3%
50	Montgomery, AL	0.365079	0.144737	0.206897	0.364865	0.302632	27.7%
	COMPANY TOTAL	0.371955	0.369256	0.368141	0.360587	0.38631	37.1%

FORBA 0236067
CONFIDENTIAL

Company		3/26/2007 Daily Actual	3/27/2007 Daily Actual	3/28/2007 Daily Actual	3/29/2007 Daily Actual	3/30/2007 Daily Actual	Average
0	Pueblo, CO	$ 18,800	$ 16,900	$ 22,100	$ 22,200	$ 11,100	$ 18,220
1	Colorado Springs, CO	15,500	16,800	17,800	17,900	11,500	$ 15,900
2	Denver, CO	21,200	22,100	20,800	22,800	11,200	$ 19,620
3	Albuquerque, NM	21,300	21,400	21,800	24,800	9,500	$ 19,760
4	Santa Fe, NM	9,200	9,100	11,900	14,300	9,500	$ 10,800
5	Aurora, CO	22,500	22,100	20,400	24,400	23,700	$ 22,620
6	Phoenix, AZ	8,600	9,600	11,900	15,300	14,100	$ 11,900
7	Indy 1, IN	$ 9,100	$ 12,500	$ 11,100	$ 10,500	$ 8,500	$ 10,340
8	Gary, IN	13,400	14,200	12,900	13,200	13,000	$ 13,340
9	Thornton, CO	20,000	22,000	19,200	23,100	21,100	$ 21,080
10	Greenville, SC	$ 20,100	$ 17,800	$ 16,600	$ 15,900	$ 7,100	$ 15,500
11	Columbia, SC	12,800	13,500	12,600	13,700	12,400	$ 13,000
12	Tucson, AZ	16,400	13,200	17,500	15,900	14,600	$ 15,520
13	Charleston, SC	14,200	13,800	12,500	12,600	20,000	$ 14,620
14	Indy 2, IN	14,600	8,500	12,900	9,800	10,000	$ 11,160
15	KCK, KS	15,800	15,400	16,900	14,500	15,900	$ 15,700
16	Atlanta, GA	11,400	10,200	9,300	7,900	7,400	$ 9,240
17	Florence, SC	13,700	15,300	15,400	15,000	9,500	$ 13,780
18	Wichita, KS	21,100	22,700	20,600	17,700	21,200	$ 20,660
19	Macon, GA	17,700	16,600	15,600	11,000	13,200	$ 14,820
20	Tulsa, OK	30,200	23,500	27,700	33,800	29,000	$ 28,840
21	Augusta, GA	11,000	11,200	14,400	9,400	6,200	$ 10,440
22	Syracuse, NY	11,400	12,900	11,800	11,100	10,400	$ 11,520
23	Savannah, GA	18,600	10,500	15,600	7,700	13,400	$ 13,160
24	OKC 1, OK	30,500	40,200	40,500	29,000	34,100	$ 34,860
25	Rochester, NY	16,000	14,300	17,900	15,900	14,700	$ 15,760
26	Springfield, MA	21,900	22,200	25,300	24,400	25,400	$ 23,840
27	Columbus, OH	21,600	17,000	21,000	18,700	23,200	$ 20,300
28	Boise, ID	14,900	10,300	12,100	10,400	12,000	$ 11,940
29	Albany, NY	16,600	13,700	17,000	20,600	16,200	$ 16,820
30	Lawrence, MA	14,200	14,700	10,700	14,200	15,000	$ 13,760
31	Worcester, MA	24,100	24,300	26,500	26,200	23,900	$ 25,000
32	Roselawn, OH	13,800	13,400	6,700	10,200	10,100	$ 10,840
33	Dayton, OH	22,200	19,000	23,100	19,800	23,700	$ 21,560
34	Mattapan, MA	15,000	12,200	11,200	10,900	12,200	$ 12,300
35	Lynn, MA	11,000	10,500	8,900	9,100	7,000	$ 9,300
36	Cincinnati, OH	6,800	9,400	7,000	10,500	7,200	$ 8,180
37	Reno, NV	11,300	10,800	11,200	11,700	11,700	$ 11,340
38	East Albuquerque, NM	11,600	17,100	12,100	16,600	12,200	$ 13,920
39	Fort Wayne, IN	18,700	15,600	17,000	17,000	13,200	$ 16,300
40	Spartanburg, SC	9,300	11,300	8,100	11,100	8,100	$ 9,580
41	Richmond, VA	8,000	8,500	6,200	6,800	9,500	$ 7,800
42	Toledo, OH	13,400	9,400	14,700	13,200	10,600	$ 12,260
43	Myrtle Beach, SC	9,900	7,800	5,900	8,000	7,700	$ 7,860
44	Topeka, KS	9,800	10,800	9,300	9,500	14,000	$ 10,680
45	Roanoke, VA	16,700	16,900	16,800	14,900	16,600	$ 16,380
46	OKC 2, OK	13,300	12,900	13,900	8,300	17,600	$ 13,200
47	Baltimore, MD	18,000	18,300	18,500	19,200	21,200	$ 19,040
48	Omaha, NE	10,100	8,000	9,500	18,400	11,400	$ 11,480
49	Washington, DC	28,300	22,700	26,400	22,800	18,700	$ 23,780
50	Montgomery, AL	15,300	9,200	10,900	8,600	11,000	$ 11,000
	COMPANY TOTAL	810,900	772,300	797,700	790,500	731,700	780,620

FORBA 0236068
CONFIDENTIAL

Company	3/26/2007 Daily Patients	3/27/2007 Daily Patients	3/28/2007 Daily Patients	3/29/2007 Daily Patients	3/30/2007 Daily Patients	Average
0 Pueblo, CO	97	95	90	101	51	87
1 Colorado Springs, CO	97	84	98	116	53	90
2 Denver, CO	103	103	104	104	57	94
3 Albuquerque, NM	92	92	125	121	58	98
4 Santa Fe, NM	58	55	69	79	64	65
5 Aurora, CO	102	99	96	103	123	105
6 Phoenix, AZ	54	56	63	59	69	60
7 Indy 1, IN	57	56	59	63	56	58
8 Gary, IN	69	56	60	82	60	65
9 Thornton, CO	75	83	82	89	90	84
10 Greenville, SC	111	94	93	86	26	82
11 Columbia, SC	68	75	75	67	57	68
12 Tucson, AZ	78	68	87	60	60	71
13 Charleston, SC	65	61	67	58	68	64
14 Indy 2, IN	72	45	81	43	53	59
15 KCK, KS	97	87	111	76	105	95
16 Atlanta, GA	44	42	40	33	46	41
17 Florence, SC	65	70	72	77	48	66
18 Wichita, KS	111	111	100	97	108	105
19 Macon, GA	82	69	78	51	63	69
20 Tulsa, OK	98	94	113	113	102	104
21 Augusta, GA	56	54	44	50	43	49
22 Syracuse, NY	74	69	74	70	64	70
23 Savannah, GA	66	46	53	46	65	55
24 OKC 1, OK	104	121	106	94	65	98
25 Rochester, NY	81	83	87	77	88	83
26 Springfield, MA	98	94	109	95	110	101
27 Columbus, OH	106	75	91	99	110	96
28 Boise, ID	82	60	78	68	82	74
29 Albany, NY	73	75	80	81	83	78
30 Lawrence, MA	44	50	39	52	58	49
31 Worcester, MA	76	93	88	100	89	89
32 Roselawn, OH	57	54	43	48	47	50
33 Dayton, OH	98	79	106	81	80	89
34 Mattapan, MA	56	36	33	31	41	39
35 Lynn, MA	44	50	40	50	29	43
36 Cincinnati, OH	46	59	51	55	48	52
37 Reno, NV	64	62	58	63	73	64
38 East Albuquerque, NM	53	49	46	59	55	52
39 Fort Wayne, IN	98	70	72	61	48	70
40 Spartanburg, SC	49	43	43	41	37	43
41 Richmond, VA	35	37	31	41	36	36
42 Toledo, OH	72	47	75	69	58	64
43 Myrtle Beach, SC	38	29	32	33	41	35
44 Topeka, KS	57	47	45	57	67	55
45 Roanoke, VA	71	86	81	83	87	82
46 OKC 2, OK	44	45	47	30	54	44
47 Baltimore, MD	88	77	80	85	89	84
48 Omaha, NE	28	29	31	54	42	37
49 Washington, DC	80	80	86	69	58	75
50 Montgomery, AL	80	65	69	47	53	63
COMPANY TOTAL	3,713	3,459	3,681	3,567	3,317	3,547

FORBA 0236069
CONFIDENTIAL

FORBA 0236070
CONFIDENTIAL

Rank	Clinic
1	Pueblo, CO
2	Colorado Springs, CO
3	Denver, CO
4	Albuquerque, NM
5	Santa Fe, NM
6	Aurora, CO
7	Phoenix, AZ
8	Indy 1, IN
9	Gary, IN
10	Trenton, CO
11	Greenville, SC
12	Columbia, SC
13	Tucson, AZ
14	Charleston, SC
15	Indy 2, IN
16	KCK, KS
17	Atlanta, GA
18	Florence, SC
19	Wichita, KS
20	Macon, GA
21	Tulsa, OK
22	Augusta, GA
23	Syracuse, NY
24	Savannah, GA
25	OKC 1, OK
26	Rochester, NY
27	Springfield, MA
28	Columbus, OH
29	Boise, ID
30	Albany, NY
31	Lawrence, MA
32	Worcester, MA
33	Roselawn, OH
34	Dayton, OH
35	Malden, MA
36	Lynn, MA
37	Cincinnati, OH
38	Reno, NV
39	East Albuquerque, NM
40	Fort Wayne, IN
41	Spartanburg, SC
42	Richmond, VA
43	Toledo, OH
44	Myrtle Beach, SC
45	Topeka, KS
46	Roanoke, VA
47	OKC 2, OK
48	Baltimore, MD
49	Omaha, NE
50	Washington, DC
51	Montgomery, AL

Company	3/19/2007 BA Rate	3/20/2007 BA Rate	3/21/2007 BA Rate	3/22/2007 BA Rate	3/23/2007 BA Rate	Average	
0 Pueblo, CO	0.325203	0.19469	0.217391	0.190083	0.153846	21.6%	
1 Colorado Springs, CO	0.45	0.320755	0.333333	0.25	0.203704	31.2%	
2 Denver, CO	0.288889	0.398438	0.296	0.344444	0.294118	32.4%	
3 Albuquerque, NM	0.416667	0.516129	0.333333	0.335443	0.410256	40.2%	
4 Santa Fe, NM	0.353535	0.173333	0.35	0.213333	0.315789	28.1%	
5 Aurora, CO	0.333333	0.245283	0.272727	0.321839	0.224299	27.9%	
6 Phoenix, AZ	0.358491	0.313725	0.262626	0.333333	0.252427	30.4%	
7 Indy 1, IN	0.349057	0.516393	0.336283	0.228261	0.294118	34.5%	
8 Gary, IN	0.198675	0.262295	0.409091	0.459184	0.540881	37.4%	
9 Thornton, CO	0.327731	0.284483	0.252874	0.340206	0.305556	30.2%	
10 Greenville, SC	0.369427	0.198473	0.29771	0.367647	0.179104	28.2%	
11 Columbia, SC	0.482143	0.455782	0.506667	0.468531	0.544118	49.1%	
12 Tucson, AZ	0.401786	0.333333	0.309091	0.359649	0.362832	35.3%	
13 Charleston, SC	0.150538	0.086022	0.257143	0.213483	0.2	18.1%	
14 Indy 2, IN	0.19	0.206522	0.298701	0.191176	0.263736	23.0%	
15 KCK, KS	0.255639	0.229167	0.383117	0.354839	0.436709	33.2%	
16 Atlanta, GA	0.357143	0.5	0.291667	0.547368	0.417582	42.3%	
17 Florence, SC	0.380952	0.452381	0.36036	0.491667	0.425532	42.2%	
18 Wichita, KS	0.368421	0.387283	0.41573	0.310734	0.352941	36.7%	
19 Macon, GA	0.422222	0.490066	0.47541	0.541985	0.383838	46.3%	
20 Tulsa, OK	0.342697	0.310345	0.484536	0.281437	0.35468	35.5%	
21 Augusta, GA	0.506329	0.337209	0.347826	0.320988	0.398058	38.2%	
22 Syracuse, NY	0.465116	0.410448	0.310078	0.37069	0.414063	39.4%	
23 Savannah, GA	0.490196	0.52	0.421569	0.344086	0.525253	46.0%	
24 OKC 1, OK	0.130719	0.246914	0.375	0.298137	0.257862	26.2%	
25 Rochester, NY	0.294574	0.364964	0.411765	0.496241	0.443662	40.2%	
26 Springfield, MA	0.358108	0.377483	0.356643	0.381944	0.496552		38.9%
27 Columbus, OH	0.393064	0.403226	0.461078	0.401163	0.454054	42.3%	
28 Boise, ID	0.352459	0.337349	0.277108	0.384615	0.5	37.0%	
29 Albany, NY	0.338462	0.372881	0.38806	0.516667	0.310924	38.5%	
30 Lawrence, MA	0.205882	0.309859	0.434211	0.363636	0.358025	33.4%	
31 Worcester, MA	0.354839	0.233871	0.324786	0.284404	0.432	32.6%	
32 Roselawn, OH	0.443038	0.36	0.621212	0.382716	0.48913	45.9%	
33 Dayton, OH	0.408451	0.351145	0.449275	0.193798	0.441558	36.9%	
34 Mattapan, MA	0.470588	0.396552	0.4375	0.393443	0.385542	41.7%	
35 Lynn, MA	0.475	0.289157	0.458333	0.486111	0.360656	41.4%	
36 Cincinnati, OH	0.458015	0.526786	0.455446	0.533333	0.525862	50.0%	
37 Reno, NV	0.136842	0.363636	0.285714	0.202381	0.228571	24.3%	
38 East Albuquerque, NM	0.495146	0.456522	0.372093	0.233766	0.378788	38.7%	
39 Fort Wayne, IN	0.316327	0.203883	0.117647	0.311828	0.375	26.5%	
40 Spartanburg, SC	0.333333	0.409091	0.253012	0.232558	0.289474	30.3%	
41 Richmond, VA	0.361702	0.3	0.377358	0.384615	0.507463	38.6%	
42 Toledo, OH	0.435897	0.464646	0.356589	0.352	0.359375	39.4%	
43 Myrtle Beach, SC	0.369565	0.396226	0.26	0.306122	0.456522	35.8%	
44 Topeka, KS	0.387597	0.489051	0.426752	0.459627	0.403846	43.3%	
45 Roanoke, VA	0.521472	0.5	0.544218	0.459259	0.553672	51.6%	
46 OKC 2, OK	0.386364	0.333333	0.33871	0.289474	0.264368	32.2%	
47 Baltimore, MD	0.432624	0.458065	0.4	0.445205	0.398496	42.7%	
48 Omaha, NE	0.333333	0.413793	0.5	0.263158	0.25	35.2%	
49 Washington, DC	0.347826	0.456	0.333333	0.295918	0.363636	35.9%	
50 Montgomery, AL	0.258065	0.3125	0.243902	0.474138	0.465649	35.1%	
COMPANY TOTAL	0.354667	0.350489	0.368141	0.360587	0.38631	36.4%	

FORBA 0236071
CONFIDENTIAL

Company	3/19/2007 Daily Actual	3/20/2007 Daily Actual	3/21/2007 Daily Actual	3/22/2007 Daily Actual	3/23/2007 Daily Actual	Average
0 Pueblo, CO	$ 15,700	$ 19,700	$ 19,700	$ 21,000	$ 13,700	$ 17,960
1 Colorado Springs, CO	13,600	13,500	13,600	14,700	7,700	$ 12,620
2 Denver, CO	18,100	16,100	20,300	15,900	4,000	$ 14,880
3 Albuquerque, NM	17,400	17,900	23,400	20,800	7,900	$ 17,480
4 Santa Fe, NM	11,300	13,800	7,300	8,700	9,600	$ 10,140
5 Aurora, CO	15,800	17,300	14,200	12,900	18,500	$ 15,740
6 Phoenix, AZ	13,900	16,400	15,200	15,300	14,500	$ 15,060
7 Indy 1, IN	$ 12,400	$ 11,100	$ 12,000	$ 12,600	$ 12,900	$ 12,200
8 Gary, IN	16,500	12,400	11,800	10,800	15,100	$ 13,320
9 Thornton, CO	18,800	20,100	18,400	17,600	20,600	$ 19,100
10 Greenville, SC	$ 16,500	$ 18,900	$ 19,300	$ 15,000	$ 11,000	$ 16,140
11 Columbia, SC	15,500	17,200	15,800	12,800	9,900	$ 14,240
12 Tucson, AZ	12,500	12,200	15,500	12,600	13,300	$ 13,220
13 Charleston, SC	16,700	16,600	16,900	17,500	18,800	$ 17,300
14 Indy 2, IN	18,700	15,900	16,900	10,200	16,900	$ 15,720
15 KCK, KS	18,600	18,700	15,900	17,800	15,800	$ 17,360
16 Atlanta, GA	9,800	9,000	9,500	10,800	10,500	$ 9,920
17 Florence, SC	15,300	17,200	12,700	13,200	7,500	$ 13,180
18 Wichita, KS	19,100	20,100	19,000	22,800	19,400	$ 20,080
19 Macon, GA	18,300	15,400	14,100	10,700	12,000	$ 14,100
20 Tulsa, OK	42,400	29,200	28,500	27,500	28,600	$ 31,240
21 Augusta, GA	6,400	11,300	16,000	9,800	11,400	$ 10,980
22 Syracuse, NY	12,000	13,400	14,900	11,600	13,200	$ 13,020
23 Savannah, GA	12,000	12,900	13,200	10,700	11,500	$ 12,060
24 OKC 1, OK	33,400	41,400	31,700	35,000	36,600	$ 35,620
25 Rochester, NY	15,700	14,300	15,100	12,600	14,200	$ 14,380
26 Springfield, MA	22,900	26,000	23,900	22,500	23,300	$ 23,720
27 Columbus, OH	23,000	20,800	18,900	23,500	19,700	$ 21,180
28 Boise, ID	12,400	9,800	11,600	9,700	7,600	$ 10,220
29 Albany, NY	16,000	19,200	16,900	16,600	12,800	$ 16,300
30 Lawrence, MA	14,300	14,800	14,100	12,600	14,500	$ 14,060
31 Worcester, MA	24,700	24,600	23,400	21,100	19,300	$ 22,620
32 Roselawn, OH	8,100	9,600	5,800	9,400	11,800	$ 8,940
33 Dayton, OH	18,900	20,600	19,200	21,100	20,400	$ 20,040
34 Mattapan, MA	11,300	12,200	9,200	13,100	16,500	$ 12,460
35 Lynn, MA	9,300	11,100	8,800	10,100	6,000	$ 9,060
36 Cincinnati, OH	11,500	11,000	7,400	8,000	8,800	$ 9,340
37 Reno, NV	12,300	10,400	12,100	13,100	15,000	$ 12,580
38 East Albuquerque, NM	9,700	10,100	12,200	12,900	10,600	$ 11,100
39 Fort Wayne, IN	18,500	20,400	16,600	16,300	17,000	$ 17,760
40 Spartanburg, SC	16,300	14,100	12,200	13,600	14,600	$ 14,160
41 Richmond, VA	6,800	6,300	7,100	5,500	8,400	$ 6,820
42 Toledo, OH	13,200	9,100	15,500	15,000	16,600	$ 13,880
43 Myrtle Beach, SC	5,900	5,200	7,200	8,300	5,100	$ 6,340
44 Topeka, KS	13,000	12,000	18,100	15,000	16,100	$ 14,640
45 Roanoke, VA	15,500	16,600	16,100	13,800	18,000	$ 16,000
46 OKC 2, OK	15,300	14,200	10,300	11,400	14,300	$ 13,100
47 Baltimore, MD	15,500	17,600	15,700	18,400	15,800	$ 16,600
48 Omaha, NE	12,500	8,900	6,100	11,600	11,200	$ 10,060
49 Washington, DC	25,100	21,700	24,900	20,300	23,000	$ 23,000
50 Montgomery, AL	18,100	16,900	16,400	12,300	15,500	$ 15,840
COMPANY TOTAL	806,500	805,200	780,600	756,100	737,000	777,080

Company	3/19/2007 Daily Patients	3/20/2007 Daily Patients	3/21/2007 Daily Patients	3/22/2007 Daily Patients	3/23/2007 Daily Patients	Average
0 Pueblo, CO	83	91	90	98	55	83
1 Colorado Springs, CO	66	72	64	78	43	65
2 Denver, CO	96	77	88	59	24	69
3 Albuquerque, NM	91	75	92	105	46	82
4 Santa Fe, NM	64	62	52	59	52	58
5 Aurora, CO	76	80	64	59	83	72
6 Phoenix, AZ	68	70	73	66	77	71
7 Indy 1, IN	69	59	75	71	72	69
8 Gary, IN	121	90	65	53	73	80
9 Thornton, CO	80	83	65	64	75	73
10 Greenville, SC	99	105	92	86	55	87
11 Columbia, SC	87	80	74	76	62	76
12 Tucson, AZ	67	66	76	73	72	71
13 Charleston, SC	79	85	78	70	68	76
14 Indy 2, IN	81	73	54	62	67	67
15 KCK, KS	99	111	95	100	89	99
16 Atlanta, GA	63	44	51	43	53	51
17 Florence, SC	78	69	71	61	27	61
18 Wichita, KS	108	106	104	122	110	110
19 Macon, GA	78	77	64	60	61	68
20 Tulsa, OK	117	120	100	120	131	118
21 Augusta, GA	39	57	60	55	62	55
22 Syracuse, NY	69	79	89	73	75	77
23 Savannah, GA	52	48	59	61	47	53
24 OKC 1, OK	173	202	105	113	118	142
25 Rochester, NY	91	87	80	67	79	81
26 Springfield, MA	95	94	92	89	73	89
27 Columbus, OH	105	111	90	103	101	102
28 Boise, ID	79	55	60	56	49	60
29 Albany, NY	86	74	82	58	82	76
30 Lawrence, MA	54	49	43	49	52	49
31 Worcester, MA	80	95	79	78	71	81
32 Roselawn, OH	44	48	25	50	47	43
33 Dayton, OH	84	85	76	104	86	87
34 Mattapan, MA	36	35	36	37	51	39
35 Lynn, MA	42	59	39	37	39	43
36 Cincinnati, OH	71	53	55	49	55	57
37 Reno, NV	82	63	65	67	81	72
38 East Albuquerque, NM	52	50	54	59	41	51
39 Fort Wayne, IN	67	82	90	64	65	74
40 Spartanburg, SC	78	65	62	66	54	65
41 Richmond, VA	30	35	33	32	33	33
42 Toledo, OH	66	53	83	81	82	73
43 Myrtle Beach, SC	29	32	37	34	25	31
44 Topeka, KS	79	70	90	87	93	84
45 Roanoke, VA	78	84	67	73	79	76
46 OKC 2, OK	54	52	41	54	64	53
47 Baltimore, MD	80	84	81	81	80	81
48 Omaha, NE	40	34	25	42	45	37
49 Washington, DC	75	68	80	69	77	74
50 Montgomery, AL	92	88	93	61	70	81
COMPANY TOTAL	3,872	3,786	3,558	3,534	3,371	3,624

Company	Clinic	3/12/2007 Conversions	3/13/2007 Conversions	3/14/2007 Conversions	3/15/2007 Conversions	3/16/2007 Conversions	Average	
0	Pueblo, CO	15	10	15	11	8	11.8	
1	Colorado Springs, CO	8	7	12	6	6	7.8	
2	Denver, CO	18	10	12	14	10	12.8	
3	Albuquerque, NM	12	14	6	11	2	9	
4	Santa Fe, NM	5	10	21	8	6	10	
5	Aurora, CO	12	15	14	20	15	15.2	
6	Phoenix, AZ	7	9	15	7	11	9.8	
7	Indy 1, IN	6	10	14	5	7	8.4	
8	Gary, IN	7	9	11	16	11	10.8	
9	Thornton, CO	18	19	18	12	9	15.2	
10	Greenville, SC	14	13	13	12	6	11.6	
11	Columbia, SC	3	9	2	1	2	3.4	
12	Tucson, AZ	16	15	9	5	12	11.4	
13	Charleston, SC	15	5	18	17	19	14.8	
14	Indy 2, IN	15	15	11	12	13	13.2	
15	KCK, KS	6	10	7	11	16	10	
16	Atlanta, GA	6	3	1	3	7	4	
17	Florence, SC	5	2	3	3	0	2.6	
18	Wichita, KS	18	20	19	29	17	20.6	
19	Macon, GA	8	4	7	10	2	6.2	
20	Tulsa, OK	14	15	20	18	18	17	
21	Augusta, GA	6	5	7	8	6	6.4	
22	Syracuse, NY	6	2	9	8	2	5.4	
23	Savannah, GA	15	13	14	7	11	12	
24	OKC 1, OK	13	13	18	21	14	15.8	
25	Rochester, NY	11	6	7	10	7	8.2	
26	Springfield, MA	7	12	11	8	2	8.9	40
27	Columbus, OH	15	19	16	14		16	
28	Boise, ID	16	12	10	12	8	11.2	
29	Albany, NY	6	6	5	6	8	6.5	31
30	Lawrence, MA	9	11	10	10	3	8.6	
31	Worcester, MA	9	10	13	7	4	9.6	43
32	Roselawn, OH	15	16	14	15	13	14.6	
33	Dayton, OH	4	10	6	14	3	7.4	
34	Mattapan, MA	9	4	7	9	5	6.8	
35	Lynn, MA	3	3	0	0	1	1.4	
36	Cincinnati, OH	6	10	6	6	7	7	
37	Reno, NV	12	8	12	12	7	10.2	
38	East Albuquerque, NM	0	6	4	1	1	2.4	
39	Fort Wayne, IN	4	6	3	10	3	5.2	
40	Spartanburg, SC	5	5	10	13	7	8	
41	Richmond, VA	6	3	0	1	1	2.2	
42	Toledo, OH	40	34	23	21	26	28.8	
43	Myrtle Beach, SC	8	6	6	9	4	6.6	
44	Topeka, KS	5	7	9	5	9	7	
45	Roanoke, VA	5	1	7	3	2	3.6	
46	OKC 2, OK	4	8	11	6	3	6.4	
47	Baltimore, MD	3	3	9	4	2	4.2	
48	Omaha, NE	8	8	7	3	3	5.8	
49	Washington, DC, DC	1	1	1	0	0	0.6	
50	Montgomery, AL	1	4	7	7	3	4.4	
	COMPANY TOTAL	480	476	510	481	360	461	

FORBA 0236074
CONFIDENTIAL

Company	3/12/2007 BA Rate	3/13/2007 BA Rate	3/14/2007 BA Rate	3/15/2007 BA Rate	3/16/2007 BA Rate	Average		
0 Pueblo, CO	40.7%	35.0%	37.5%	26.6%	4.9%	28.9%		
1 Colorado Springs, CO	42.7%	35.9%	31.3%	31.7%	50.0%	38.3%		
2 Denver, CO	36.5%	32.1%	38.5%	27.3%	32.2%	33.3%		
3 Albuquerque, NM	40.3%	52.0%	39.2%	52.9%	48.6%	46.6%		
4 Santa Fe, NM	27.4%	42.7%	41.7%	36.8%	23.4%	34.4%		
5 Aurora, CO	15.9%	30.5%	33.0%	40.6%	19.4%	27.9%		
6 Phoenix, AZ	45.7%	39.8%	32.6%	46.3%	32.0%	39.3%		
7 Indy 1, IN	38.2%	34.8%	17.8%	28.7%	41.6%	31.8%		
8 Gary, IN	57.7%	39.5%	45.6%	37.3%	50.4%	46.1%		
9 Thornton, CO	37.0%	22.9%	28.4%	43.5%	37.8%	33.9%		
10 Greenville, SC	30.2%	35.5%	33.3%	38.6%	26.3%	32.8%		
11 Columbia, SC	44.8%	44.2%	38.5%	42.9%	41.4%	42.3%		
12 Tucson, AZ	29.9%	38.9%	35.2%	39.0%	31.6%	34.9%		
13 Charleston, SC	17.6%	51.8%	25.6%	25.9%	25.4%	29.3%		
14 Indy 2, IN	34.6%	25.3%	37.4%	37.8%	39.8%	35.0%		
15 KCK, KS	35.7%	34.1%	42.5%	26.8%	31.6%	34.1%		
16 Atlanta, GA	29.0%	37.1%	34.9%	47.8%	24.1%	34.6%		
17 Florence, SC	61.8%	47.6%	51.1%	46.0%	35.8%	48.5%		
18 Wichita, KS	40.9%	38.6%	30.5%	48.5%	37.0%	39.1%		
19 Macon, GA	49.4%	51.1%	47.0%	50.0%	49.6%	49.4%		
20 Tulsa, OK	42.0%	30.7%	39.4%	40.4%	47.4%	40.0%		
21 Augusta, GA	33.3%	33.3%	43.3%	54.5%	38.2%	40.5%		
22 Syracuse, NY	52.0%	44.6%	48.5%	45.7%	39.6%	46.1%		
23 Savannah, GA	50.5%	58.2%	48.9%	53.8%	49.5%	52.2%		
24 OKC 1, OK	39.9%	12.1%	3.7%	33.3%	37.8%	25.3%		
25 Rochester, NY	41.6%	37.1%	38.8%	36.3%	47.8%	40.3%		
26 Springfield, MA	37.8%	27.8%	33.6%	30.5%	45.8%		175.41%	38.98%
27 Columbus, OH	46.9%	52.2%	47.4%	46.6%	48.4%	48.3%		
28 Boise, ID	45.9%	21.8%	27.6%	39.0%	35.3%	33.9%		
29 Albany, NY	48.9%	41.5%	38.1%	35.4%	49.2%		213.03%	44.85%
30 Lawrence, MA	47.4%	27.4%	34.2%	29.7%	58.8%	39.5%		
31 Worcester, MA	38.7%	32.5%	39.7%	34.7%	68.6%		214.13%	47.58%
32 Roselawn, OH	53.1%	38.8%	49.3%	52.8%	46.3%	48.1%		
33 Dayton, OH	31.5%	31.9%	24.1%	30.6%	34.5%	30.5%		
34 Mattapan, MA	26.8%	39.4%	49.4%	26.9%	61.4%	40.8%		
35 Lynn, MA	43.8%	41.2%	41.1%	50.0%	50.0%	45.2%		
36 Cincinnati, OH	59.1%	48.1%	53.2%	58.7%	55.0%	54.8%		
37 Reno, NV	32.1%	23.5%	24.6%	32.7%	39.6%	30.5%		
38 East Albuquerque, NM	45.5%	47.9%	45.8%	50.6%	35.1%	45.0%		
39 Fort Wayne, IN	27.1%	24.2%	26.7%	41.0%	27.1%	29.2%		
40 Spartanburg, SC	52.7%	30.8%	33.3%	42.3%	38.6%	39.6%		
41 Richmond, VA	39.7%	43.1%	31.1%	63.6%	44.6%	44.4%		
42 Toledo, OH	28.8%	42.3%	43.5%	47.0%	45.5%	41.4%		
43 Myrtle Beach, SC	18.4%	41.7%	31.5%	14.0%	47.2%	30.5%		
44 Topeka, KS	46.2%	52.9%	31.1%	32.8%	43.2%	41.2%		
45 Roanoke, VA	42.1%	53.3%	54.6%	50.9%	52.5%	50.7%		
46 OKC 2, OK	35.8%	35.7%	34.4%	43.3%	24.6%	34.8%		
47 Baltimore, MD	33.1%	40.5%	43.2%	43.7%	49.7%	42.0%		
48 Omaha, NE	35.1%	38.2%	47.2%	33.9%	31.1%	37.1%		
49 Washington, DC	50.4%	48.2%	40.2%	27.9%	48.8%	43.1%		
50 Montgomery, AL	43.3%	35.8%	42.2%	22.8%	33.3%	35.5%		
COMPANY TOTAL	0.404822	0.385122	0.378101	0.403253	0.415799	0.397419		

Company	3/12/2007 Daily Actual	3/13/2007 Daily Actual	3/14/2007 Daily Actual	3/15/2007 Daily Actual	3/16/2007 Daily Actual	Average	
0 Pueblo, CO	$ 14,500	$ 17,700	$ 19,800	$ 18,900	$ 13,500	$ 16,880	
1 Colorado Springs, CO	15,000	14,300	16,400	14,100	6,000	$ 13,160	
2 Denver, CO	12,600	14,000	11,100	11,200	9,600	$ 11,700	
3 Albuquerque, NM	13,200	15,400	16,300	13,700	6,400	$ 13,000	
4 Santa Fe, NM	10,100	9,100	11,000	11,700	9,800	$ 10,340	
5 Aurora, CO	16,300	15,900	15,800	14,500	17,200	$ 15,940	
6 Phoenix, AZ	7,700	16,400	13,700	9,300	11,900	$ 11,800	
7 Indy 1, IN	13,100	13,300	13,200	9,500	10,200	$ 11,860	
8 Gary, IN	11,400	14,100	13,500	13,000	11,300	$ 12,660	
9 Thornton, CO	17,600	19,500	17,600	15,800	19,200	$ 17,940	
10 Greenville, SC	19,900	16,700	19,300	14,400	8,900	$ 15,840	
11 Columbia, SC	15,000	14,900	13,200	10,400	11,300	$ 12,960	
12 Tucson, AZ	16,000	13,800	15,400	11,100	15,800	$ 14,420	
13 Charleston, SC	18,800	8,000	12,700	16,200	13,300	$ 13,800	
14 Indy 2, IN	13,400	16,000	14,900	15,700	10,300	$ 14,060	
15 KCK, KS	12,200	10,700	10,900	11,600	13,500	$ 11,780	
16 Atlanta, GA	12,400	9,100	7,000	7,400	10,800	$ 9,340	
17 Florence, SC	10,200	13,100	14,900	13,700	5,400	$ 11,460	
18 Wichita, KS	20,800	20,000	20,200	20,900	19,000	$ 20,180	
19 Macon, GA	18,200	14,900	18,900	17,900	11,700	$ 16,320	
20 Tulsa, OK	28,400	27,700	29,300	33,700	27,100	$ 29,240	
21 Augusta, GA	14,900	11,400	11,600	7,900	8,800	$ 10,920	
22 Syracuse, NY	11,900	12,700	12,500	12,700	10,400	$ 12,040	
23 Savannah, GA	10,400	10,600	14,700	8,900	13,100	$ 11,540	
24 OKC 1, OK	25,500	26,900	34,800	29,400	20,000	$ 27,320	
25 Rochester, NY	15,600	15,600	14,500	16,000	13,600	$ 15,060	
26 Springfield, MA	22,800	23,600	24,000	23,200	15,000	$ 24,133	108,600
27 Columbus, OH	20,400	22,000	25,100	22,300	19,400	$ 21,840	
28 Boise, ID	13,400	10,100	9,900	7,000	10,100	$ 10,100	
29 Albany, NY	18,500	14,000	16,500	14,100	13,700	$ 16,168	76,800
30 Lawrence, MA	11,100	11,900	14,900	12,200	9,700	$ 11,960	
31 Worcester, MA	20,700	23,600	26,200	24,700	13,000	$ 24,044	108,200
32 Roselawn, OH	11,100	12,300	9,100	10,100	10,700	$ 10,660	
33 Dayton, OH	16,900	17,200	23,900	21,500	19,100	$ 19,720	
34 Mattapan, MA	14,900	12,400	13,800	11,700	9,600	$ 12,480	
35 Lynn, MA	9,200	9,300	8,400	8,300	7,600	$ 8,560	
36 Cincinnati, OH	8,300	10,300	7,400	6,200	9,100	$ 8,260	
37 Reno, NV	12,100	14,400	12,900	14,100	11,100	$ 12,920	
38 East Albuquerque, NM	15,000	10,100	13,600	8,900	7,400	$ 11,000	
39 Fort Wayne, IN	18,800	16,800	18,600	17,600	20,000	$ 18,360	
40 Spartanburg, SC	13,800	10,300	9,200	11,600	14,200	$ 11,820	
41 Richmond, VA	11,200	8,800	6,300	4,500	7,400	$ 7,640	
42 Toledo, OH	17,900	13,700	12,500	12,300	14,900	$ 14,260	
43 Myrtle Beach, SC	9,100	7,000	9,700	10,300	8,000	$ 8,820	
44 Topeka, KS	12,400	11,100	13,600	8,500	10,400	$ 11,200	
45 Roanoke, VA	16,900	16,400	15,900	16,100	14,000	$ 15,860	
46 OKC 2, OK	11,000	12,100	10,200	9,900	12,600	$ 11,160	
47 Baltimore, MD	19,100	19,900	17,700	12,900	13,700	$ 16,660	
48 Omaha, NE	12,800	12,200	10,500	8,900	10,400	$ 10,960	
49 Washington, DC	21,100	19,700	39,200	28,200	21,300	$ 25,900	
50 Montgomery, AL	12,900	16,700	11,900	15,900	12,600	$ 14,000	
COMPANY TOTAL	766,500	747,700	794,200	720,600	643,100	734,420	

FORBA 0236076
CONFIDENTIAL

Company	3/12/2007 Daily Patients	3/13/2007 Daily Patients	3/14/2007 Daily Patients	3/15/2007 Daily Patients	3/16/2007 Daily Patients	Average		
0 Pueblo, CO	67	80	70	80	58	71		
1 Colorado Springs, CO	71	75	77	71	30	65		
2 Denver, CO	61	57	59	56	40	55		
3 Albuquerque, NM	86	71	93	72	36	72		
4 Santa Fe, NM	69	55	49	60	59	58		
5 Aurora, CO	90	66	63	63	87	74		
6 Phoenix, AZ	44	59	60	44	68	55		
7 Indy 1, IN	81	75	83	62	66	73		
8 Gary, IN	60	72	68	69	63	66		
9 Thornton, CO	63	74	63	52	69	64		
10 Greenville, SC	104	91	92	81	56	85		
11 Columbia, SC	95	82	88	80	78	85		
12 Tucson, AZ	75	66	68	61	78	70		
13 Charleston, SC	84	41	61	63	53	60		
14 Indy 2, IN	70	71	62	56	59	64		
15 KCK, KS	74	60	69	52	67	64		
16 Atlanta, GA	76	56	56	48	85	64		
17 Florence, SC	52	66	65	68	34	57		
18 Wichita, KS	97	97	114	87	102	99		
19 Macon, GA	78	67	71	72	63	70		
20 Tulsa, OK	98	113	106	112	113	108		
21 Augusta, GA	66	56	55	46	55	56		
22 Syracuse, NY	71	72	70	75	81	74		
23 Savannah, GA	47	38	47	42	54	46		
24 OKC 1, OK	86	131	131	80	56	97		
25 Rochester, NY	80	88	82	86	72	82		
26 Springfield, MA	89	104	91	98	71		453	$ 101
27 Columbus, OH	95	87	92	94	94	92		
28 Boise, ID	59	68	63	50	66	61		
29 Albany, NY	67	72	78	84	66		367	$ 77
30 Lawrence, MA	41	53	50	45	35	45		
31 Worcester, MA	73	85	76	81	44		359	$ 80
32 Roselawn, OH	38	52	38	42	43	43		
33 Dayton, OH	85	77	107	86	91	89		
34 Mattapan, MA	52	40	40	38	27	39		
35 Lynn, MA	36	40	43	38	35	38		
36 Cincinnati, OH	52	54	52	45	54	51		
37 Reno, NV	72	78	82	72	64	74		
38 East Albuquerque, NM	55	50	58	38	50	50		
39 Fort Wayne, IN	70	75	77	62	70	71		
40 Spartanburg, SC	52	54	42	45	81	55		
41 Richmond, VA	41	37	31	20	36	33		
42 Toledo, OH	99	75	61	61	78	75		
43 Myrtle Beach, SC	31	28	37	37	28	32		
44 Topeka, KS	57	56	62	41	54	54		
45 Roanoke, VA	95	71	74	85	76	80		
46 OKC 2, OK	43	45	40	34	46	42		
47 Baltimore, MD	99	88	75	71	78	82		
48 Omaha, NE	50	42	28	41	42	41		
49 Washington, DC	62	59	73	88	62	69		
50 Montgomery, AL	72	86	67	95	70	78		
COMPANY TOTAL	3,530	3,455	3,459	3,229	3,143	3,363		

FORBA 0236077
CONFIDENTIAL

Clinic	3/1/2007	3/2/2007	3/5/2007	3/6/2007	3/7/2007	3/8/2007	3/9/2007	Average Conversions
Pueblo, CO	11	4	13	10	18	30	12	13.6
Colorado Springs, CO	11	4	6	13	7	6	5	7.4
Denver, CO	5	12	13	11	11	3	10	9.3
Albuquerque, NM	13	5	3	21	9	10	6	9.6
Santa Fe, NM	13	10	9	15	10	11	3	10.1
Aurora, CO	13	12	10	14	17	18	14	14.0
Phoenix, AZ	12	8	5	7	8	11	5	8.0
Indy 1, IN	3	3	3	7	14	11	9	7.1
Gary, IN	16	7	7	7	10	5	10	8.9
Thornton, CO	18	19	14	27	12	16	16	17.4
Greenville, SC	1	0	6	12	10	9	7	6.4
Columbia, SC	5	2	4	8	3	6	0	4.0
Tucson, AZ	3	11	13	15	13	16	12	11.9
Charleston, SC	17	12	18	23	10	10	23	16.1
Indy 2, IN	12	11	13	18	10	14	12	12.9
KCK, KS	14	7	5	7	11	20	9	10.4
Atlanta, GA	6	5	4	1	7	4	5	4.6
Florence, SC	12	0	4	3	1	4	3	3.9
Wichita, KS	0							0.0
Macon, GA	5	7	8	2	12	9	3	6.6
Tulsa, OK	16	19	11	16	9	16	21	15.7
Augusta, GA	5	3	3	11	5	7	21	7.9
Syracuse, NY	7	10	12	7	5	4	3	6.9
Savannah, GA	7	2	14	14	13	19	8	11.0
OKC 1, OK	11	10	14	16	13	13	15	13.1
Rochester, NY	5	9	7	8	13	14	4	8.6
Springfield, MA	7	15	10	5	14	7	11	9.9
Columbus, OH	14	15	14	22	23	18	20	18.0
Boise, ID	5	11	8	13	12	14	10	10.4
Albany, NY	6	6	4	6	8	3	1	4.9
Lawrence, MA	6	8	6	5	2	8	6	5.9
Worcester, MA	3	3	6	11	6	9	6	6.3
Roselawn, OH	20	18	14	19	13	15	17	16.6
Dayton, OH	11	14	10	16	10	10	8	11.3
Mattapan, MA	5	6	3	7	2	8	14	6.4
Lynn, MA	1	0	1	2	1	4	2	1.6
Cincinnati, OH	8	4	8	18	6	5	3	7.4
Reno, NV	11	7	1	13	8	4	3	6.7
East Albuquerque, NM	6	5	1	6	4	3	3	4.0
Fort Wayne, IN	10	4	6	2	4	2	5	4.7
Spartanburg, SC	9	8	7	11	9	7	5	8.0
Richmond, VA	6	3	0	4	0	7	1	3.0
Toledo, OH	25	26	20	24	36	33	33	28.1
Myrtle Beach, SC	9	9	11	5	6	3	4	6.7
Topeka, KS	8	10	10	4	6	5	13	7.7
Roanoke, VA	6	7	3	5	3	3	2	4.1
OKC 2, OK	4	4	7	4	5	2	8	4.9
Baltimore, MD	4	1	5	2	7	10	1	4.3
Omaha, NE			2	1	3	1	1	1.6
Washington, DC, DC	6	0	2	1	4	5	2	2.9
Montgomery, AL	2	4	6	5	6	3	1	3.9
COMPANY TOTAL	431	380	384	504	446	477	416	434.0

Company	3/1/2007 BA Rate	3/2/2007 BA Rate	3/5/2007 BA Rate	3/6/2007 BA Rate	3/7/2007 BA Rate	3/8/2007 BA Rate	3/9/2007 BA Rate	Average
0 Pueblo, CO	0.165138	0.301587	0.382114	0.092593	0.165138	0.299145	0.125	**0.218673**
1 Colorado Springs, CO	0.466667	0.44	0.324324	0.235849	0.386364	0.324786	0.212121	**0.341444**
2 Denver, CO	0.5	0.107143	0.333333	0.319588	0.329114	0.391304	0.075472	**0.293708**
3 Albuquerque, NM	0.47651	0.392405	0.478873	0.51938	0.410959	0.428571	0.203125	**0.415689**
4 Santa Fe, NM	0.446154	0.246914	0.481818	0.289157	0.269231	0.52	0.35	**0.371896**
5 Aurora, CO	0.354545	0.313559	0.318681	0.351064	0.298969	0.34375	0.178947	**0.308502**
6 Phoenix, AZ	0.478873	0.472527	0.094118	0.388889	0.383333	0.057143	0.458824	**0.333387**
7 Indy 1, IN	0.401515	0.482456	0.293651	0.295082	0.452381	0.375887	0.25	**0.364425**
8 Gary, IN	0.537736	0.61194	0.589041	0.490566	0.452703	0.556522	0.544828	**0.540476**
9 Thornton, CO	0.424528	0.336066	0.315217	0.315789	0.237113	0.353535	0.422764	**0.343573**
10 Greenville, SC	0.325	0.381579	0.329193	0.428571	0.301471	0.315385	0.235294	**0.330927**
11 Columbia, SC	0.561538	0.51145	0.407692	0.434783	0.5125	0.481481	0.414634	**0.474868**
12 Tucson, AZ	0.394231	0.495652	0.378378	0.31068	0.40367	0.428571	0.326316	**0.391071**
13 Charleston, SC	0.303371	0.329268	0.208791	0.192771	0.26506	0.208333	0.258427	**0.252289**
14 Indy 2, IN	0.345679	0.357895	0.382979	0.358491	0.366071	0.37234	0.31	**0.356208**
15 KCK, KS	0.364486	0.394958	0.359649	0.463918	0.425	0.245455	0.366071	**0.37422**
16 Atlanta, GA	0.35	0.2375	0.47619	0.362745	0.467391	0.232558	0.515789	**0.377453**
17 Florence, SC	0.534351	0.646154	0.55	0.416667	0.428571	0.473282	0.435484	**0.497787**
18 Wichita, KS	0.407643	0.417178	0.375723	0.309859	0.381579	0.377622	0.405714	**0.382188**
19 Macon, GA	0.57047	0.550336	0.541935	0.489051	0.532895	0.398496	0.364341	**0.492503**
20 Tulsa, OK	0.364198	0.382022	0.393443	0.457317	0.442857	0.309677	0.422857	**0.396053**
21 Augusta, GA	0.585859	0.473118	0.44186	0.51087	0.48913	0.240506	0.424242	**0.452227**
22 Syracuse, NY	0.352941	0.616541	0.611111	0.646154	0.461538	0.470149	0.401515	**0.508564**
23 Savannah, GA	0.607143	0.368421	0.435897	0.488372	0.505376	0.322581	0.531915	**0.465672**
24 OKC 1, OK	0.421875	0.329412	0.315789	0.191304	0.237037	0.40367	0.428571	**0.332523**
25 Rochester, NY	0.330935	0.381295	0.451852	0.467153	0.387324	0.401575	0.335938	**0.393725**
26 Springfield, MA	0.35461	0.478261	0.408451	0.270833	0.388889	0.323741	0.401361	**0.375164**
27 Columbus, OH	0.594771	0.564706	0.418301	0.416667	0.483871	0.458904	0.531073	**0.49547**
28 Boise, ID	0.338235	0.475248	0.414141	0.305263	0.43	0.39604	0.228261	**0.369598**
29 Albany, NY	0.487395	0.709091	0.4375	0.422764	0.447154	0.381356	0.375	**0.465751**
30 Lawrence, MA	0.402778	0.56701	0.461538	0.415385	0.418919	0.314286	0.258621	**0.405505**
31 Worcester, MA	0.342342	0.663366	0.316239	0.336449	0.365217	0.4	0.258065	**0.383097**
32 Roselawn, OH	0.454545	0.509259	0.43	0.412371	0.360465	0.511905	0.369048	**0.43537**
33 Dayton, OH	0.510638	0.347222	0.261194	0.309353	0.217391	0.352113	0.266667	**0.323511**
34 Mattapan, MA	0.526316	0.545455	0.561644	0.55	0.522388	0.455696	0.493151	**0.522093**
35 Lynn, MA	0.5	0.507463	0.552632	0.468354	0.532258	0.395349	0.385714	**0.477396**
36 Cincinnati, OH	0.543103	0.623853	0.605263	0.578125	0.53913	0.398374	0.507576	**0.542204**
37 Reno, NV	0.360825	0.339806	0.44086	0.206897	0.302083	0.296703	0.302326	**0.321357**
38 East Albuquerque, NM	0.402597	0.362637	0.444444	0.358025	0.319149	0.428571	0.275862	**0.370184**
39 Fort Wayne, IN	0.370787	0.303571	0.378641	0.236559	0.397849	0.367816	0.262626	**0.331121**
40 Spartanburg, SC	0.466667	0.471154	0.428571	0.342593	0.297297	0.338028	0.223404	**0.366816**
41 Richmond, VA	0.474576	0.528571	0.322581	0.409836	0.326531	0.470588	0.395833	**0.41836**
42 Toledo, OH	0.363636	0.503704	0.451613	0.475728	0.46087	0.392523	0.407692	**0.436538**
43 Myrtle Beach, SC	0.465517	0.326923	0.166667	0.222222	0.254902	0.5	0.333333	**0.324224**
44 Topeka, KS	0.56701	0.432624	0.387097	0.532609	0.353535	0.444444	0.357143	**0.439209**
45 Roanoke, VA	0.496552	0.57764	0.5375	0.514793	0.704819	0.406667	0.512821	**0.535827**
46 OKC 2, OK	0.5	0.3125	0.369863	0.386667	0.447368	0.34375	0.3125	**0.381807**
47 Baltimore, MD	0.414966	0.38255	0.397351	0.413793	0.590909	0.372093	0.315436	**0.412443**
48 Omaha, NE	1	1	0.512195	0.145161	0.25	0.323077	0.317073	**0.506787**
49 Washington, DC	0.518868	0.446154	0.358974	0.380531	0.586538	0.340426	0.478992	**0.444355**
50 Montgomery, AL	0.664516	0.930556	0.326087	0.456376	0.387324	0.514493	0.808824	**0.584025**
COMPANY TOTAL	**0.45**	**0.468042**	**0.41094**	**0.389601**	**0.410092**	**0.381997**	**0.378738**	**0.412773**

Company	3/1/2007 Daily Actual	3/2/2007 Daily Actual	3/5/2007 Daily Actual	3/6/2007 Daily Actual	3/7/2007 Daily Actual	3/8/2007 Daily Actual	3/9/2007 Daily Actual	Average
0 Pueblo, CO	$ 21,500	$ 11,400	$ 16,000	$ 19,800	$ 18,600	$ 24,900	$ 14,000	$18,028.57
1 Colorado Springs, CO	13,800	6,500	14,200	13,500	17,400	13,400	8,700	$12,500.00
2 Denver, CO	7,900	8,800	12,900	12,900	12,200	11,000	10,300	$10,857.14
3 Albuquerque, NM	19,100	9,000	13,300	14,800	18,500	18,600	10,500	$14,828.57
4 Santa Fe, NM	8,500	11,300	9,700	13,300	10,000	7,500	8,900	$9,885.71
5 Aurora, CO	13,700	15,600	12,600	14,000	15,100	17,600	15,700	$14,900.00
6 Phoenix, AZ	8,700	13,000	9,300	6,700	9,000	14,900	11,300	$10,414.29
7 Indy 1, IN	10,900	8,900	14,800	13,000	12,300	16,600	16,300	$13,257.14
8 Gary, IN	12,100	10,400	11,900	13,600	18,200	8,700	13,200	$12,585.71
9 Thornton, CO	15,700	19,700	16,100	20,300	19,700	17,400	19,700	$18,371.43
10 Greenville, SC	$ 15,800	7,300	17,900	14,800	15,600	16,000	7,100	$13,500.00
11 Columbia, SC	10,700	11,700	13,700	14,900	12,600	12,200	16,400	$13,171.43
12 Tucson, AZ	11,900	11,000	16,500	14,500	15,200	15,900	13,400	$14,057.14
13 Charleston, SC	16,400	14,800	16,500	13,800	14,700	11,900	16,800	$14,985.71
14 Indy 2, IN	8,700	13,700	12,400	16,400	16,900	12,400	14,800	$13,614.29
15 KCK, KS	12,800	11,300	13,000	11,000	13,400	14,900	12,500	$12,700.00
16 Atlanta, GA	9,000	7,400	8,300	8,800	10,300	9,200	6,800	$8,542.86
17 Florence, SC	16,800	5,600	15,900	15,500	17,500	16,900	7,200	$13,628.57
18 Wichita, KS	18,900	18,200	20,600	20,400	24,300	20,500	17,400	$20,042.86
19 Macon, GA	16,100	14,300	17,100	15,800	15,500	19,000	20,900	$16,957.14
20 Tulsa, OK	26,700	27,800	37,200	23,800	19,000	26,700	27,600	$26,971.43
21 Augusta, GA	9,100	10,700	9,000	11,500	10,300	13,000	14,000	$11,085.71
22 Syracuse, NY	15,100	10,000	10,300	8,200	12,500	9,700	11,100	$10,985.71
23 Savannah, GA	7,000	8,200	13,600	12,800	12,000	14,800	10,400	$11,257.14
24 OKC 1, OK	25,600	20,900	25,000	36,000	29,200	16,000	27,800	$25,785.71
25 Rochester, NY	15,800	13,900	13,600	14,800	18,700	15,700	15,100	$15,371.43
26 Springfield, MA	21,700	20,700	21,900	21,500	22,500	24,700	22,600	$22,228.57
27 Columbus, OH	18,100	20,100	25,300	23,000	21,000	21,400	18,500	$21,057.14
28 Boise, ID	8,000	9,300	8,900	9,600	9,000	9,000	10,400	$9,171.43
29 Albany, NY	13,600	5,300	14,700	15,500	15,800	13,600	16,300	$13,542.86
30 Lawrence, MA	12,500	13,500	11,200	11,100	12,400	12,800	11,500	$12,142.86
31 Worcester, MA	20,500	10,400	19,100	24,200	25,300	21,900	28,000	$21,342.86
32 Roselawn, OH	10,600	9,900	9,400	12,000	9,000	8,800	10,900	$10,085.71
33 Dayton, OH	19,700	19,900	24,800	22,400	22,000	21,700	19,600	$21,442.86
34 Mattapan, MA	11,300	10,900	12,200	10,900	8,500	13,500	12,900	$11,457.14
35 Lynn, MA	9,300	9,100	9,300	8,000	6,400	15,100	9,300	$9,500.00
36 Cincinnati, OH	8,400	7,300	8,200	8,400	7,600	10,600	8,900	$8,485.71
37 Reno, NV	11,600	10,300	10,300	15,700	13,100	11,200	9,900	$11,728.57
38 East Albuquerque, NM	12,300	12,200	8,900	17,900	13,900	13,600	18,100	$13,842.86
39 Fort Wayne, IN	15,300	15,300	17,600	14,600	14,900	12,100	17,200	$15,285.71
40 Spartanburg, SC	9,700	15,400	12,600	13,900	13,100	11,300	15,800	$13,114.29
41 Richmond, VA	8,900	6,500	9,300	10,200	8,200	9,200	6,400	$8,385.71
42 Toledo, OH	12,100	15,800	10,600	10,100	14,600	15,000	16,800	$13,571.43
43 Myrtle Beach, SC	9,100	9,300	8,100	8,400	8,200	5,000	8,400	$8,071.43
44 Topeka, KS	9,000	14,200	13,600	8,700	11,200	8,900	17,100	$11,814.29
45 Roanoke, VA	16,300	13,300	16,100	14,800	12,600	16,900	15,100	$15,014.29
46 OKC 2, OK	8,200	10,600	10,500	8,800	10,400	11,800	11,700	$10,285.71
47 Baltimore, MD	16,900	17,700	17,600	18,300	16,700	16,200	20,900	$17,757.14
48 Omaha, NE			5,400	10,200	10,600	10,100	13,200	$9,900.00
49 Washington, DC	19,500	21,400	22,700	22,800	15,300	20,500	21,800	$20,571.43
50 Montgomery, AL	8,000	1,000	17,500	13,700	15,400	12,600	3,800	$10,285.71
COMPANY TOTAL	678,900	620,800	737,200	749,600	746,400	742,900	733,000	715542.9

FORBA 0236080
CONFIDENTIAL

Company	3/1/2007 Total Patients Seen	3/2/2007 Total Patients Seen	3/5/2007 Total Patients Seen	3/6/2007 Total Patients Seen	3/7/2007 Total Patients Seen	3/8/2007 Total Patients Seen	3/9/2007 Total Patients Seen	Average
0 Pueblo, CO	91	44	76	98	91	82	56	76.9
1 Colorado Springs, CO	72	28	75	81	81	79	52	66.9
2 Denver, CO	43	50	64	68	53	42	49	52.4
3 Albuquerque, NM	78	48	74	62	86	80	51	68.4
4 Santa Fe, NM	36	61	57	59	57	36	52	51.1
5 Aurora, CO	71	81	62	61	68	63	78	69.1
6 Phoenix, AZ	37	48	77	33	37	66	46	49.1
7 Indy 1, IN	79	59	89	86	69	88	99	81.3
8 Gary, IN	49	52	60	81	81	51	66	62.9
9 Thornton, CO	61	81	63	65	74	64	71	68.4
10 Greenville, SC	108	47	108	80	95	89	39	80.9
11 Columbia, SC	57	64	77	78	78	70	96	74.3
12 Tucson, AZ	63	58	69	71	65	56	64	63.7
13 Charleston, SC	62	55	72	67	61	57	66	62.9
14 Indy 2, IN	53	61	58	68	71	59	69	62.7
15 KCK, KS	68	72	73	52	69	83	71	69.7
16 Atlanta, GA	52	61	55	65	49	66	46	56.3
17 Florence, SC	61	23	63	77	84	69	35	58.9
18 Wichita, KS	93	95	108	98	94	89	104	97.3
19 Macon, GA	64	67	71	70	71	80	82	72.1
20 Tulsa, OK	103	110	111	89	78	107	101	99.9
21 Augusta, GA	41	49	48	45	47	60	57	49.6
22 Syracuse, NY	88	51	56	46	77	71	79	66.9
23 Savannah, GA	33	48	44	44	46	63	44	46.0
24 OKC 1, OK	74	57	78	93	103	65	76	78.0
25 Rochester, NY	93	86	74	73	87	76	85	82.0
26 Springfield, MA	91	72	84	105	88	94	88	88.9
27 Columbus, OH	62	74	89	98	80	79	83	80.7
28 Boise, ID	45	53	58	66	57	61	71	58.7
29 Albany, NY	61	32	72	71	68	73	80	65.3
30 Lawrence, MA	43	42	42	38	43	48	43	42.7
31 Worcester, MA	73	34	80	71	73	75	92	71.1
32 Roselawn, OH	48	53	57	57	55	41	53	52.0
33 Dayton, OH	69	94	99	96	108	92	110	95.4
34 Mattapan, MA	27	30	32	27	32	43	37	32.6
35 Lynn, MA	43	33	34	42	29	52	43	39.4
36 Cincinnati, OH	53	41	45	54	53	74	65	55.0
37 Reno, NV	62	68	52	69	67	64	60	63.1
38 East Albuquerque, NM	46	58	50	52	64	52	63	55.0
39 Fort Wayne, IN	56	78	64	71	56	55	73	64.7
40 Spartanburg, SC	40	55	56	71	52	47	73	56.3
41 Richmond, VA	31	33	42	36	33	36	29	34.3
42 Toledo, OH	70	67	51	54	62	65	77	63.7
43 Myrtle Beach, SC	31	35	35	35	38	21	34	32.7
44 Topeka, KS	42	80	57	43	64	55	81	60.3
45 Roanoke, VA	73	68	74	82	49	89	76	73.0
46 OKC 2, OK	29	33	46	46	42	42	55	41.9
47 Baltimore, MD	86	92	91	85	63	81	102	85.7
48 Omaha, NE	0	0	20	53	42	44	56	30.7
49 Washington, DC	51	72	75	70	43	62	62	62.1
50 Montgomery, AL	52	10	93	81	87	67	26	59.4
COMPANY TOTAL	3,014	2,863	3,360	3,381	3,320	3,323	3,368	3232.4

FORBA 0236081
CONFIDENTIAL

EXHIBIT 64

[redacted]
SVP and Chief Compliance Officer
[redacted]

CONFIDENTIAL
FOIL Exempt
FOIA Exempt

March 12, 2012

[redacted]
Assistant Inspector General for Legal Affairs
DHHS Office of Inspector General
Washington, DC 20201

[redacted]
Office of Counsel to Inspector General
DHHS Office of Inspector General
7900 Oak Lane, Suite 200
Miami Lakes, FL 33016

RE: Notice of Material Breach and Intent to Exclude

Dear [redacted] and [redacted]

I am writing to respond to the Notice of Material Breach and Intent to Exclude dated March 8, 2012 (the "Notice"), which Church Street Health Management, LLC ("CSHM") received on March 9, 2012. In that Notice, you stated that the Office of Inspector General ("OIG") of the Department of Health and Human Services has concluded that CSHM is in material breach of several provisions of our Corporate Integrity Agreement ("CIA"), and that the OIG therefore intends to exercise its right under the CIA to exclude CSHM from participation in Federal health care programs if CSHM does not cure those breaches to the OIG's satisfaction. For the reasons set forth hereinafter, CSHM believes that it has either already cured the breaches identified in the Notice, or will have cured them within the thirty day period afforded us under Section X.E.3 of the CIA.

Although we provide great detail in our response below, we believe that the breaches have been cured through numerous corrective actions taken by CSHM. CSHM significantly improved the educational process surrounding certifications as part of the preparation of the Reporting Year 2 Annual Report. Since receiving the Independent Monitor's Reports with respect to Small Smiles Dental Centers of Manassas, CSHM has undertaken a number of significant corrective actions to prevent a similar recurrence. CSHM has revised and distributed policies related to local anesthesia, pulp therapy and protective stabilization, to name a few. CSHM has conducted mandatory training on local anesthesia, pulp therapy and recent policy changes, highlighting the change in the protective stabilization policy.

CSHM has created and begun using a new risk based audit tool. CSHM has effectively reduced the risk of fraud and abuse to the federal government by closely monitoring pulpotomy-to-crown ratios across all CSHM Associated Dental Centers. CSHM has hired a new Chief Dental Officer while retaining the former Chief Dental Officer (to ensure high quality training programs, research papers and policy development). For these, and other reasons set forth more fully below, CSHM believes that exclusion is not warranted or appropriate in this case.

CSHM recognizes that its performance under the CIA has been deficient, and that the OIG has been dissatisfied with our performance in many respects. CSHM's shortcomings in Year 1 of the CIA are well documented at this point. Since taking over as Chief Compliance Officer last spring, however, I and CSHM have devoted ourselves to improving CSHM's compliance program, and I believe that overall we have made great strides in that effort. Nothing means more to us than continuing to serve and support our associated dental centers, so that they, in turn, can provide high quality services to an under-served segment of our population. We believe that CSHM's continued existence is essential to meeting critical healthcare needs that would otherwise go unmet. As you know, access to dental care remains an intractable problem for low-income children and families in this country. CSHM is dedicated to meeting that need, and doing so in a manner that is consistent with the highest quality standards of care and in compliance with Federal health care program requirements. Last year, our associated dental centers had over one million patient visits, the vast majority of which involved the provision of basic oral hygiene care and preventative treatment such as sealants. We hope that the OIG will permit us to continue serving and supporting our associated dental centers, as we continue to strengthen and improve our compliance program.

We understand that under the terms of our CIA, CSHM has thirty days to respond to the Notice. CSHM is submitting this response within one business day of receiving the Notice, however, because our cash position is tenuous at best and we are candidly out of time. Accordingly, we are forced to ask that the OIG take the extraordinary step of expediting its review of this response. We respectfully request that the OIG schedule a meeting on Tuesday, March 13, 2012 with CSHM and representatives of its senior lenders to discuss CSHM's response, and let us and our lenders know whether CSHM has cured the material breaches to the OIG's satisfaction by no later than **5:00 p.m. CST on Wednesday, March 14, 2012.** We make this request only because, without a response by that time, CSHM will not be able to regain access to cash and move forward with its proposed restructuring and will instead have to move to a liquidation.

Upon receipt of the Notice, CSHM became unable to borrow funds under its Debtor-in-Possession Credit Facility and does not have funds sufficient to cover accruing payroll and other obligations. In addition, the lenders under the DIP Credit Facility have indicated that they are not willing to go forward with the proposed restructuring if CSHM is subject to potential exclusion. This means that on Thursday of this week, we will likely be required to convert from a Chapter 11 reorganization to a liquidation proceeding under either Chapter 7 or 11 of the Bankruptcy Code. We believe liquidation under these circumstances will result in the closure of associated dental centers, which in turn will deprive children of much needed access to care and result in more than 1,500 lost jobs across the United States. CSHM will also no longer be able to meet its payment obligations to the Department of Justice and the settling states. We have been

working diligently to avoid that result and hope that you will work collaboratively with us to avoid this dire outcome.

Set forth below is an Executive Summary of CSHM's response to each alleged material breach, as well as a more detailed Discussion about how CSHM has either already addressed the deficiency or will do so within 30 days.

EXECUTIVE SUMMARY

Management Certifications and Accountability

We believe that CSHM has addressed the alleged material breach regarding certifications submitted with our first Annual Report to the OIG on March 15, 2011, for the following reasons:

- None of the "Certifying Employees" identified in the Notice continue to be Certifying Employees. [redacted] ceased to be an employee and owner of the Manassas, Virginia dental center in January 2012 and is no longer associated with CSHM or any other associated dental center. In addition, I replaced the former Chief Compliance Officer in April 2011, and we hired a new Chief Dental Officer in January 2012.

- We have implemented significant training and revamped our process for certifications to be submitted with our Reporting Year 2 Annual Report, to ensure that every Certifying Employee understands the importance of the certification, and his or her obligation to proactively review and confirm that the area(s) under their supervision were in compliance with all applicable Federal health care program requirements, state dental board requirements and the obligations of the CIA. The training and process changes are described in detail in the discussion section below.

CSHM's Review of the Monitor's Findings at Manassas Center

CSHM has cured, or within 30 days will cure, the alleged material breaches relating to the Manassas Center as follows:

- CSHM has implemented additional policies and procedures to ensure compliance and quality of care at the Manassas Center and other associated dental centers. These include revised policies regarding protective stabilization, local anesthesia and appropriate amount of treatment in a single visit, and subsequent training on these policies. We also implemented a revised audit template to better assist our Clinical Auditors in identifying quality of care, coding and billing issues, and we continue to refine our Clinical Risk Assessment Focus Tool (CRAFT) and information systems to better identify and respond to quality of care and compliance issues. These are described in greater detail in the discussion section below.

- CSHM has cured, or has taken steps to cure, the alleged material breach relating to billing and reimbursement by refunding fees received for services specifically cited in the Monitor's September 22, 2011 Desk Audit Report, including a proportionate amount of fees for pulpotomies performed by the former lead dentist in the Manassas Center based on an error rate of medically unnecessary pulpotomies. Some of the payors have returned the refunds checks without cashing them and CSHM has reissued these refunds to the payors (along with additional correspondence regarding the reason for the refund). CSHM has also initiated refunds for medically unnecessary services specifically cited in the Monitor's December 23, 2011 Site Visit Report.

- In January 2012, the lead dentist for the Manassas Center ceased to be employed by the center and all of her relationships with CSHM or its associated dental centers were terminated. In addition, the Manassas Center is in the process of being closed or sold to a third party by the center's owner, and CSHM will cease to have any relationship with the Manassas Center on or about the end of April, 2012. Steps are being taken to facilitate a transition of patients to a new provider in accordance with Virginia law. In the interim, CSHM is continuing to implement a corrective action plan to ensure compliance at the Manassas Center.

CSHM's Change to Termination Policy and Procedure

CSHM has cured the alleged material breach regarding CSHM's policies and procedures in terminating its relationship with Covered Persons found to have violated professionally-recognized standards of health care:

- Effective today, CSHM revised its policy regarding "Adverse Events, Quality of Care Reportable Events, and OMIG Patient Care Matters" to provide for termination of practitioners who have violated professionally recognized standards of healthcare, and delete reference to the possibility of remediation plans developed by the Chief Dental Officer and approved by the OIG. A copy of the revised policy is attached to this response as **Attachment W**.

- In a September 26, 2011 Quality of Care Reportable Event notice and subsequent conference call, CSHM proposed a remediation plan for a Covered Person who was found to have violated professionally recognized standards of care. The Covered Person was terminated this morning.

CSHM's Review of Pulp-to-Crown Ratios and Provision of Medically Unnecessary Services at Other CSHM Facilities

CSHM will cure the potential material breach relating to 12 dentists identified as having a relatively high pulp-to-crown ratio as follows:

- Within 30 days, CSHM will conduct a post-payment claims audit targeting pulpotomies performed by these 12 providers and promptly refund any amounts associated with medically unnecessary pulpotomies. Our Chief Dental Officer will prepare or oversee an analysis of a statistically-valid sample of pulpotomies performed by these 12 providers during a specified period, and an error rate for medically unnecessary pulpotomies will be determined based on this analysis. The error rate will be applied to the total amount of pulpotomies performed by each of the 12 providers during an almost two-year period to determine the amount of any repayment obligations.

- If the post-payment claims audit results in a repayment obligation in excess of $15,000, CSHM will report these as Substantial Overpayments in accordance with the CIA. In addition, if our Chief Dental Officer determines that a Quality of Care Reportable Event has occurred, we will report the event in accordance with the CIA. We will also terminate our relationship with any provider who is found to have violated professionally recognized standards of care.

- CSHM has also implemented a Progressive Corrective Action Plan to identify pulp-to-crown outliers and provide focused provider communication and education. This plan and related communication and education are described in greater detail in the discussion section below.

Quality of Care Reportable Event Requirements

Earlier today, CSHM cured the alleged material breach regarding failure to provide requisite notice to the Virginia state licensing board by sending written notice to the Virginia state licensing board of CSHM's investigation and corrective actions with respect to the Manassas Center. A copy of the notice is attached as **Attachment BB** to this response.

DISCUSSION

Set forth below is CSHM's response to each alleged material breach. In each case, we have included detailed information about how CSHM has either already addressed the deficiency or plans to do so promptly.

Management Certifications and Accountability

The first breach identified by the OIG in its Notice relates to the certification signed by [redacted], former Lead Dentist of the Small Smiles Dental Centers of Manassas ("Manassas Center") under Section III.A.7 of the CIA, which CSHM submitted with its first Annual Report to the OIG on March 15, 2011. The Notice also references CSHM's previous submissions of false certifications by CSHM's former Chief Compliance Officer and former Chief Dental Officer, which resulted in the imposition of Stipulated Penalties by the OIG in May 2011. As you know, [redacted] is no longer employed by any

CSHM Associated Dental Center as of January 20, 2012. In addition, as more fully detailed below, CSHM is in the process of terminating the Management Services Agreement with the Manassas Center and assisting the owner with closing or selling the practice.

CSHM recognizes that it is impossible as a practical matter to go back and "cure" [redacted] false certification. However, when I took over as Chief Compliance Officer last year, I recognized that CSHM's approach to the certification process for its first Annual Report could be improved. Accordingly, in connection with the certifications for the second Annual Report, I took several critical steps to proactively revamp the process to ensure that every Certifying Employee appreciated and understood the importance of their certification, and understood their obligation to proactively review and confirm that the area(s) under their supervision were in compliance with all applicable Federal health care program requirements, state dental board requirements and the obligations of the CIA.

On December 8 and 9, 2011, CSHM held its General Compliance Training required under Section III.C.1 of the CIA. Attendance was mandatory for all Covered Persons and all certifying individuals received this training. The annual certification process was covered in this mandatory training.[1] The training around annual certifications was much more extensive than in Reporting Year 1. The annual certification process was covered by my predecessor in Year 1 by stating that the annual certification is to certify that "they complied with everything they were supposed to comply with and are not aware of any violations". The slide outlining the certification process does not specify any further details, including who is required to certify.[2]

The annual certification process was a featured topic in both December 2011 and January 2012 Compliance Liaison meetings. As most certifications had been obtained prior to the February 2012 meeting, the topic was not covered in that Compliance Liaison meeting. The full presentations from these meetings are included as **Attachment C** with the relevant slides placed at the front of the presentation.

CSHM's efforts in December 2011 and January 2012 to ensure that Compliance Liaisons had a solid understanding of the certification process were the culmination of other significant changes I made to Compliance Liaison meetings in 2011. Beginning with the May 2011 meeting, Compliance Liaison meetings have been conducted in the form of webinars. The communicated vision of Compliance Liaison meetings has been to achieve a "train the trainer" approach with respect to compliance matters. I believe the Compliance Liaisons learn and retain more from these monthly meetings when they not only hear the discussion, but also have materials to view. (My predecessor conducted conference calls in the monthly meeting rather than webinars.) To further ensure retention of the subject matter by the Compliance Liaison and to provide continual reminders of compliance matters to all other staff, the Compliance Liaisons have been instructed that one of their responsibilities is to then train their staff on the

[1] Copies of the full presentation are included as **Attachment A**. The relevant slides discussing the annual certification process have been placed at the front of the presentation. The full presentation that includes the audio component of the training has been placed on a CD that will arrive to your office today. Due to the size of that file, the full presentation is too large to send in any manner other than overnight delivery.

[2] The single slide covering the annual certification process in Reporting Year 1 General Compliance Training (which was held a full year prior to obtaining the certifications) is included as **Attachment B**.

information presented in Compliance Liaison meetings. To ensure that they do so, the presentation used in the meeting is immediately uploaded to CSHM's intranet after each Compliance Liaison meeting. A member of the Compliance Department has been polling the Compliance Liaisons approximately 2 weeks after each Compliance Liaison meeting using email voting polls. The voting poll inquires as to whether the Compliance Liaison has shared the information from the most recent Compliance Liaison meeting with their staff. Again, the annual certification process was a featured topic in both December 2011 and January 2012 Compliance Liaison meetings. In contrast, I have reviewed the minutes of December 2010 through March 2011 Compliance Liaison meetings and noted that my predecessor did not discuss the annual certification process at all in these meetings.

The annual certification process was also discussed in detail in CSHM's January 2012 Compliance Committee meeting. During that meeting, I previewed the educational process I would be deploying (as described in subsequent paragraphs) with respect to the annual certifications. On January 26, 2012, I held mandatory conference calls for all individuals required to sign a certification as part of CSHM's Reporting Year 2. The calls were held at 11:00, 12:00 and 1:00 CST to allow for individuals in CSHM Associated Dental Centers to attend these calls during lunch hours or at an alternative time, depending on the treatment needs in the dental center that particular day. During these calls, I walked through a memorandum that had been provided via e-mail on January 25, 2012 to each individual required to sign the annual certification. The e-mail showing that the memorandum was provided to each certifying individual on January 25, 2012, is included as **Attachment D**. I am also including as **Attachment E** my copy of the internal memorandum that shows my talking points during these calls.

I began the calls by explaining the goals and purpose of the mandatory meeting. My first goal was to remove the mystery of the certification process. My intent was to provide concrete and detailed reminders as to what each individual would be certifying to without creating a "scary" process. I also explained that it was my belief that by the end of the call each participant would be able to see that the certification relates to topics that they would find quite familiar because these topics are part of CSHM's and the dental centers' daily practices and culture. My second goal was to stress the importance of the annual certification. I shared that these certifications should not be taken lightly and reiterated what an important component of the Annual Report the certification represents. My third goal was to ensure that the annual certification process was understood and could be explained by the individual signing the certification. I emphasized to the group that the certification should not be signed thoughtlessly, but only after careful consideration of its requirements.

I then reminded each certifying individual that at the most basic level, compliance can be boiled down to 3 things: i) following professionally recognized standards of care (including AAPD guidelines and dental board regulations), ii) federal program healthcare requirements, and iii) compliance with our CIA. My goal was then to translate formal, legal sounding phrases into the everyday associations by using the geography of each dental center. You can see the key phrases that are highlighted on my talking point copy that I discussed during each call and how the memorandum correlates to CSHM's CIA.

Finally, I discussed three things that I recommended each individual do before signing a certification: i) personal due diligence, ii) viewing the annual Compliance Training (if they had not already done so), and

iii) using that training as a point of reference when conducting personal due diligence and reviewing the CIA. I wrapped up the call by asking each certifying individual to call me if they had any questions about the annual certification process of if they had any exceptions to note. I shared my contact information once more. No such communications were delivered by my predecessor when obtaining the annual certifications for Reporting Year 1.

Although we have identified improvements undertaken in Reporting Year 2 that did not occur in Reporting Year 1, CSHM believes it is important to provide details regarding the Reporting Year 1 certification process. As I signed a certification submitted as part of the Reporting Year 1 obligation, I can share my personal experience. My predecessor hand delivered the certification for me to sign and offered to answer any questions that I had about the process or the CIA. While I did not observe my predecessor's entire process, I have no reason to believe that she did not follow this same process with every other Certifying Employee at the management company. I also confirmed through a review of my predecessor's emails that she conducted a certification call with CSHM's Regional Operations teams, the Chief Operating Officer, and the Patient Advocate to equip them to answer any questions about the certification process prior to obtaining certifications from Certifying Employees in CSHM Associated Dental Centers. The Operations teams then assisted in obtaining the Reporting Year 1 certifications from CSHM Associated Dental Centers.

For all the reasons set forth above, we believe CSHM is in compliance with the obligations of the CIA with respect to Reporting Year 2 annual certifications and plan to submit the required Reporting Year 2 annual certifications as part of our Annual Report due March 14, 2012.

Policy and Procedure Requirements

CSHM's Review of the Monitor's Findings at Manassas Center

The OIG has found CSHM to be in material breach of the CIA based upon CSHM's failure to comply with Sections III.B.2.d, III.B.2.g, III.B.2.n, and III.B.2.u of the CIA, and found the severity of the quality of care concerns identified by the Monitor at the Manassas Center to be a flagrant violation of the CIA.

As detailed in the Notice, CSHM has previously acknowledged that we "failed to take adequate steps to address and correct quality of care issues that [the Monitor] identified in [the] September 22, 2011 report regarding [the Manassas Center]." CSHM also acknowledged the "ineffectiveness of corrective actions taken to date" at the Manassas Center. We agree with the OIG that the Monitor identified serious quality of care concerns at the Manassas Center. As previously noted, [redacted] is no longer employed by any CSHM Associated Dental Center as of January 20, 2012. In addition, as more fully detailed below, CSHM is in the process of either terminating the Management Services Agreement with the Manassas Center, or assisting the owner with closing the practice. We also recognize that, despite marked improvement in Manassas, the corrective action plans ("CAPs") we implemented after the Monitor's Desk Audit Report were not fully effective. As we will not be satisfied with less than full compliance with CAP's, we characterized our responses accordingly.

However, our January 13, 2012 response to the Monitor's Site Visit Report regarding the Manassas Center also acknowledged that [redacted] was changing her practice patterns because of the implementation of our corrective action plan. Examples of clinical improvements identified since the inception of the CAP included:

- A decrease in [redacted] pulp-to-crown ratio from 97% pre-CAP to 53% post-CAP
- A 50% decrease in stabilization utilization by [redacted] post-CAP
- No instances of protective stabilization in the Manassas Center for longer than 45 minutes post-CAP per recent clinical chart audits
- A dramatic reduction in the number of cases involving 6 or more crowns in a single visit (from 18 cases pre-CAP, to 1 case post-CAP)
- Clinical chart audits showing appropriate injection techniques with at least .5 carpules of anesthesia delivered post-CAP

Again, CSHM acknowledged in our January 13, 2012 response that, our actions had not resulted in the intended effect – namely full compliance. By our own admission, we still view the Manassas findings from the Monitor's reports as failures on our part. We were not successful in preventing each and every instance of the provision of care that fell below professionally recognized standards of care. However, we note that DentaQuest, which administers the Medicaid dental program for Virginia, recently fully reinstated [redacted] to treat and receive reimbursement for treatment of Medicaid patients (CSHM was not involved in the appeal or reinstatement process). Notice of [redacted] reinstatement is included as **Attachment F**. We believe that the clinical changes described above and the decision by DentaQuest to reinstate [redacted] shows that while we were not yet 100% effective in implementing our corrective action plan, she demonstrated a certain degree of improvement. With that said, we do not accept "a degree of improvement" as an acceptable outcome to our corrective action plans.

Through CSHM's monitoring of the CAP implemented after the Monitor's Desk Audit report regarding the Manassas Center (again, with summaries of certain metrics presented above), CSHM sincerely believed that we were effectively executing the CAP. CSHM fully expected the site visit to result in outcomes similar to other recent reports from the Monitor. We cite these recent Monitor reports to provide concrete examples of CSHM's commitment and ability to implement effective and timely corrective action plans and monitor compliance with such plans. For example, the Monitor previously expressed serious concerns about the quality of care in Small Smiles Dental Centers of Beaumont ("Beaumont Center"), based upon a site visit in early 2011.

After we implemented corrective actions, the Monitor's February 15, 2012 Site Visit report regarding the Beaumont Center offers as its first critical finding: "Overall, the Monitor was able to determine the recommendations from the on-site visit in February 2011 had been taken seriously and corrective action was implemented." Additionally, the February 15, 2012 Report noted improvements in several areas:

- Staff interviewed articulated they now use a gauze shield during treatment to prevent swallowed objects. Staff members interviewed articulated dental assistants are no longer re-cementing stainless steel crowns (SSCs).

- While there were still some findings related to documentation, overall, the documentation has improved. The Monitor noted there have been multiple trainings throughout the year related to chart documentation.
- The Monitor observed one dentist reviewing previous Health History forms prior to treatment. The CDO has also issued a Best Practices e-mail addressing this issue and CSHM modified a form to include a checklist that requires the dentist to indicate the health history was reviewed.
- The Monitor observed the appropriate use of nitrous oxide inhalation analgesia.
- With the exception of one dentist[3], the Monitor observed proper injection techniques that lessened the awareness of discomfort during the injection. The Monitor also observed dentists routinely checking for adequacy of anesthesia before beginning treatment.
- Two dentists and the dental assistants demonstrated excellent behavior management skills.
- Staff members and dentists reported they are not feeling rushed.
- Staff members evidenced knowledge and comfort with using the hotline. The Monitor noted four hotline complaints since the prior visit[4].

Similarly, the Monitor performed a desk review of Small Smiles Dental Centers of Austin ("Austin Center"), issuing a report on July 29, 2011. The Monitor's February 2, 2012 report regarding a follow up site visit to the Austin Center notes the following critical finding:

> "Although the record review findings from the Monitor's visit to the Clinic show some of the same documentation deficiencies found in the desk review, it appears CSHM and Clinic staff members are implementing measures to address those issues. The Clinic has implemented an internal chart audit process to address chart documentation issues. During morning huddles, the Monitor observed training related to Tooth Chart documentation and medical necessity. The Clinic Coordinator also discussed documentation issues that were found through the internal chart audit process. Chart documentation and quality of care issues related to slot restorations and medical necessity have been addressed by CSHM through training and should be monitored more

[3] As of February 8, 2012, this dentist was separated from any CSHM Associated Dental Center.

[4] CSHM actively and routinely promoted the Disclosure Program after the Monitor's Site Visit Report, recognizing that the Disclosure Program is a critical source for detecting quality of care issues. CSHM's Chief Operating Officer held a conference call with all leadership teams in all CSHM Associated Dental Centers in April 2011 with the express purpose of educating leadership on the importance of CSHM's Hotline and CSHM's non-retaliation policy. CSHM provided wallet cards to each employee in May 2011 that included the phone number for CSHM's Hotline. CSHM included the Disclosure Program or CSHM's non-retaliation policy in monthly Compliance Liaison webinars in April, May, June and August 2011. The Disclosure Program was also the topic emphasized by the Chief Compliance Officer in CSHM's 3rd Quarter 2011 "Word of Mouth" newsletter which is provided to all employees. Finally, the Disclosure Program was heavily emphasized as part of CSHM's General Compliance Training conducted in December 2011.

> accurately with the implementation of the new chart audit tool initiated in November of 2011. In addition, the quality of care issue related to slot preparations in primary molars was addressed in [redacted] Best Practices dated November 22, 2011. The Monitor did not find evidence of the continuation of slot restorations being performed on primary molars during the record review process or treatment observations."

Finally, in the Monitor's March 7, 2012 site visit report on Small Smiles Dental Centers of Reno, the Monitor reported the following critical finding: "CSHM's chart audit process and Clinical Risk Assessment Focus Tool (CRAFT) have been effective in identifying and monitoring the overuse of X-rays."

As the Manassas Reports obviously did not reflect outcomes similar to those in Beaumont, Austin and Reno, CSHM has taken a number of corrective actions to prevent the provision of care that falls below professionally recognized standards of care. These global corrective measures began with Behavior Management training on September 27 and 29, 2011 which was mandatory for all staff in all CSHM Associated Dental Centers. Also, as a direct result of the Manassas reports, CSHM revised a number of policies, including the protective stabilization policy, the local anesthesia policy, and the policy on appropriate amount of treatment in a single visit. CSHM added new information on policies related to pediatric restorative dentistry, pulp therapy, and documentation of medical necessity. The Behavior Management training course materials are included as **Attachment G**[5]. Each of the policy revisions or additions is included in **Attachments H and I**. Prior to memorializing the guidance into policies in January 2012, the information was provided in the form of Best Practice Memos. Best Practices Memos dated November 22, 2011 and January 19, 2012 are included as **Attachments J and K**. The January 19, 2012 Best Practice Memo provides further information regarding the protective stabilization policy change.

CSHM took measures to ensure that the relevant portions of the policies and procedures were distributed to all individuals whose job functions relate to those policies and procedures. These measures included: i) providing information regarding policy changes in the December 2011 and January 2012 Compliance Liaison meetings (with dissemination practices as described in a previous portion of this response), ii) distributing an informational memorandum to all CSHM Associated Dental Centers, along with instructions to the Office Managers for distributing the policies and tracking signatures that Covered Persons had received the relevant portions of the new or revised policies and procedures that relate to their job function, iii) mandatory trainings for dentists on local anesthesia conducted on December 14 and 15, 2011, iv) mandatory training for dentists on pulp therapy conducted on February 28 and 29, 2012, and v) a mandatory Clinical Issues webinar for dentists that highlighted recent policy revisions conducted on January 17 and 18, 2012. The January 2012 Compliance Liaison meeting slides are included as **Attachment L**. The email instructions and informational memos regarding the policy dissemination

[5] The full presentation that includes the audio component of the training has been placed on a CD that will arrive to your office today. Due to the size of that file, the full presentation is too large to send in any manner other than overnight delivery.

process are included as **Attachments M through O**. The course materials for the local anesthesia, pulp therapy and clinical issues trainings are included as **Attachments P through R**[6].

Also in response to the Monitor's Manassas Desk Audit Report (and other desk audit reports received prior to the Manassas Report), CSHM began using a revised audit template for November 2011 audits and thereafter which incorporates the recommendations of the Monitor from numerous Desk Audits. CSHM believes that the revised template better assists Clinical Auditors to systematically and proactively identify quality of care issues like those raised by the Monitor in the Manassas Center. The creation of the revised chart audit template began with the completion of a Risk Assessment. The Risk Assessment was a collaborative effort that included CSHM's Chief Compliance Officer, Chief Dental Officer, and Chief Operating Officer, with presentation to the Compliance Committee of CSHM's Board of Directors. Once the risk profile was categorized, CSHM considered controls in place to mitigate the risks identified as well as gaps in controls requiring further consideration. CSHM identified opportunities for improvement as well as controls that needed strengthening and began diligently working towards systems modifications.

With respect to the chart audit modifications, nine major risks were identified in the Risk Assessment. The following subsets of some of those risks were identified as major components of the Chart Audit Process:

1. Overtreatment/undertreatment
2. Lack of long term care follow through
3. Missed diagnoses
4. Improper use of local anesthesia
5. Lack of follow up on health histories
6. Improper use of stabilization
7. Improper use of nitrous oxide
8. Adverse events
9. Lack of documentation of medical necessity
10. Lack of informed consent
11. Substandard quality of care
12. Coding/billing inaccuracies

CSHM's Chart Audit Process Task Force worked risk-by-risk to identify "what could go wrong" and how to identify potential problem areas in the dental records. The Task Force then drafted questions that must be asked in the revised Chart Audit Tool to prompt CSHM's Clinical Auditors to identify quality of care matters and ensure that the Chart Audit Process would be a strong control to mitigate identified risks. The Chart Audit Task Force then cross referenced against CSHM's existing Chart Audit Tool and recent Desk Audit Reports from the Monitor to ensure the questions included in the revised Chart Audit Tool

[6] The full presentation that includes the audio component of the training has been placed on a CD that will arrive to your office via overnight mail today. Due to the size of that file, the full presentation is too large to send in any manner other than overnight delivery.

were comprehensive. Finally, the Task Force wrote guidelines for scoring, including defining when matters must be escalated to CSHM's Chief Dental Officer for further review.

In summary, CSHM has invested considerable resources into the development of a risk based Chart Audit Tool with clear and instructive guidelines. Every CSHM Clinical Auditor was part of each Chart Audit Tool development session, which also included CSHM's Chief Dental Officer and Chief Compliance Officer (while not clinical, I have an audit background). These development sessions were designed to thoroughly equip each Clinical Auditor to identify quality of care issues and provided the opportunity to learn from CSHM's Chief Dental Officer. CSHM submitted the revised Chart Audit Tool to all leadership teams at all CSHM Associated Dental Centers for review and comment in October 2011. Additionally, all staff members in CSHM Associated Dental Centers were trained on the revised Chart Audit Tool on October 25 and 26, 2011. During September and October 2011, CSHM piloted the revised Chart Audit Tool simultaneously with the existing audit tool to ensure that auditors had a high degree of familiarity before full implementation began. Again, CSHM implemented the revised Chart Audit Tool for all audits conducted in November 2011 and thereafter. CSHM believes that the modifications have greatly improved CSHM's ability to detect and respond to quality of care issues and CSHM continues to seek steps to improve upon this newly revised process and system for auditing. The audit template used prior to November 2011 is included as **Attachment S**. The revised audit template questions and guidelines are included as **Attachment T**.

CSHM also continues to refine our process for identifying and responding to quality of care matters through the Clinical Risk Assessment Focus Tool ("CRAFT"), a data mining tool with focus on certain pre-set filters (such as cases having 7 or more crowns, 7 or more pulpotomies, 11 or more fillings, and 6 or more extractions). CSHM's recently appointed Chief Dental Officer, [redacted], has been appointed as the Chair of the CRAFT Committee. Although he has only been employed with CSHM since January 30, 2012, he has carefully studied CRAFT reports and minutes from the past year in order to identify recommendations and modifications to improve this process as a means for reviewing patient care matters such as quality protocols, quality assessments, patient safety issues and utilization reviews. [redacted] is planning to present his proposed modifications to the CRAFT program in an upcoming visit with the Monitor on April 12, 2012. [redacted] is Board Certified in Pediatric Dentistry and someone who chose to come to CSHM precisely for one reason – to drive and improve the quality of care provided by dentists in the CSHM Associated Dental Centers. [redacted] is an experienced clinician who has already begun making an immediate impact in the 4 centers he has visited during his brief tenure. [redacted] curriculum vitae are included as **Attachment U**. We have great confidence in [redacted] and we believe that he will enable us to make huge strides in mentoring and training the dentists who work in CSHM Associated Dental Centers. I hope that you will give us, and [redacted], the opportunity to demonstrate that CSHM can make a difference in driving quality of care in CSHM Associated Dental Centers. As we stated in our January 13, 2012 response to the Monitor's Site Visit of Manassas, driving quality of care in CSHM Associated Dental Centers is the goal of our Corporate Integrity Agreement, and it is the right thing for the centers and the patients served.

CSHM has also undertaken programming modifications to review key metrics identified as high risk, such as number of teeth treated in a single sitting. The SQL programming is extremely complex for these

query modifications, especially in light of the architecture of the data tables storing information in the patient accounting system used by CSHM Associated Dental Centers. The programming necessary to modify our process for record selections in quarterly chart audits or CRAFT audits is in the final stages, with CSHM's Internal Audit Department actively engaged in testing the queries. In summary, CSHM's vision for the CRAFT Committee is to maintain sharp focus on indicators which represent the highest risk to the patients served by CSHM Associated Dental Centers. We are confident that under [redacted] leadership CSHM will further improve processes to routinely monitor key metrics and outliers to ensure our reviews appropriately aid in the detection of important quality of care issues.

The Notice also cites a material breach on the part of CSHM with respect to Section III.B.2.n of the CIA, specifically as the Monitor identified issues relating to billing for services not rendered in the September 22, 2011 Desk Audit Report. In that report, Patient #006 was identified by both CSHM and the Monitor as having a periapical radiograph taken on tooth #E and an additional periapical radiograph taken of tooth #O per the patient's Account History Report while the documentation in the record reflects that no radiographs were taken due to poor cooperation by the patient. The Monitor further states that the documentation received from the Clinic to complete the Desk Audit did not indicate that the billing error had been corrected. CSHM's October 31, 2011 response to the Monitor's Desk Audit Report indicated that CSHM received confirmation from the Office Manager on October 24, 2011 that the refund had been initiated with respect to patient #006. CSHM confirmed on January 16, 2012 that the payor had processed the recoupment for the two radiographs totaling $22.36. The Notice does not cite other instances of billing for services that were not rendered as part of the December 23, 2011 Site Visit Report.

CSHM also infers that the Notice references a violation of Section III.B.2.n in the CIA because the dental records used for billing and reimbursement did not support medically necessary services. CSHM confirmed that the Office Manager initiated refunds with respect to specifically identified medically unnecessary services presented in the Monitor's September 22, 2011 Desk Audit Report. CSHM also developed an error rate with respect to medically unnecessary pulpotomies and applied this error rate to the full population of pulpotomies performed by [redacted] from January 15, 2010 (the date CSHM entered into a CIA) through September 26, 2011 (the day before initial corrective actions occurred). CSHM issued checks to the affected payors in November 2011. While the majority of payors have accepted the refunds based upon our self disclosure, certain of these payors have returned the checks to CSHM without cashing them, despite the provision of a lengthy letter to the payors detailing the circumstances giving rise to the repayment obligation. CSHM has researched who the Chief Financial Officer is for each of these payors and has reissued checks that were sent to the CFO rather than the refunds department with an accompanying letter explaining the circumstances as an additional effort to refund this money to the payor. CSHM also confirmed with the Office Manager that she had initiated refunds with respect to specifically identified medically unnecessary services stemming from the Monitor's Site Visit Report.

Finally, CSHM did not immediately comply with the obligation under Section III.B.2.u of the CIA to terminate is relationship with the dentists at the Manassas Center as a result of the findings of the Monitor that the dentists violated professionally recognized standards of care. As detailed in our January 13, 2012 response to the Monitor's Site Visit, CSHM earnestly believed that the greater good would be served by

retraining and rehabilitating [redacted] In retrospect, we acknowledge that this decision was in conflict with the terms of the CIA. Although the approach we took was genuinely well intentioned, we recognize that it was misguided. CSHM notified the OIG on January 26, 2012 that [redacted] had separated from the Manassas Center and was no longer the owner of the Virginia Centers as of January 20, 2012[7].

The employees of the Manassas Center, including the Associate Dentist, were notified in person on February 27, 2012 of two possible fates for the Manassas Center: termination of the Management Services Agreement with CSHM and the closure or sale of the Manassas Center. CSHM, on behalf of the owner of the Manassas Center, has identified a third party interested in purchasing the Manassas Center or its assets from the current owner so that the Center could continue to provide access to care in the Manassas, Virginia community. If the interested party (or any other potentially interested party) does not commit to close the transaction to own the Manassas Center or its assets in the near term, the Manassas Center will close. A notice in accordance with the provisions of Section IV of the CIA is enclosed as **Attachment V**.

CSHM's Board of Directors voted to explore the options for exiting the MSA with the Manassas Center on January 27, 2012. However, because of the severity of the quality of care concerns identified by the Monitor at the Manassas Center, CSHM nevertheless continued implementing the Corrective Action Plan submitted as part of the January 13, 2012 response to the Monitor's Site Visit Report as if the termination of the MSA was not imminent. CSHM strongly believes that despite the impending separation between CSHM and the Manassas Center, monitoring the quality of care and compliance with the CAP is critical for the duration of the relationship between CSHM and the Manassas Center. CSHM's Chief Dental Officer and I visited the Manassas Center on February 2 and 3, 2012, performing various steps in the CAP. Notably, the Chief Dental Officer confirmed that no more than two quadrants had been treated in a single visit during the month of January 2012 and that a protective stabilization device had not been used in the Manassas Center during that time period. The CAP provides for visits to the Manassas Center every other month for the initial monitoring period. In the event that CSHM is still providing management services to the Manassas Center through the end of April 2012, the Chief Dental Officer and I will visit the Manassas Center again to monitor compliance with the CAP and evaluate quality of care rendered. CSHM will also continue to monitor the quality of care provided at the Manassas Center through chart audits, monthly CRAFT outlier reviews and the Disclosure Program.

With respect to the Opportunity to Cure provisions in the Notice, CSHM believes that:

- Through the numerous corrective measures deployed and described above with respect to Section III.B.2.d and III.B.2.g, CSHM believes the alleged material breach has been cured.
- CSHM has taken action to cure the material breach with respect to Section III.B.2.n.4 of the CIA by reporting all identified overpayments to federal (state) health care programs

[7] Please note that CSHM has evidenced understanding of the obligation to terminate its relationship with any Covered Person who has been found to violate professionally recognized standards of care in connection with the termination of the Lead Dentist at the Albany Access Dentistry Center, as communicated in the most recent Quality of Care Reportable Event notice submitted to the OIG on December 2, 2011.

and other payors. CSHM will consider the breach fully cured when the payors have cashed the checks issued to repay the overpayment. CSHM will routinely follow up with payors to ensure that they have processed the repayment.

- CSHM has taken action (prior to receipt of the Notice) to cure the material breach with respect to Section III.B.2.u of the CIA and is in the process of terminating the MSA in an orderly manner that complies with the required timelines to ensure continuity of care for patients as stipulated by the state of Virginia regulations.

CSHM's Change to Termination Policy and Procedure

The OIG has found CSHM to be in material breach of the CIA based upon CSHM's failure to comply with Section III.B.2.u of the CIA, and finds the severity of the quality of care concerns identified by the Monitor at the Manassas Center to be a flagrant violation of the CIA.

In coming to this conclusion, the OIG references CSHM's policy entitled "Adverse Events, Quality of Care Reportable Events, and OMIG Patient Care Matters," which was revised in January 2012. More specifically, the OIG faults CSHM for permitting its Chief Dental Officer to develop a remediation plan with the approval of the OIG as an alternative to automatic termination of a dentist who deviates from professionally recognized standards of care on any occasion. In making this policy revision, CSHM had no intention for the Chief Dental Officer to obviate the termination requirement with his/her own remediation plan. As described below, the revisions to the policy were made to reflect an approach that CSHM developed in concert with the OIG in 2011, to avoid the summary and automatic termination of providers who may be competent clinicians but whose conduct on a particular occasion falls short of professionally recognized standards of care. We regret that the language in the revised policy did not clearly articulate that CSHM's policy is to terminate its relationship with any Covered Person who is found to have violated professionally recognized standards of care.

On March 31, 2011, CSHM approached the OIG with respect to an individual provider whom we believed had violated professionally recognized standards of care. The basis for the appeal to the OIG with respect to this individual provider was that the provider had made a grave mistake, but was an individual CSHM believed had consistently provided high quality care up to that point. In other words, the incident that gave rise to the Quality of Care Reportable Event was a very rare exception, not an incident that was reflective of the provider's daily practice patterns. The OIG allowed CSHM and the individual provider to execute a robust remediation plan based upon the facts and circumstances of that quality of care incident. CSHM believes that allowing the remediation plan in this instance resulted in a "punishment fits the crime" outcome that also successfully heightened awareness of important patient health history considerations across all CSHM Associated Dental Centers. With this policy change, CSHM did not intend to suggest that remediation plans replaced the mandate in the CIA to terminate its relationship with Covered Persons who are found to have violated professionally recognized standards of care. The revision was made merely to reflect the single instance where a remediation plan had been viewed by the OIG, the Quality of Care Monitor and CSHM as an appropriate alternative to termination.

Further, with the benefit of hindsight, CSHM recognizes that the timing and content of the policy change would likely appear to the OIG that the change was initiated in order to rehabilitate [redacted] in connection with the Manassas Center report and other providers in the future who may have circumstances more similar to [redacted] than to the aforementioned provider who had consistently provided high quality care up with the exception of the instance giving rise to the Quality of Care Reportable Event. Again, this was certainly not our intent with the policy change. Once more, the reason for the policy change was to allow the possibility of remediation for providers who are competent clinicians but whose conduct on a particular occasion falls short of professionally recognized standards of care and to do so only if approved by the OIG.

After receiving the Notice, CSHM took the following steps to immediately cure this breach:

- CSHM has revised the policy effective March 12, 2012, to remove any reference to the possibility of remediation plans approved by the OIG with respect to Quality of Care Reportable Events. This revision was approved in accordance with CSHM's Policy and Procedure Development policy. We have included a copy of the communication describing this policy revision and the revised policy that will be uploaded to CSHM's intranet today as **Attachment W**.
- Based upon the facts and circumstances of another quality of care incident, CSHM requested an audience with the OIG and the Quality of Care Monitor regarding another Covered Person who had been found to have violated professionally recognized standards of care. This request was made in the Quality of Care Reportable Event notice submitted on September 26, 2011. CSHM's Chief Dental Officer detailed the specifics of the incident in a conference call with the OIG and the Quality of Care Monitor on December 1, 2011. Because the remediation plan that was proposed in the Quality of Care Reportable Event notice on September 26, 2011 and the conference call on December 1, 2011 was neither approved nor denied, the provider was terminated this morning[8].

CSHM's Review of Pulp-to-Crown Ratios and Provision of Medically Unnecessary Services at Other CSHM Facilities

The OIG has found CSHM to be in material breach of the CIA based upon CSHM's failure to comply with Section III.B.2.g of the CIA, in that CSHM has failed to develop and implement a policy to promptly and appropriately investigate overpayment issues relating to medically unnecessary services with respect to the 12[9] dentists it has identified and acknowledged as potentially at risk for this type of conduct.

[8] CSHM communicated to the provider when the event occurred that the remediation plan may not be approved. The provider fully understood that termination would occur if the OIG did not approve the proposed remediation plan. CSHM had been executing the remediation plan until such time as the OIG communicated approval or denial of the remediation plan. In light of the Notice, CSHM determined it was necessary for the provider in question to be terminated and that termination occurred this morning.

[9] As the OIG noted in its Notice, CSHM originally identified 13 dentists with high "pulp-to-crown" ratios similar to those at the Manassas Center in CSHM's October 31, 2011 Response to the Monitor's Manassas Desk Audit Report. CSHM later clarified that it had identified 12 dentists, not 13 dentists with high "pulp-to-crown" ratios. Throughout

In response to the Monitor's September 22, 2011 Desk Audit report, CSHM considered necessary corrective and preventative measures that had to be taken not only at the Manassas Center, but across all CSHM Associated Dental Centers. CSHM determined that data mining 100% of billing codes was the most efficient and effective method to conduct a robust global review of other providers having similar pulpotomy-to-crown ratios.

As you are aware, CSHM identified 12 dentists through this process whose treatment approach warranted further review. CSHM committed to the following in our October 31, 2011 response to the Monitor's September 22, 2011 Desk Audit Report:

> Over the next month, [redacted] [the Chief Dental Officer at the time] will discuss his philosophy with each of the remaining 12 dentists identified and determine the need to conduct a webinar presenting his training module on pulpotomies and indirect pulp therapy. The CRAFT Committee will monitor the pulp-to-crown ratio for each of these 12 individuals after [redacted] discussion and develop additional next steps as appropriate. In addition to the review of specific providers, [redacted] will include indirect pulp therapy as an alternative to pulpotomies in an upcoming Best Practice Memo to reinforce this philosophy among all providers.

[redacted] did include indirect pulp therapy as an alternative to pulpotomies in a Best Practices Memo dated November 22, 2011. The information in this Best Practices Memo was memorialized into policy as of January 13, 2012 as part of both the Quality Assurance Protocol Policy and the Clinical Policies and Guidelines Policy. Again, the November 22, 2011 Best Practices Memo is included as **Attachment J**. The aforementioned policies are included as **Attachments H and I**.

Soon after my appointment as Chief Compliance Officer, I consulted an outside compliance expert (who was engaged to assist me with the transition) as to CSHM's obligation with respect to addressing any potentially systemic issues identified in the course of executing our compliance program. This occurred on July 12, 2012, well before CSHM received the Monitor's Manassas Desk Audit Report in September 2011. The specific question was whether CSHM had an obligation any time a quality of care issue had been confirmed in a particular center to 1) perform a system wide analysis to evaluate whether the issue might be replicated in other centers and 2) conduct post payment audits for any center that appeared to have similar practice patterns. CSHM was advised that we should perform a system wide utilization analysis to evaluate whether the issue might be replicated in other centers, and take appropriate remedial action. He also suggested that we focus on real time issue identification and targeted provider education based on analysis of material clinical and billing anomalies among centers.

In November 2011, I again consulted with our outside compliance expert to follow-up on previous discussions about CSHM's obligations to perform a post-payment audit or system-wide analysis of outliers. CSHM received an outline of a Progressive Corrective Action Model on November 9, 2011 with the advice to consider how this model could be incorporated into its compliance program. CSHM began

---

the remainder of this response, CSHM will reference 12 dentists as the number of dentists identified in the October 31, 2011 Response to the Monitor's Manassas Desk Audit Report.

following the Progressive Corrective Action Model in practice[10],and formally adopted this model as a written policy on January 13, 2012. Because it was not yet a formalized written policy at the time, CSHM did not explicitly refer to the Progressive Corrective Action Model in our October 31, 2011 Manassas Response. Rather, CSHM described the initial steps of the Progressive Corrective Action Model in our response to the Monitor's report. I am including the Progressive Corrective Action Model as **Attachment X** and the policy in which CSHM adopted the Corrective Action Model principles as **Attachment Y**. CSHM also vetted the Progressive Corrective Action Model with external legal counsel prior to adopting the methodology into policy. CSHM was again assured that the principles were a solid foundation and the model was an accepted methodology within the health care industry to approach corrective actions after a potentially systemic issue had been identified in a specific center or for a specific provider.

Although described more fully in the respective attachment, the Progressive Corrective Action Model is based upon the principles outlined in the Medicare Program Integrity Manual (PIM Section 3.7 *et seq.*). The principles underlying the PCA model include:

- Targeting claims risks that pose the greatest financial risk to the Medicare (Medicaid, as adopted by CSHM) program;
- Data analysis to identify performance outliers;
- Focused provider communication and education; and
- Progressive audit procedures applied to persistent outliers gradually escalating from pre-payment reviews (for low to moderate error rates) to retrospective extrapolation (for high error rates).

As part of CSHM's October 31, 2011 response to the Monitor's Desk Audit report, CSHM targeted pulpotomies as claims risks that posed the greatest financial risk to the Medicaid programs and performed data analysis to identify performance outliers. Throughout November and early December, CSHM conducted focused provider communication and education. Since that time, and as evidenced in November minutes (on the October CRAFT report), December minutes (on the November CRAFT report), January minutes (on the December CRAFT report) and February CRAFT minutes (on the January CRAFT report), CSHM has evaluated the results of the focused provider communication and education and monitored for persistent outliers with respect to high pulp-to-crown ratios. Relevant excerpts from the aforementioned minutes and reports are included as **Attachment Z**[11].

[10] CSHM also referenced the Progressive Corrective Action Model in a December 31, 2011 Substantial Overpayment Reportable Event notice.

[11] CSHM has included only the relevant excerpts to allow for quick and easy reference since the CRAFT Reports are voluminous. Moreover, CSHM already provided the full sets of minutes and reports to the OIG on January 26, 2012 and February 6, 2012. CSHM will provide the full set of minutes and reports, should the OIG request, or in the event that the full set of information assists the OIG in evaluating our response to the Notice.

The November 2011 CRAFT minutes reflect initial focused provider communication and education with Small Smiles Dental Centers of Youngstown, which included 3 of the 12 outlier providers[12]. The December CRAFT minutes reflect an update from [redacted] (the Chief Dental Officer at the time) regarding the focused provider communications and education conducted with all providers identified as outliers during the preparation of the Manassas Center response. Although the minutes do not reflect the full breadth and depth of the discussion, the December CRAFT meeting discussion was extensive with respect to the individual provider communication and education conducted by [redacted] and his designees.

As the discussions with providers occurred in late November and early December, the results of the focused provider communications and education becomes more evident in the January CRAFT minutes (which again reflects a discussion on December billing data and the December CRAFT Report). For the month of December, 4 providers had high pulp-to-crown ratios. Two of these providers were outliers identified in CSHM's Manassas response, two were new outliers; meaning that 10 of 12 providers receiving focused provider communication and education changed practice patterns as a result of this communication and education. The focused provider communication and education further improved January 2012 results, with only 1 outlier provider with a high pulp-to-crown ratio. The single outlier from January's billing data was not one of the original 12 providers identified as an outlier in the Manassas Report response. February 2012 results also reveal 1 outlier with a high pulp-to-crown ratio for the month. This single outlier has not been an outlier since CSHM began reviewing this metric and was not one of the 12 outliers identified in the Manassas Center response.

When CSHM initially identified pulp-to-crown ratios as a metric to evaluate in utilization reviews, we were not aware of any studies or literature suggesting what an appropriate pulp-to-crown ratio might be. CSHM's Chief Dental Officer at the time, [redacted], established 70% as a threshold for initial reviews. [redacted] later learned that the November/December 2011 issue of *Pediatric Dentistry* contained an article entitled "Pulpotomy to stainless steel crown ratio in children with early childhood caries: A cross-sectional analysis." The study took place in the Nationwide Children's Hospital dental clinic in Columbus, Ohio and involved 521 patients with early childhood caries and published pulp-to-crown ratios of 37% for children who were 0-36 months old, 35% for children who were 36-72 months old, and 31% for children who were greater than 72 months old, with an overall average of 34%. Based upon a discussion of this study in the February CRAFT meeting, CSHM's new Chief Dental Officer, [redacted], determined that the Committee would begin to review outliers above 50%. The overall average of pulp-to-crown ratios among all CSHM Associated Dental Centers is 26% YTD 2012 (through March 7, 2012).

Also during this time [redacted] joined CSHM as Chief Dental Officer. During his first week of employment with CSHM, [redacted] visited the Small Smiles Dental Center of Akron ("Akron Center").

[12] The November 2011 CRAFT minutes also reference the "LD of Akron" with details that "not only is her ratio high, but she performs a high number of pulpotomies per month". The minutes should have referenced an Associate Dentist rather than the Lead Dentist (LD). The Lead Dentist at the Akron Center was not an outlier with respect to pulp-to-crown ratios. The outlier Associate Dentist is no longer employed with any CSHM Associated Dental Center.

[redacted] also attended this site visit, which occurred on January 31 and February 1, 2012. As you may recall, 3 of the 12 providers identified with high pulp-to-crown ratios during CSHM's preparation of the October 31, 2011 response to the Monitor's Manassas Desk Audit Report were dentists in the Akron Center. (As detailed in footnote 5, however, one of those three providers is no longer employed by any CSHM Associated Dental Center.) During this visit, [redacted] and [redacted] observed the quality of care provided by the dentists in the Akron Center, performed record reviews and discussed their findings from the observations and record reviews with the dentists. [redacted] and [redacted] also discussed indications for pulpotomies and the principles included in the newly revised policies as they relate to pulpotomies. [redacted] and [redacted] noted the improvement in the pulp-to-crown ratios during December 2011 and January 2012 with respect to the Akron Center's dentists. As [redacted] had initially counseled the dentists in the Youngstown Center regarding pulpotomies (after the Monitor's reports on Youngstown), [redacted] continued follow up with this Center through a site visit on February 3, 2012. [redacted] continued clinical mentoring with respect to pulp therapy during this site visit.

On January 17, 2012, [redacted] of the OIG requested information regarding the outliers identified in CSHM's response to the Monitor's Manassas report. CSHM responded on January 26, 2012, and its response included the 12 outlier provider's pulp-to-crown ratios prior to implementing the Progressive Action Model as Item II.D. The schedule provided also included each provider's pulp-to-crown ratio for a one month time period (December 19, 2011 through January 20, 2012) after initial focused provider communications and education occurred. This information is included as **Attachment AA**. CSHM has also included a new column to show the provider's pulp-to-crown ratio from January 21, 2012 through March 8, 2012.

On December 14, 2011, CSHM hosted a meeting in Nashville, Tennessee for the owners of each CSHM Associated Dental Center. We updated the owners about recent trends in Monitor reports, detailing recent findings with respect to medically unnecessary pulpotomies, non-use of local anesthesia in cases where local anesthesia should have been used, and injection techniques to ensure maximum effectiveness of local anesthesia delivery, in particular. [redacted] discussed the guidelines he had recently published in a Best Practices Memo and communicated that these guidelines would be published into policy within weeks. [redacted] spoke more specifically about examples of medically unnecessary pulpotomies that had been noted (for instance, when the decay is not halfway to the DEJ, pulps are necrotic or there is evidence of a radiolucency furcation).

To further illustrate the seriousness with which we have taken this issue and the efforts expended, I conducted a call on January 31, 2011 with 34 providers (referenced in our October 31, 2011 response to the Monitor's Desk Audit Report) to communicate with them that they had been identified by CSHM as an outlier with respect to pulp-to-crown ratios. I explained that many of them performed pulpotomies very infrequently, but that the call was for any provider who had a high ratio, regardless of frequency. We discussed the company average of pulpotomy-to-crown ratios and I detailed recent clinical findings in Monitor reports with respect to medically unnecessary pulpotomies.

Based upon the information detailed above, CSHM sincerely believes that it took an appropriate, robust and responsible approach to promptly and appropriately investigating issues identified internally,

implementing effective and timely corrective action plans, and monitoring compliance with such plans in accordance with Section III.B.2.g of CSHM's CIA. Moreover, we believe that the model is effectively minimizing high risk claims risks to the Medicaid programs in the states that CSHM Associated Dental Centers operates with respect to pulpotomies. We hope that the information presented in this portion of our response letter provides better insight into the analysis and consideration we put forth in responding to outliers identified during the preparation of the October 31, 2011 Manassas Center response to the Monitor's Desk Audit. CSHM will now take the following actions on the following timetable[13]:

- Within 30 days, CSHM will conduct a post-payment claims audit targeting pulpotomies performed by the 12 providers. The post payment claims audit will be conducted by testing a statistically valid sample from dates of services having pulpotomies performed between August and October 2011.
- The Chief Dental Officer, and his designees (who will have a clinical background) in the event that the sample population cannot reasonably be reviewed by the Chief Dental Officer in 30 days, will prepare an analysis of any medical unnecessary pulpotomies performed by outlier providers. An error rate will be determined from this analysis. The pulpotomy error rate will be applied to the full population of pulpotomies performed from January 15, 2010 through December 19, 2011 (when focused provider communications and education concluded and CSHM began to see the decline in the pulp-to-crown ratios) to determine the amount of any repayment obligations. In the event that a designee performs the analysis as directed by the Chief Dental Officer, the Chief Dental Officer will review and approve the conclusions of the analysis.
- CSHM will promptly refund any amounts associated with medically unnecessary pulpotomies.
- In the event that the samples individually or collectively produce a repayment obligation in excess of $15,000, CSHM will report these as Substantial Overpayments in accordance with Section III.I.2 of the CIA.
- After completion of the sample probe audits, CSHM's Chief Dental Officer will determine whether a Quality of Care Reportable Event has occurred. Upon making the determination that a Quality of Care Reportable Event has occurred, CSHM will report the event in accordance with Section III.I.2 of the CIA, including a report to the applicable state licensing board. CSHM will also terminate its relationship with any provider who is found to have violated professionally recognized standards of care through this record review.

[13] CSHM also employed the Progressive Action Model as a remedial action with respect to a Substantial Overpayment in Small Smiles Dental Centers of Denver. The OIG was notified of this Substantial Overpayment on December 13, 2011. CSHM will develop a methodology similar to the outline to conduct post payment audits on pulpotomies to evaluate potential repayment obligations in other centers with respect to the Denver Substantial Overpayment.

Quality of Care Reportable Event Requirements

The OIG has found CSHM to be in material breach of the CIA based upon CSHM's failure to comply with the obligations of Section III.I.2.c and III.I.2.d of the CIA to provide written notice of CSHM's investigation and actions taken to correct violations to the state licensing board in the state of Virginia. This is an oversight for which I take full responsibility. I and others at CSHM have worked diligently over the past 11 months to prove to the OIG that CSHM can be a worthy partner under the Corporate Integrity Agreement. It is extremely important to me personally that CSHM is fully compliant with our CIA and I deeply regret this failure on my part.

To cure this breach, I enclose a copy of the required notice to the state licensing board in the state of Virginia with respect to the Manassas Center as **Attachment BB**. CSHM believes that with the submission of this notice the alleged material breach has been cured.

Conclusion

For all of the reasons set forth above, CSHM respectfully urges the OIG not to exercise its right to exclude CSHM from Federal health care programs. CSHM had endeavored to cure every breach identified in the Notice, and strongly believes that it has turned the corner in its efforts to strengthen and improve its compliance program since last spring. CSHM has embraced its obligations under its CIA and is dedicated to promoting a culture of compliance and quality of care at all of its affiliated dental centers. Our work and our mission are also critical to meeting the needs of a patient population that is widely recognized as still not being adequately served in this country. As I noted at the outset, CSHM Associated Dental Centers had over one million patient visits last year. We believe that our continued existence is therefore critical to meeting the needs of a very significant number of low-income children.

We are also the only dental practice management company operating under a Quality of Care CIA. Our CIA, and our partnership with the OIG, affords the government a unique and unprecedented opportunity to impact the quality of care being provided to pediatric patients in 21 different states and the District of Columbia. We welcome the opportunity to become the "gold standard" for compliance in this segment of healthcare. If we can succeed in this regard, it will be a tremendous victory for both the federal government and CSHM. Conversely, if the OIG excludes CSHM at this point, our Associated Dental Centers will fail, and patients will be faced with the prospect of potentially receiving no care, or care from a provider who does not have the benefit of the compliance oversight currently provided by CSHM and its Quality of Care Monitor. For these reasons, I urge the OIG to permit CSHM to continue our work and our efforts to become a corporate citizen the OIG can be proud to have as a partner.

Time is of the essence, as we explained on Friday, March 9, 2012. Without clarity from the OIG regarding its intentions by 5:00 p.m. CST on Wednesday, March 14, 2012, CSHM's lenders will not continue to support and fund CSHM's restructuring efforts, and on Thursday we will likely be forced to move to liquidate our assets. For that reason, we respectfully request that the OIG expedite its review and consideration of this response, permit us to remain in the program, and enable CSHM to complete its restructuring and emerge from bankruptcy a more vital organization.

For all the reasons set forth above, we strongly believe that we can and will ultimately be a success story the OIG will be proud of. Please give us that chance by letting us know if we can meet on Tuesday, March 13, 2012 to discuss our response to the Notice and whether we have cured the breaches identified in the Notice to the OIG's satisfaction. We very much hope to hear your response by Wednesday if at all possible.

Respectfully Submitted,

[redacted]

Chief Compliance Officer

CC: CSHM Board of Directors, [redacted]

EXHIBIT 65

STOCK PLEDGE AGREEMENT

THIS STOCK PLEDGE AGREEMENT ("Agreement") is entered into as of October 1, 2010, by and between [redacted], DDS, DDS ("Owner"), an individual, and FORBA Holdings, LLC, a Delaware limited liability company ("FORBA").

RECITALS:

A. Small Smiles Dentistry for Children, Albuquerque, P.C. (the "Company") is a New Mexico professional corporation that conducts a dental practice in the Albuquerque, New Mexico area, and Owner is a shareholder of the Company.

B. Pursuant to the Amended and Restated Management Services Agreement (the "Management Services Agreement"), dated as of September 26, 2006, between FORBA and the Company, FORBA provides certain business services to the Company.

C. [redacted], DDS (the "Prior Owner") is a party to a Stock Pledge Agreement, dated as of August 12, 2008, with FORBA (the "Prior Stock Pledge Agreement") with respect to his ownership interests in the Company. As an inducement for FORBA to release the Prior Owner from their obligations under the Prior Stock Pledge Agreement, so that Owner may purchase the outstanding ownership interests of the Company, Owner is willing to guaranty the Company's performance under the Management Services Agreement, including payment of the management fees, subject to the terms and conditions of this Agreement.

D. Owner desires to pledge to, and grant a security interest in, all of the shares of capital stock or other ownership or equity interests or securities in the Company that are owned or held by Owner, whether now or hereafter, to FORBA, in order to secure Owner's obligations under such guaranty. Owner desires to transfer all of such ownership interests to a designee of FORBA for value, and FORBA desires that such designee to purchase such ownership interests, if certain events of default occur, subject to the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the premises and agreements set forth herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

ARTICLE I
OBLIGATIONS AND COVENANTS OF OWNER

1.1 Guaranty of Management Fee.

(a) Owner hereby irrevocably and unconditionally guarantees to FORBA, on behalf of the Company, the full and timely payment and performance of all of the Company's duties and obligations under the Management Services Agreement, including, without limitation, the payment of management fees and other amounts payable or reimbursable to FORBA under the Management Services Agreement (collectively, the "Guaranteed Obligations"); provided, however, that Owner shall be liable to FORBA with respect to the Guaranteed Obligations only to the extent of the Collateral and FORBA shall have no recourse against any assets of Owner other than the Collateral with respect to the Guaranteed Obligations.

(b) The obligations of Owner under this Section 1.1 are continuing, absolute and unconditional and shall remain in full force and effect until the entire amount of the Guaranteed Obligations shall have been paid in full and discharged, and such obligations shall not be affected, modified or impaired by any state of facts or the happening from time to time of any event whatsoever.

(c) Owner hereby waives each of the following with respect to the Guaranteed Obligations and this Section 1.1: diligence, presentment, demand of payment, protest, filing of claims with a court in the event of bankruptcy of the Company or any other person or entity liable in respect of the Guaranteed Obligations, any right to require FORBA to proceed first against the Company or any other person or entity, notice of dishonor or nonpayment of any such liabilities, notice of the release of any other guarantor of the Guaranteed Obligations, notice of the release or sale of any Collateral, and any other notice and all demands whatsoever. Owner hereby waives

notice from FORBA of the Guaranteed Obligations, of the issuance of the instruments evidencing the Guaranteed Obligations, and of acceptance of, or notice and proof of reliance on, the benefits of this Section 1.1.

(d) The obligations of Owner hereunder shall not be discharged except by full and final payment and discharge of the Guaranteed Obligations or transfer of the Collateral to Transferee (as defined below).

1.2 Collateral. Owner hereby represents and warrants to FORBA that:

(a) Owner is or, upon the consummation of the purchase of all shares of capital stock of and other equity and ownership interests in the Company (the "Purchase"), will be the record and beneficial holder and owner of 100 shares of common stock, no par value per share, of the Company (such shares, together with any and all extensions, modifications, renewals and/or replacements thereof, and any and all dividends and rights declared or granted in connection therewith and all other products and proceeds thereof, collectively, the "Collateral"). Except for the Collateral, Owner holds and owns no shares of capital stock or other ownership or equity interests or securities in the Company ("Equity Interests"), and no options, warrants, subscriptions, convertible securities or other rights, agreements or commitments to purchase or acquire any Equity Interests in the Company.

(b) Owner holds and owns (or upon the closing of the Purchase, will hold and own) the Collateral, beneficially and of record, free and clear of any restrictions on transfer, taxes, mortgage, pledge, lien, encumbrance, charge or other security interest, option, warrant, purchase rights, contracts, commitments, equities, claims and demands (collectively, "Encumbrances"), other than the pledge to FORBA hereunder and the Buy-Sell Agreement (as defined below). Owner has (or upon the closing of the Purchase, will have) the full, absolute and unrestricted right, power, capacity and authority to pledge the Collateral to FORBA and to sell, transfer, assign and deliver the Collateral to the Transferee (as defined below), and the delivery of such Collateral to the Transferee will convey to the Transferee valid, marketable and indefeasible title to such Collateral, free and clear of any and all Encumbrances. The Collateral is duly authorized, validly issued, fully paid and non-assessable and was not issued in violation of any preemptive rights or any right of first refusal or other similar right in favor of any person. Owner is not a party to any option, warrant, purchase right, or other contract or commitment that could require Owner to sell, transfer or otherwise dispose of any of the Collateral, other than pursuant to this Agreement and the Buy-Sell Agreement. Owner is not a party to any voting trust, proxy or other agreement or understanding with respect to the voting of any of the Collateral with any party.

(c) The authorized Equity Interests of the Company consists of 100,000 shares of common stock, no par value per share, 100 shares of which are issued and outstanding as of the date hereof. There are no other classes of securities of the Company outstanding. Other than the Buy-Sell Agreement, this Agreement and a comparable Stock Pledge Agreement (the "Buyer Pledge Agreement") being entered into by William Nash, DDS ("Buyer"), there are no options, warrants, preemptive rights, calls, subscriptions, convertible securities or other contracts, understandings, arrangements, rights, agreements or commitments that obligate the Company or a shareholder of the Company to issue, transfer or sell any Equity Interests or any other securities of the Company.

1.3 Grant of Security Interest. Owner hereby pledges to, and grants a security interest in, the Collateral to FORBA to secure the full and timely payment and performance of Owner's obligations set forth in Section 1.1 above. Concurrently with the execution and delivery of this Agreement, Owner shall deliver to FORBA the capital stock certificate(s), if any, representing the Collateral, duly endorsed in blank or, if not endorsed in blank, Owner shall give FORBA a duly executed stock power in blank. Owner agrees to execute a UCC financing statement with respect to the Collateral promptly upon request by FORBA.

1.4 Conditional Agreement to Transfer Collateral To Designee.

(a) Owner shall immediately given written notice, in reasonable detail, to FORBA if any of the following events occurs:

(i) Owner breaches or defaults under this Agreement, including, without limitation, the full and timely performance of Owner's guaranty under Section 1.1 hereof (each, an "Event of Default"); or

(ii) The Company breaches or defaults under the Management Services Agreement.

(b) Upon an Event of Default, Owner shall, at the request of FORBA, transfer the Collateral to the Transferee at such time and place as shall be determined solely by FORBA, for the Purchase Price set forth in Article III below.

1.5 Covenants of Owner. Owner hereby covenants and agrees that, during the term of this Agreement, in order to protect the rights of FORBA hereunder:

(a) Owner shall not, directly or indirectly, sell, assign, encumber, pledge, transfer, hypothecate, bequeath or otherwise dispose of (each, a "Transfer") any item of Collateral nor any legal or beneficial interest therein, except for the pledge to FORBA and conveyance to the Transferee as provided in this Agreement or otherwise with FORBA's prior, express written consent, which consent may be withheld in FORBA's sole discretion. The parties acknowledge that, concurrently herewith, Owner and Buyer are entering into a written Buy-Sell Agreement pursuant to which Buyer or his designee may purchase the Equity Interests of Owner upon the occurrence of certain events (the "Buy-Sell Agreement"). FORBA hereby consents to such Buy-Sell Agreement; provided that Buyer enters into the Buyer Pledge Agreement and Owner hereby agrees that such Buy-Sell Agreement shall not be terminated, amended, supplemented or altered at any time during the term of this Agreement without the prior, express written consent of FORBA. If any item of Collateral or any right therein is Transferred contrary to this Agreement, such Transfer shall be void, and FORBA shall retain a security interest in such item and in the proceeds of such disposition.

(b) The Company shall not issue any additional shares of capital stock of the Company without FORBA's prior, express written consent, which consent may be withheld in FORBA's sole discretion.

(c) The Articles of Incorporation, the Bylaws and the other governing or organizational documents of the Company shall not be amended, altered, terminated or supplemented without the prior, express written consent of FORBA, which consent may be withheld in FORBA's sole discretion.

(d) Upon the occurrence of any Event of Default and transfer of the Collateral to the Transferee, Owner shall immediately resign all positions held as an officer, manager or director of the Company.

1.6 After Acquired Interests. In the event of any issuance or Transfer of any Equity Interests hereafter to Owner (including, without limitation, in connection with any stock split, stock dividend, option or warrant exercises, recapitalization, reorganization or the like), such Equity Interests shall be automatically included in the Collateral and subject to this Agreement.

ARTICLE II
DESIGNATION OF TRANSFEREE AND TRANSFER OF COLLATERAL

Upon an Event of Default, FORBA may designate a Transferee to purchase the Collateral from Owner, with notice to Owner, and Owner shall transfer the Collateral and all of Owner's rights, title and interest therein to such Transferee at the time and place designated by FORBA in such notice in exchange for the Purchase Price, free and clear of all Encumbrances, and Owner shall deliver to the Transferee any and all certificates evidencing such Collateral, duly endorsed for transfer, and duly executed stock powers with respect to such Collateral. For purposes of this Agreement, "Transferee" means one or more individuals who is eligible to own an ownership interest in the Company under the laws of the State of New Mexico, and who is designated by FORBA to be the transferee of the Collateral.

ARTICLE III
PAYMENT OF PURCHASE PRICE

The purchase price for the Collateral purchased by such Transferee (the "Purchase Price") shall be a total of $100. The Purchase Price shall be payable to Owner or his or her personal representative in cash upon transfer of the Collateral to such Transferee.

ARTICLE IV
COMMERCIALLY REASONABLE DISPOSITION

The parties acknowledge that it would be impossible to realize a commercially reasonable price on the disposition of the pledged Collateral by public sale and very difficult to do so by private sale, except on the terms

and conditions in Articles II and III of this Agreement. Therefore, the parties hereto acknowledge that a disposition of the Collateral under Articles II and III is a commercially reasonable disposition, and agree that the determination of the Purchase Price under Article III is commercially reasonable and that they will be bound by such price.

ARTICLE V
TERM

This Agreement shall continue for as long as the Management Services Agreement, or any renewal thereof, is in effect.

ARTICLE VI
REPRESENTATIONS AND WARRANTIES OF OWNER

Owner hereby represents and warrants to FORBA that:

6.1 Qualification and Individual Power. Owner is an individual licensed to practice dentistry in the State of New Mexico. Owner has all required individual power and authority and all licenses, permits and authorizations necessary to own and operate a dental practice in the State of New Mexico, and to execute, deliver and perform this Agreement.

6.2 No Conflicts. Neither the execution or the delivery of this Agreement, nor the consummation of the transactions contemplated hereby, will conflict with, result in a breach of, constitute a default under, result in a violation of, result in the creation of any lien, security interest, charge or encumbrance upon the Collateral other than that contained in this Agreement, give any third party the right to accelerate any obligation, or require any authorization, consent, approval, exemption or other action by or notice to any court, other governmental body, or other third party, under any indenture, mortgage, lease, loan agreement or other agreement or instrument to which Owner or the Company is bound or affected, or any law, statute, rule, regulation, judgment or decree to which Owner or the Company is subject.

6.3 Legal Proceedings. There are no actions, suits, proceedings, orders or investigations pending or threatened against Owner, at law or in equity, or before or by any federal, state, municipal or other governmental department, commission, board, bureau, agency or instrumentality, domestic or foreign, and to the best of Owner's knowledge, there is no basis for the foregoing.

ARTICLE VII
INDEMNIFICATION

7.1 Indemnification of FORBA. Owner shall indemnify and hold harmless FORBA and its officers, directors, managers, employees, agents and Affiliates, and will reimburse such persons, from, against and for any loss, liability, damage or expense (including reasonable legal expenses and costs) incurred or suffered by any of them as a result of or in connection with the breach by Owner of any representation, warranty or covenant of Owner contained in this Agreement.

7.2 Indemnification of Owner. FORBA shall indemnify and hold harmless Owner, and will reimburse Owner, from, against and for any loss, liability, damage or expense (including reasonable legal expenses and costs) arising from or in connection with the breach by FORBA of any representations, warranty or covenant of FORBA in this Agreement.

ARTICLE VIII
DEFAULT AND REMEDIES

8.1 Remedies Upon Occurrence of Event of Default. Upon the occurrence of any Event of Default and continuously thereafter until waived in writing, FORBA shall have the right and option to cause Owner to immediately transfer the Collateral to Transferee, free of any equity of redemption or other claims, or to exercise any other remedy available to FORBA as a secured party under law or equity.

8.2 Construction of Rights and Remedies and Waiver of Notice and Consent.

(a) This Article applies to all rights and remedies provided by this Agreement or by law or equity.

(b) Unless otherwise expressly provided herein, any right or remedy may be pursued without notice to or further consent of Owner, both of which Owner waives.

(c) No right, power or remedy conferred upon or reserved to FORBA by this Agreement is intended to be exclusive of any other right, power or remedy, but each and every such right, power and remedy shall be cumulative and concurrent and shall be in addition to any other right, power and remedy given hereunder, now or hereafter existing at law, in equity or by statute. No delay, forbearance or omission by FORBA in exercising any right, power or remedy accruing upon any default shall exhaust or impair any such right, power or remedy or shall be construed to be a waiver of any such default or an acquiescence therein, and every right, power and remedy given to FORBA by this Agreement may be exercised from time to time, in any order, and as often as may be deemed expedient by FORBA. No delay, forbearance or omission in exercising any right or remedy on any one or more occasions shall operate as a waiver thereof on any future occasion, and no single or partial exercise of any right or remedy shall preclude any other exercise thereof or the exercise of any other right or remedy.

8.3 Distributions on Stock; Voting Rights. So long as no Event of Default has occurred, Owner shall (a) have the right, from time to time, to vote and give proxies and consents with respect to the Collateral and consent to or ratify action taken at, or waive notice of, any meeting of shareholders of the Company with the same force and effect as if such Collateral were not pledged hereunder, and (b) be entitled to receive any and all cash dividends and other distributions with respect to the Collateral.

ARTICLE IX
MISCELLANEOUS

9.1 Notices. Any notice, demand or communication required, permitted, or desired to be given hereunder shall be deemed effectively given only when personally delivered, when received by facsimile or other electronic means or overnight courier, or 10 days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

If to FORBA:

FORBA Holdings, LLC
618 Church Street, Suite 520
Nashville TN 37219
Fax No. (615) 750-0303
Attention: [redacted], Chairman and Chief Executive Officer

If to Owner:

[redacted]

or to such other address, and to the attention of such other person or officer as any party may designate.

9.2 Arbitration. Except for claims for injunctive relief, all disputes arising out of or in connection with this Agreement shall be settled by binding arbitration in Nashville, Tennessee. Evidentiary matters shall be determined in accordance with the Federal Rules of Evidence. The arbitrator shall be selected by mutual agreement of the parties or, failing such agreement, shall be a single qualified (in light of the subject matter hereof) arbitrator selected by the American Arbitration Association. Following a demand for arbitration, the parties shall have discovery rights in accordance with the Federal Rules of Civil Procedure. Judgment upon the award entered by the arbitrator may be entered in any court having jurisdiction hereof. The prevailing party shall be entitled to an award of reasonable costs of arbitration, including reasonable attorneys' fees, incurred in connection therewith as determined by the arbitrator.

9.3 No Control or Ownership of Practice or Company By FORBA. The parties acknowledge and agree that this Agreement is commercially reasonable and is intended to provide economic protection to FORBA in the event of a default under the Management Services Agreement by the Company. By entering into and performing under this Agreement, Owner and the Company expressly do not delegate to FORBA, and FORBA expressly does not accept or assume and hereby disclaims, any power, duties, responsibilities or control vested in the Company as the owner,

proprietor and operator of its dental practice, nor any ownership interest or control of the Company or its dental practice or Equity Interests. The Company is the owner, operator and proprietor of its dental practice and shall be responsible for and have authority over the practice of dentistry at such practice. If a court or other governmental authority of competent jurisdiction makes a final decision that any term of this Agreement causes FORBA to engage in the practice of dentistry, as defined under the laws of the State of New Mexico, or to otherwise violate the statutes, regulations and other laws governing the practice of dentistry in the State of New Mexico, or if legal counsel to Owner and FORBA mutually conclude the same, then the parties to this Agreement shall negotiate in good faith to amend this Agreement to preserve the underlying economic and financial arrangements between the parties under this Agreement to the greatest extent possible in a manner consistent with any such decision, determination or mutual conclusion, and pending the effectiveness of any such amendment, such term shall be deemed waived and unenforceable and its non-performance shall not constitute a breach or default of this Agreement.

9.15 Consent of Spouse. If Owner is married on the date of this Agreement, then Owner's spouse shall concurrently execute and deliver to FORBA a consent of spouse in the form of Exhibit 9.15 hereto ("Consent of Spouse"), effective on the date hereof. Notwithstanding the execution and delivery thereof, such consent shall not be deemed to confer or convey to the spouse any rights in the Collateral or other Equity Interests that do not otherwise exist by operation of law or the agreement of the parties. If Owner should marry or remarry subsequent to the date of this Agreement, then Owner shall within 30 days thereafter obtain his or her new spouse's acknowledgement of and consent to the existence and binding effect of all restrictions contained in this Agreement by causing such spouse to execute and deliver a Consent of Spouse acknowledging the restrictions and obligations contained in this Agreement and agreeing and consenting to the same.

9.3 Miscellaneous. This Agreement: (i) shall be governed by Tennessee law, without reference to its conflict of law principles; (ii) sets forth the entire understanding and agreement of the parties, and supersedes all prior oral or written understandings and agreements, with respect to the subject matter hereof; (iii) shall not be amended or terminated nor any provision hereof waived unless in a writing signed by all parties that expressly sets forth such amendment, termination or waiver; (iv) shall not be transferred or assigned by either party, in whole or part, without the prior written consent of the other party; (v) shall be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns; (vi) if held to be invalid or unenforceable, in whole or part, such term or provision shall be ineffective only to the extent of such invalidity or unenforceability without invalidating or rendering unenforceable the remaining terms and provisions of this Agreement; and (vii) may be executed in counterparts, each of which shall be deemed an original and which together shall constitute one and the same instrument. It is the intent of the parties that each part hereof shall be given its plain meaning, and that rules of construction that would construe any ambiguity against the draftsman, by virtue of being the draftsman, shall not apply. In the event of litigation relating to this Agreement, the prevailing party shall be entitled to recover attorneys' fees and costs of litigation in addition to all other remedies available at law or in equity. All expenses incurred in connection herewith shall be borne by the respective party incurring such expense. The representations, warranties and covenants of the parties contained in this Agreement shall survive the date hereof and shall not be extinguished thereby notwithstanding any investigation or other examination by any party. From time to time, at FORBA's request, and without further consideration, Owner will execute, acknowledge and deliver all instruments of further assurance and do all such acts and things as may reasonably be required more effectively to convey, transfer to and vest in FORBA and its assignees, all rights and interests conveyed pursuant to the terms hereof.

[Remainder of page intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

FORBA HOLDINGS, LLC

By: [redacted]

OWNER

[redacted]

EXHIBIT 9.15

FORM OF CONSENT OF SPOUSE

I, [redacted], am the spouse of [redacted], DDS, DDS, and hereby acknowledge that I have read the Stock Pledge Agreement, dated as of October 1, 2010, in connection with Small Smiles Dentistry for Children, Albuquerque, P.C. (the "Company"), to which a form of this Consent is attached as an Exhibit (the "Agreement"), and that I know the contents of the Agreement. Capitalized terms herein that are not otherwise defined shall have the meanings ascribed thereto in the Agreement.

I am aware that the Agreement contains provisions regarding rights of parties upon an Event of Default with respect to the Equity Interests in the Company which my spouse may own, including any interest I might have therein.

I hereby agree that my interest, if any, in any Equity Interests in the Company subject to the Agreement shall be irrevocably bound by the Agreement and further understand and agree that any community property interest I may have in such Equity Interests shall be similarly bound by the Agreement.

I am aware that the legal, financial and related matters contained in the Agreement are complex and that I am free to seek independent professional guidance or counsel with respect to this Consent. I have either sought such guidance or counsel or determined after reviewing the Agreement carefully that I will waive such right.

Dated as of October 1, 2010.

[redacted]

EXHIBIT 66

ATTACHMENT A-1
SMILES FOR CHILDREN
SCHEDULE OF ALLOWABLE FEES
****PLEASE REFER TO OFFICE REFERENCE MANUAL ON DENTAQUEST'S WEBSITE FOR COVERED SERVICES****

Code	Description	Fee
D0120	Periodic Oral Exam	$19.55
D0140	Limited Oral Exam	$24.09
D0145	Oral evaluation under 3yrs of age	$19.55
D0150	Comprehensive Oral Exam	$30.37
D0160	detailed & extensive oral evaluation	$30.37
D0170	re-evaluation	$24.09
D0180	comprehensive periodontal evaluation	$30.37
D0210	Xray Complete Series Adult	$69.75
D0220	Xray Intraoral Single	$10.84
D0230	Xray Intraoral Additional	$10.84
D0240	Xray Intraoral Occlusal Single	$11.90
D0250	Xray Extraoral Lateral Jaw	$45.77
D0260	Xray Extraoral Ea. Additional	$41.65
D0270	Bitewings single Film	$10.84
D0272	Xray Bitewing 2 Films	$19.55
D0273	Bitewing 3 Films	$23.28
D0274	Xray Bitewings 4 Films	$26.77
D0330	Xray Extraoral Panoramic	$52.37
D0340	Xray Extraoral Cephalometric	$69.86
D0470	Diagnostic Models	$50.59
D1110	Prophylaxis Adult Age 13-20	$45.77
D1120	Prophylaxis Child Age 0-12	$32.51
D1203	Topical Fluoride Child Age 0-12	$20.17
D1204	Topical Fluoride Adult Age 13-20	$20.17
D1206	Topical Fluoride Varnish	$20.17
D1351	Sealant, Per Tooth	$31.31
D1510	Space Maintainer Fixed Unilateral Band Treatment	$133.70
D1515	Space Maintainer Fixed Bilateral	$221.64
D1520	Space Maintainer Removable Unilateral	$133.70
D1525	Space Maintainer Removable Bilateral	$221.64
D1550	Recement of Space Maintainer	$51.80
D1555	Removal of fixed space maintainer	$42.16
D2140	Restor Amalgam 1 Sfc Primary/Perm	$57.60
D2150	Restor Amalgam 2 Sfc Perm	$73.26
D2160	Restor Amalgam 3 Sfc Perm	$86.50
D2161	Restor Amalgam 4 Sfc Perm	$97.35
D2330	Resin Acid Etch, 1 Surf, Anterior	$72.05
D2331	Resin Acid Etch, 2 Surf, Anterior	$86.50
D2332	Resin Acid Etch, 3 Surf, Anterior	$111.81
D2335	Resin Acid Etch, 4+Surf, Anterior	$128.68
D2390	Resin-based Composite Crown, Anterior	$153.63
D2391	Resin-based Composite – One Surface, Posterior	$72.05
D2392	Resin-based Composite – Two Surfaces, Posterior	$86.50
D2393	Resin-based Composite -- Three Surfaces, Posterior	$111.81
D2394	Resin-based Composite, 4 or more	$123.87
D2644	Onlay- Porcelain/Ceramic	$485.00
D2710	Crown Plastic/Acrylic (Lab)	$237.30
D2720	Crown Resin W/ High Noble Metal	$485.00
D2721	Crown Resin W/Predom. Base Metal	$485.00
D2722	Crown Resin W/Noble Metal (Semi-Precious)	$485.00
D2740	Crown- Porcelain/Ceramic Substrate	$485.00
D2750	Crown, Porcelain, Fused to High Noble Metal	$485.00
D2751	Crown Porcelain, Fused to Predominantly Base Metal	$485.00
D2752	Crown Porcelain Fused to Noble Metal (Semi-Precious)	$485.00
D2790	Crown-Full Cast High Noble Metal	$485.00
D2791	Crown, Full cast Predom Base Metal	$485.00
D2792	Crown, Full Cast Predominantly Noble Metal (Semi-Precious)	$485.00
D2794	Crown – Titanium	$485.00
D2910	recement inlay	$42.16
D2915	Recement Post and Core	$42.16
D2920	Recement Crowns	$42.16
D2930	Crown Stainless Stl, Prefab	$132.82
D2931	Crown Stnls Stl Crown, Permnt	$132.82
D2932	Prefabricated Resin Crown	$124.37
D2933	Prefabricated Stainless Steel Crown with Resin Window	$174.48
D2934	Stainless Steel CR – Esthetic	$174.48
D2940	Sedative Filling	$39.75
D2950	Crown Buildup, Including Pins	$106.96
D2951	Pin Retention, In Addition to Res	$19.27
D2952	Cast Post & Core in Adtn to Crn	$119.37
D2954	Prefab Steel Post & Core in Addi	$106.96
D2962	Labial Veneer Laminate-Porcelain Lab	$351.20
D2970	Temporary Crown	$67.90
D3110	Pulp Cap Direct	$17.86
D3120	Pulp Cap Indirect	$17.86
D3220	Therapeutic Pupotomy	$80.69
D3221	Gross Pulpal Debridement, Primary and Permanent Teeth	$65.47
D3230	Pupil Therapy, Anterior-Primary	$160.68
D3240	Pupil Therapy, Post-Primary	$202.33
D3310	Endodontics Anterior	$363.75
D3320	Endodontics Bicuspid	$417.10
D3330	Endodontics Molar	$658.63
D3346	Retreatment of Prev. Root Canal-Anterior	$418.31
D3347	Retreatment of Prev. Root Canal-Bicuspid	$479.67
D3348	Retreatment of Prev. Root Canal-Molar	$757.42
D3351	Apexification Initial Visit	$89.27
D3352	Apexification-Interim	$59.51
D3353	Apexification Complete	$392.76
D3410	Apicoectomy	$269.82
D3421	Apicoectomy Biscuspid One Root	$269.82
D3425	Apicoectomy, Molar One Root	$269.82
D3426	Apicoectomy, Each Additional	$119.02
D3430	Periapical Retrograde Filling	$59.51
D4210	Gingivect/Gingivoplast, Per Quad	$330.05
D4211	Gingivect/Gingivoplast, - One to Three Teeth, Per Quad	$194.00
D4240	gingival flap w/ root planing - 4+ teeth per quad	$330.04
D4249	Crown lengthening-hard tissue	$291.00
D4260	Periosseous Surgery Per Quad	$511.94
D4261	Periosseous Surgery – One to Three teeth, Per Quad	$357.00
D4263	Bone Graft, 1st Site-Quad	$211.46
D4264	Bone Graft, Addtl Site-Quad	$105.73
D4270	Pedicle Soft Tissue Graft Procedure	$237.30
D4271	Free Soft Tissue Procedure (Including Donor Site Surgery)	$327.31
D4273	Subepithelial Soft Tissue Graf	$386.75
D4320	Temporary Splint Intracoronal	$142.12
D4321	Temporary Splint Extracoronal	$249.35
D4341	Definitive Scaling and Rt. Pln, Per Q	$90.35
D4342	Periodontal Scaling and Root Planing-1 to 3 Teeth per Quad	$47.61
D4355	Debridement per Quad	$18.98
D4910	Perio. Maintenance Following Treatment	$60.23
D5110	Denture Complete Upper	$654.60
D5120	Denture Complete Lower	$654.60

Code	Description	Fee
D5130	Immediate Denture- Maxillary	$654.60
D5140	Immediate Denture- Mandibular	$654.60
D5211	Upper Partial Acrylic Base (Including Any	$640.83
D5212	Lower Partial Acrylic Base (Including Any	$640.83
D5213	Upper Partial Cast Base Acrylic Saddles	$720.07
D5214	Lower Partial Base Cast Base with Acrylic	$720.07
D5225	Max Partial Denture, Flex Base	$640.83
D5226	Mand Partial Denture, Flex Base	$640.83
D5281	Removable Unilateral Partial Denture	$265.77
D5410	Denture Adjust, Complete Upper	$31.31
D5411	Adjust Complete Denture-Lower	$31.31
D5421	Adjust Partial Denture-Upper	$19.27
D5422	Adjust Partial Denture-Lower	$19.27
D5510	Repr Broken Complete Dent Base	$80.69
D5520	Replace Missing/Broken Teeth-Complete	$66.24
D5610	Brkn Acrylic Saddle or Base	$80.69
D5620	Repair Cast Framework	$116.86
D5630	Repair or Replace Broken Clasp	$112.02
D5640	Brkn Dntur Replace Teeth Only	$105.99
D5650	Dntr Pry Add Tooth Not Abutmt	$92.76
D5660	Dntur Prt Add Clasp To Partial Dentures	$112.02
D5730	Reline Complete Upper Denture (Chairside)	$196.32
D5731	Reline Complete Lower Denture (Chairside)	$196.32
D5740	Reline Upper Partial (Chairside)	$99.97
D5741	Reline Lower Partial Denture (Chairside)	$99.97
D5750	Denture Reline-Complete Upper (Laboratory)	$230.03
D5751	Reline Complete Lower Denture (Laboratory)	$230.03
D5760	Dntur Reline Partial Lab Upper	$142.12
D5761	Reline Lower Partial Denture (Laboratory)	$142.12
D5850	tissue conditioning - max	$121.25
D5851	Tissue conditioning, mandibular	$121.25
D5860	overdenture - complete - by report	$654.60
D5861	overdenture - partial - by report	$654.60
D5951	Feeding Aid	$379.67
D6205	Pontic, Resin Based	$485.00
D6210	pontic crown - metal high noble	$485.00
D6211	Pontic-Cast Predominantly Base Metal (Non	$485.00
D6212	Pontic-Cast Predominantly Base Metal (Non	$485.00
D6214	Pontic- Titanium	$485.00
D6240	Pontic-Porcelain fused to High Noble Metal	$485.00
D6241	Pontic- Porcelain Fused Predominantly Base Metal	$485.00
D6242	Pontic- Porcelain Fused Noble Metal	$485.00
D6245	Pontic- Porcelain/Ceramic	$485.00
D6250	Pontic-Resin with High Noble Metal	$485.00
D6251	Pontic Resin with Predominantly Base Metal	$485.00
D6252	Pontic Resin with Noble Metal (Semi-Preci	$485.00
D6545	Cast Metal Retainer For Bonded Bridge	$284.75
D6548	Retainer-Porcelain/Ceramic	$284.75
D6710	Crown, Resin Based	$485.00
D6720	Crown, Resin w/ High Noble Metal	$485.00
D6721	Crown Resin with Predominantly Base Metal	$485.00
D6722	Crown Resin with Noble Metal (Semi-Precio	$485.00
D6740	Crown Porcelain/Ceramic	$485.00
D6750	Crown Porcelain Fused to High Noble Metal	$485.00
D6751	Crown Porcelain Fused to Base Metal	$485.00
D6752	Crown Porcelain Fused to Noble Mental (SE)	$485.00
D6790	Crown Full Cast High Noble Metal	$485.00
D6791	Crown Full Cast Predominantly Base Metal	$485.00
D6792	Crown Full Cast Nobel Metal (Semi-Preci	$485.00
D6794	Crown, Titanium	$485.00
D6930	Recement Bridge	$61.43
D6970	Cast Post and Core in Addition to Bridge	$119.37
D6972	Prefabricated Steel Post and Core in Addi	$106.96
D6973	Core Buildup Retainer	$106.96
D7111	Coronal Remnants – Deciduous Tooth	$17.86
D7140	Extraction, Erupted Tooth or Exposed Root	$66.93
D7210	Surgical Rmvl of Erupted Tooth	$124.16
D7220	Remvl Impacted, Soft Tissue	$149.38
D7230	Remvl Impacted, Partially Bony	$206.61
D7240	Remvl Impacted, Completely Bon	$239.59
D7241	Removal of Impacted Tooth – Completely Bony with Unusual Surgical Complications	$258.02
D7250	Surg Rem. Residual Tooth Roots	$124.16
D7260	Oroantral Fistula Closure	$370.91
D7261	Primary Closure of a Sinus Perforation	$178.50
D7270	Replantation Single Tooth	$327.31
D7280	Surg Exposure of Impacted tooth	$262.87
D7282	Mobilization or Erupted or Malpositioned Tooth to Aid	$121.66
D7283	Placement, Device to Aid Eruption	$96.03
D7285	Biopsy of Oral Tissue, Hard	$79.49
D7286	Biopsy of Oral Tissue, Soft	$79.49
D7288	Brush Biopsy	$59.51
D7291	transseptal/supra crestal fiberotomy - by report	$27.37
D7310	Alveoloplast, conjuct w/ Extract	$98.78
D7311	Alveoloplasty in Conjunction with Extractions – Per Quad	$47.61
D7320	Alveoloplasty–No Extractions	$166.24
D7321	Alveoloplasty, W/O Ext	$83.30
D7450	Removal of Benign Odontogenic Cyst or Tumor – up to 1.25 cm	$137.88
D7451	Removal of Benign Odontogenic Cyst or Tumor – greater than 1.25 cm	$156.18
D7460	removal nonodontogenic cyst/tumor - 1.25 cm	$137.88
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	$166.24
D7472	Removal of Torus Palatinus	$238.04
D7473	Removal of Torus Mandibularis	$166.24
D7485	Surgical Reduction of Osseous Tuberosity	$166.24
D7510	Abscess Intraoral I and D	$30.11
D7511	Incision, Drainage Intra – Com	$65.96
D7880	occlusal Orthotic Devise, By Report	$379.67
D7910	suture of small wounds - 5.0 cm	$115.16
D7911	complicated suture - 5.0 cm	$150.65
D7912	complicated suture - >5.0 cm	$181.72
D7960	Frenulectomy	$330.05
D7963	Frenuloplasty	$357.00
D7970	Excision of Hyperplastic Tissue – Per Arch	$158.98
D7971	Excision of Pericoronal Gingiva	$84.31
D7972	Surgical Reduction of Fibrous Tuberosity	$158.98
D8020	Limited Orthodontic Treatment of the Transitional Dentition	$321.62
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	$321.62
D8040	Limited Orthodontic Treatment of the Adult Dentition	$321.62
D8080	Comprehensive Orthodontic Treatment of Adult Dentition, Banding	$1,361.59
D8210	Removable Appliance Therapy	$196.39
D8220	Fixed Appliance Therapy	$238.50
D8660	pre - orthodontic treatment visit	$194.00
D8670	Quarterly Ortho Adjustments	$680.78
D8680	orthodontic retention	$145.50
D8691	repair of orthodontic appliance	$72.75
D8692	Replacement of Lost or Broken Retainer	$121.25
D8693	re-bonding, re-cementation and/or repair of fixed retainers	$42.16
D8999	Unspec. Ortho procedure	By Report
D9110	Palliative Treatment	$46.98
D9120	fixed partial denture sectioning	$67.90
D9220	General Anesthesia	$124.16
D9221	General Anesthesia, add	$62.08

Code	Description	Fee
D9230	Analgesia	$32.73
D9241	Intravenous Sedation – First 30 Minutes	$106.70
D9242	Intravenous Sedation – Each additional 15 Minutes	$48.50
D9248	Non-intravenous Sedation	$106.70
D9310	Professional Consultation	$80.69
D9420	Professional Hospital Call	$62.62
D9440	Office Visit After Hours	$31.31
D9610	Therapeutic Drug Injection	$19.27
D9612	Therapeutic Drug Injection – 2 or more	$38.55
D9630	Other Drugs and/or Medicaments, By Report	$19.27
D9910	Apply Desensitizing Medication	$31.31
D9920	Behavior Management No Medication	$66.45
D9930	Treatment of Complications (Postsurgical)	$32.51
D9940	Occlusal guard, by report	$194.00
D9951	occlusal adjustment - limited	$46.98
D9952	occlusal adjustment - complete	$79.54
D9971	odontoplasty - 1 to 2 teeth	$17.86
D9999	Approved Hospital Case	$148.65

Exhibit A Benefits Covered for
VA Smiles for Children - Under 21

Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the DentaQuest Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.
The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

For all services that require pre-payment review, Providers have the option of requesting prior authorization

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (extuding final restoration)	0-20	Teeth 1 - 32	No		
D3120	pulp cap - indirect (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No		
D3220	therapeutic pulpotomy (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals (D3310, D3320, D3330).	
D3221	gross pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	No		
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth	0-20	Teeth C - H, M - R	No		
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth	0-20	Teeth A, B, I - L, S, T	No		
D3310	Endodontic therapy, anterior (exc final rest)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	Endodontic therapy, bicuspid (exc final restore)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	Endodontic therapy, molar(excluding final restore)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3346) per 1 Lifetime Per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)