VIRGINIA BOARD OF DENTISTRY
Regulatory-Legislative Committee
AGENDA
May 2, 2014

Department of Health Professions
Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center
Henrico, Virginia 23233

TIME		PAGE
1:00 p.m.	**Call to Order – Jeffrey Levin, DDS, Chair**	
	Evacuation Announcement – Ms. Reen	
	Public Comment	
	Approval of Minutes	
	February 7, 2014 minutes	**P1-P9**
	Status Report on Regulatory Actions – Ms. Yeatts	
	Fee Slitting – Ms. Yeatts	**P10**
	• Reference Materials	**P11-P30**
	• Guidance Document 60-15	**P31-P35**
	• Board of Medicine's Statute	**P36-P37**
	• Legislative Proposal Discussion Draft	**P38**
	Practice Ownership	**P39**
	• Code Provisions	**P40-P52**
	• Tennessee's Policy Statement and Rules	**P53-P57**
	• Department of Taxation's List	**P58-P60**
	• State Corporation Commission's List	**P61-P64**
	• Congressional Report	**P65-P101**
	Permit Holder Office Inspections	**P102**
	• Revised Inspection Form	**P103-P106**
	• Guidance Document	**P107-P109**
	Next meeting	
Adjourn		

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY-LEGISLATIVE COMMITTEE
February 7, 2014

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order at 9:05 a.m., on February 7, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., Chair

MEMBERS PRESENT:
Charles E, Gaskins, III., D.D.S.
Al Rizkalla, D.D.S.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBERS ABSENT:
Surya P. Dhakar, D.D.S.
Myra Howard, Citizen Member
Evelyn M. Rolon, D.D.S.
Bruce S. Wyman, D.M.D.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Huong Q. Vu, Operations Manager

OTHERS PRESENT: Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

ESTABLISHMENT OF A QUORUM: With six members present, a quorum was established.

PUBLIC COMMENT: Melanie Bartlam, RDH, representing the Virginia Dental Hygienists' Association (VDHA), corrected the January 10, 2014 letter sent to the Board by the VDHA President. The appropriate regulations of their concern are: 18VAC60-25-100(B) and 18VAC60-25-100(C).

APPROVAL OF MINUTES: The Committee's December 5, 2013 minutes were approved as published and circulated.

STATUS REPORT ON REGULATORY ACTIONS: Ms. Yeatts reported the following:

- Periodic Review – the proposed regulations to establish four chapters were approved by the Governor. The public hearing was held on January 10, 2014. The public comment period ended on January 11, 2014, and two comments were received.
- The renewal deadline for a faculty license is stated in §54.1-2713.D of the Code, as amended in 2012. As a result, the deadline stated in the Regulations Governing Dental Practice was amended by the Board at its

September, 2013 meeting to conform to the statute. The correction was approved for publication, and it will be effective as of February 12, 2014.

- Sedation and Anesthesia permits for dentists - the emergency regulations will expire on March 15, 2014. It is no longer possible to have final regulations in place by March 15th, because they are still under review by the Secretary of Health and Human Resources. The Board will not be able to issue permits or enforce the regulations after March 15, 2014; until current regulatory process is completed.

REPORT OF THE 2014 GENERAL ASSEMBLY:

Ms. Yeatts reported there are eight DHP bills before the General Assembly and they are advancing without opposition. She reviewed the following bills:

- HB539 authorizes dispensers who are authorized to access the information in the possession of the Prescription Monitoring Program to delegate the authority to certain health care professionals employed at the same facility and under their direct supervision.
- HB611 creates an exception to the denial or suspension of a license, certificate or registration by a board within DHP for surrender in lieu of disciplinary action in another jurisdiction for cases in which the revocation or suspension in the other jurisdiction is the result of nonrenewal of the license, registration, or certification.
- HB661 increases the statute of limitations for prosecutions from one year to five years for a misdemeanor of falsifying patient records with the intent to defraud.
- HB855 requires an applicant for reinstatement whose license, registration, or certificate has been revoked to show evidence that he is safe and competent to practice.
- HB874 authorizes the Board of Pharmacy to identify "drugs of concern" and to require reporting even though it is not a scheduled drug.
- HB891 provides that special conference committees may consider applications for a license, certificate, registration, permit or issuance of a multistate licensure privilege and may grant or deny the application or issue a restricted license, certification, registration, permit, or multistate licensure privilege. The bill also provides that special conference committees may hear cases in which a holder of a permit issued by a health regulatory board is reported to be the subject of disciplinary action.
- HB923 requires the director of the Prescription Monitoring Program to mail information to a mailing address indicated on the recipient request form.
- SB635 authorizes any trained employee of a licensed restaurant, summer camp, or campground to possess and administer epinephrine.

- SB647 directs DMAS to create and to report on a teledentistry pilot program to provide dental services to eligible school-age children.

REVIEW REORGANIZING CHAPTER 20 INTO FOUR CHAPTERS PROPOSED FINAL REGULATIONS:

Dr. Levin noted that the Board is charged with periodic regulatory review. Ms. Yeatts stated that the review is required every four years from when the last review results become effective.

Ms. Reen asked the Committee members to address any changes or needed clarification as the proposed regulations are presented. The Committee's recommendations will be considered by the Board at its March meeting.

Dr. Levin asked Ms. Yeatts to lead the review.

Public Comment Received. Ms. Yeatts noted that only two comments were submitted. She stated that the comments already were merged into the chapters for review and action by the Committee.

1) The Dental Assisting National Board (DANB) suggested that the Dental Auxiliary Learning and Education (DALE) Foundation, which is DANB's affiliate, be added as a continuing education provider.

2) The Virginia Dental Hygienists' Association (VDHA) asked the Board to:

- add administration of ***local anesthesia only*** for dental hygienists.
- remove the (patient) age restriction for hygienists to administer local anesthesia.
- remove the requirement for licensed hygienists to take four (4) hours of the CE hours required every two (2) years on the specific topic of "administration of nitrous oxide and non topical anesthesia."

Ms. Yeatts noted that in regard to the age restriction request from the VDHA, the Board is not authorized to make this change because it is set in the Code of Va.; so only the General Assembly could make this change.

Adopt Recommendation to the Board. Ms. Reen noted that Chapter 21, Chapter 25, and Chapter 30 were also provided on colored paper as references for action on the public comments received, and to allow review of the regulatory changes that have been made since the Committee last worked on these chapters. She suggested that the Committee look at both the white and colored copies side by side as the proposed chapters are discussed.

CHAPTER 15 Regulations Governing the Disciplinary Process

Ms. Yeatts noted that no changes have been made in this chapter. Dr. Watkins moved to recommend that the Board adopt Chapter 15 as presented. The motion was seconded and passed.

CHAPTER 21 Regulations Governing the Practice of Dentistry

18VAC60-21-10.A - Ms. Reen noted that this new section was added to identify the terms defined in the Code of Virginia.

18VAC60-21-10.B - Ms. Yeatts stated that the "Deep sedation" definition includes an additional sentence that was included in the Emergency Regulations for Sedation and Anesthesia Permits (hereinafter referred to as the Emergency Regulations).

Ms. Swecker asked for clarification of the term "*at a later date*" in the "Direct supervision" definition. Ms. Reen stated that it means that a dental assistant II can complete a delegated procedure on another day.

Ms. Reen noted that the term "immediate" was added to the definition of "Direction" to be consistent with the Emergency Regulations.

Ms. Yeatts stated that the definition of "Titration" was also added to be consistent with the Emergency Regulations.

18VAC60-21-30.B – Ms. Yeatts noted that staff replaced "*a dentist shall display **a** license*" with "*a dentist shall display **his** license.*" After discussion, the Committee recommended "*a dentist shall display **his dental** license.*"

18VAC60-21-30.D – Ms. Reen noted that the language of this section was changed to be consistent with the Emergency Regulations.

18VAC60-2-40.A(4) and (5) – Ms. Yeatts noted that the Dental teacher's license is stricken because it was deleted legislatively in 2012. She added that a Dental faculty license is now $400, instead of $285.

18VAC60-21-50 and 18VAC60-21-60 – Ms. Reen noted that these two (2) sections were added using some of the provisions in Guidance Document 60-15 on Standards for Professional Conduct in the Practice of Dentistry.

Dr. Gaskins requested a requirement for disclosure of financial incentives received or paid for referrals in 18VAC60-21-60.B. Dr. Levin suggested the Board address this at another time so that these regulations (en-toto) do not have to undergo another comment period. All agreed.

18VAC60-21-70.A – Ms. Yeatts noted that the phrase "*and dental hygiene*" was deleted here since this chapter addresses the practice of dentists.

18VAC60-21-70.A(1) – Ms. Yeatts stated that the language in this section is new. She added that the phrase "*or dental hygienist*" was deleted because this chapter addresses the practice of dentists. She said the phrase "*or a registered dental assistant II*" was added to address that scope of practice. After discussion, the Committee added the word "***dental***" before '*service or operation.*" All agreed.

18VAC60-21-80.C and D – Ms. Reen posed two questions for the Committee in regard to these sections:
For C – What should be said about offers for which the dentist never charges a fee, or about offers that are not time-limited?
For D – What should be said about advertisements on the internet?

Dr. Gaskins asked how other DHP boards address advertising. Ms. Yeatts replied that she was not aware that any board had addressed internet advertising to date. Dr. Rizkalla suggested more time is needed to think about these two (2) sections.

After discussion, the Committee made the following changes:
For C – added "*if any*" after "*or full fee*"
For D – added "*or archived*" after "*a prerecorded*"; deleted "*on radio or television*"; replaced "*12-month period*" retention to "*two year period*" retention.

18AC60-21-80.E – Ms. Reen noted that staff replaced "*CDT-2011/2012*" with "*in effect at the time the advertisement is issued.*"

18VAC60-21-80.G(3) – Ms. Yeatts noted that the only change here is "*November, 2013.*"

18VAC60-21-90.B(6) – The Committee added "***and teeth identified.***"

18VAC60-21-90.B(7) – Ms. Yeatts noted that staff edited this section to say "*treatment rendered, the.*"

18VAC60-21-90.G - Ms. Yeatts noted that staff edited this section to say "*licensed dentist*" instead of "*licensee.*"

18VAC60-21-100 – after discussion, the Committee added after "*neurological complication*" the phrase ***"that was related to dental treatment or services provided"*** and added this sentence at the end of the section - ***Any emergency treatment of a patient by a hospital that is related to any sedation and anesthesia shall also be reported.***"

18VAC60-21-120 – Ms. Yeatts noted that "s" needed to be deleted at the end of the word "*supervision*" in the section heading.

18VAC60-21-140.A(1) – the Committee deleted the phrase "*by the dentist.*"

18VAC60-21-160.A – Ms. Yeatts stated that staff replaced "*under the indirect or under general supervision required in 18VAC60-21-120*" with "***under indirect supervision***" to be consistent with the previous sections on delegation. All agreed.

18VAC60-21-160.B (blue page 20 or White P33) - Ms. Yeatts stated that staff replaced "*shall be under the direction of the dental hygienist*" with "***shall be***

performed under the direction and indirect supervision of a dental hygienist" to be consistent with the previous sections on delegation. All agreed.

18VAC60-21-190.A – Ms. Yeatts stated that staff edited this section to say "*Application for an unrestricted dental license, registration, or permit issued by the board shall include*"

18VAC60-21-190.A(1) – after discussion the Committee added "***as specified in 18VAC60-21-200.***"

18VAC60-21-190.A(3) – Ms. Reen noted that staff edited this section because the data banks have been merged.

18VAC60-21-230.B – Ms. Yeatts noted that this section was deleted since there is no longer a teacher's license.

18VAC60-21-230.C – Ms. Yeatts noted that this now becomes the new section B and said that "*Full-time faculty*" was replaced with "***Faculty license*** "to conform to the Code.

18VAC60-21-230.E(1)(a) – Ms. Yeatts stated that staff replaced "*another state*" with "***another U.S. jurisdiction***."

18VAC60-21-240.B – Ms. Yeatts noted that staff added "***or a permit to administer conscious/moderate sedation, deep sedation, or anesthesia"*** for March 31 renewals, and moved "***a faculty license"*** to the sentence on June 30 renewals.

18VAC60-21-250.A(1) – Ms. Reen noted that the sentence allowing CE credit for passing the Virginia Dental Law Exam was deleted because the Board no longer has a contractor to administer the exam. She added that the Board still administers the exam for licensees who are required by Board Order to pass the exam.

18VAC60-21-250.A(2) – Dr. Rizkalla moved to add "*for healthcare professionals*" after "basic life support." The motion was seconded. Dr. Watkins asked what the difference is between basic CPR and CPR that is provided for healthcare professionals. After discussion, staff was asked to provide information for the March Board meeting and Dr. Rizkalla was allowed to withdraw his motion.

18VAC60-21-250.C(1) and (6) – Ms. Yeatts noted that staff added "***continuing education***" before "*providers.*"

18VAC60-21-250.C(14) – Ms. Yeatts noted that staff added the DALE Foundation as a DANB affiliate in the list of CE providers, as requested by DANB. All agreed.

18VAC60-21-260.I(1) – Ms. Yeatts noted that staff has replaced "*an approved*" with "***a.***" .

18VAC60-21-280.C(2a) – Ms. Yeatts noted that staff has added "***parenterally***" in front of "*administer Schedule VI.*"

Dr. Watkins moved to adopt Chapter 21 as amended. The motion was seconded and passed.

CHAPTER 25 Regulations Governing the Practice of Dental Hygiene
18VAC60-25-20.B – the Committee added "***dental hygiene***" in front of "*license.*"

18VAC60-25-40.C(1) (yellow page 6 or White P62) – The Committee deleted "*by the dentist.*"

18VAC60-25-40.F – Ms. Yeatts noted that this new section was added to address Virginia Dept. of Health (VDH) dental hygienists practicing under the remote supervision of a VDH dentist. She added that this practice is authorized by §54.1-2722(E) of the Code of Virginia.

18VAC60-25-100.A(3) – Ms. Yeatts noted that staff moved "***parenterally***" to follow after "***local anesthesia.***"

18VAC60-25-100.C – Ms. Yeatts noted that in response to the VDHA's comment, staff recommends deleting the language in this section and replacing it with the proposed requirement for a 28 hour course for administration of local anesthesia. She added that anyone wanting to only administer nitrous oxide could take the 8 hour course. All agreed.

18VAC60-25-110.A(5) – The Committee added "***and teeth identified.***"

18VAC60-25-110.A(7) – the Committee added "***treatment rendered.***"

18VAC60-25-130.A – Ms. Yeatts noted that staff deleted "*temporary permits*" and "*teacher's.*"

18VAC60-25-130.A(3) - Ms. Reen noted that staff changed this section to reflect that the data banks have been merged.

18VAC60-25-160 – Ms. Yeatts noted that staff deleted the word "*teacher's*" from the section heading.

18VAC60-25-190.A(2) – Ms. Yeatts noted that the VDHA recommended a change in this section. Ms. Swecker moved to delete '***administers nitrous oxide or nontopical local anesthesia***" The motion was seconded and passed. The Committee also deleted "***administration or***" after "*related to.*"

18VAC60-25-90.C(14) - Ms. Yeatts noted that staff added the DALE Foundation as a DANB affiliate in the list of CE providers as requested by DANB. All agreed.

18VAC60-25-190.C(15) – Ms. Yeatts noted that the Board added the American Academy of Dental Hygiene as a CE provider at its March 8, 2013 meeting.

Ms. Swain moved to adopt Chapter 25 as amended. The motion was seconded and passed.

CHAPTER 30 Regulations Governing the Practice of Dental Assistants

18VAC60-30-10.B – Ms. Reen noted that the term "immediate" was added to the definition of "Direction."

18VAC60-30-20.B - the Committee added the provision for a duplicate license used in Chapter 25.

18VAC60-30-70.A - Ms. Yeatts stated that staff deleted the references to general supervision. All agreed.

18VAC60-30-70.B – The Committee replaced "*to a dental assistant*" with "*to **any** dental assistant.*"

18VAC60-30-80 – Ms. Yeatts noted that staff replaced "*No dentist or dental hygienist shall permit a person not otherwise licensed by this board to*" with "***A dental assistant I or II shall not***"

18VAC60-30-100.A(2) – The Committee added "***and teeth identified.***"

18VAC60-30-100.A(3) – The Committee added "***treatment rendered.***"

18VAC60-30-115 – Ms. Reen suggested adding this new section in this location. All agreed.

18VAC60-30-130 – Ms. Yeatts noted that this section was moved to 18VAC60-30-115.

18VAC60-30-150.F – Ms. Yeatts noted that staff deleted this section because there is no CE requirement for renewal or reinstatement.

18VAC60-30-160.B – Ms. Yeatts noted staff added language on continuing competence in this section.

18VAC60-30-170.B – Ms. Yeatts noted that staff specified DANB as a credentialing organization.

18VAC60-30-170.D – Ms. Yeatts noted that this is a new section that staff has added. No other change was made.

Dr. Watkins moved to adopt Chapter 30 as amended. The motion was seconded and passed.

NEW BUSINESS:

Dr. Gaskins proposed replacing the current text in 18VAC60-20-71(2) on licensure by credentials for dentists with the following:

"Be a graduate and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry programs or a post-doctoral education program in any other specialty."

He explained that the current language is misleading to applicants and difficult for the Credentials Committee to apply correctly. He asked that this change be made by the Board at its March meeting. Ms. Reen explained that this change needed to be done in the current regulatory process or pursued separately as a new regulatory proposal. She suggested deferring this discussion to the March Board meeting, and asked Kelley to address the issues experienced by the Credentials Committee as part of her report. All agreed.

ADJOURNMENT: With all business concluded, Dr. Levin adjourned the meeting at 1:42 p.m.

Jeffrey Levin, D.D.S., Chair	Sandra K. Reen, Executive Director
Date	Date

Agenda item: Policy Development to Address Fee Splitting

The Board charged the Regulatory/Legislative Committee to develop a proposal to address concerns advanced through public comment about fee splitting between dentists and with third parties.

Ms. Yeatts researched this subject and has provided reference materials, Guidance Document 60-15, the Board of Medicine's statute and a discussion draft to facilitate discussion.

Action Options:

- Give directions to staff for researching the topic further
- Recommend a proposal for consideration by the Board on June 13, 2014.

Page 10 -
Prohibition on
Fee-Splitting

American Dental Association

PRINCIPLES OF

Ethics

AND

CODE OF

Professional Conduct

With official advisory opinions revised to April 2012.

ADA American Dental Association®

CONTENTS

I. INTRODUCTION

The dental profession holds a special position of trust within society. As a consequence, society affords the profession certain privileges that are not available to members of the public-at-large. In return, the profession makes a commitment to society that its members will adhere to high ethical standards of conduct. These standards are embodied in the *ADA Principles of Ethics and Code of Professional Conduct (ADA Code)*. The *ADA Code* is, in effect, a written expression of the obligations arising from the implied contract between the dental profession and society.

Members of the ADA voluntarily agree to abide by the *ADA Code* as a condition of membership in the Association. They recognize that continued public trust in the dental profession is based on the commitment of individual dentists to high ethical standards of conduct.

The *ADA Code* has three main components: The **Principles of Ethics**, the **Code of Professional Conduct** and the **Advisory Opinions**.

The **Principles of Ethics** are the aspirational goals of the profession. They provide guidance and offer justification for the *Code of Professional Conduct* and the *Advisory Opinions*. There are five fundamental principles that form the foundation of the *ADA Code:* patient autonomy, nonmaleficence, beneficence, justice and veracity. Principles can overlap each other as well as compete with each other for priority. More than one principle can justify a given element of the *Code of Professional Conduct*. Principles may at times need to be balanced against each other, but, otherwise, they are the profession's firm guideposts.

The **Code of Professional Conduct** is an expression of specific types of conduct that are either required or prohibited. The *Code of Professional Conduct* is a product of the ADA's legislative system. All elements of the *Code of Professional Conduct* result from resolutions that are adopted by the ADA's House of Delegates. The *Code of Professional Conduct* is binding on members of the ADA, and violations may result in disciplinary action.

The **Advisory Opinions** are interpretations that apply the *Code of Professional Conduct* to specific fact situations. They are adopted by the ADA's Council on Ethics, Bylaws and Judicial Affairs to provide guidance to the membership on how the Council might interpret the *Code of Professional Conduct* in a disciplinary proceeding.

The *ADA Code* is an evolving document and by its very nature cannot be a complete articulation of all ethical obligations. The *ADA Code* is the result of an ongoing dialogue between the dental profession and society, and as such, is subject to continuous review.

Although ethics and the law are closely related, they are not the same. Ethical obligations may–and often do–exceed legal duties. In resolving any ethical problem not explicitly covered by the *ADA Code*, dentists should consider the ethical principles, the patient's needs and interests, and any applicable laws.

II. PREAMBLE

The American Dental Association calls upon dentists to follow high ethical standards which have the benefit of the patient as their primary goal. In recognition of this goal, the education and training of a dentist has resulted in society affording to the profession the privilege and obligation of self-government. To fulfill this privilege, these high ethical standards should be adopted and practiced throughout the dental school educational process and subsequent professional career.

self-determination and confidentiality and to promote the welfare of all patients. Care should be exercised to respect the wishes of an adult patient who asks that a suspected case of abuse and/or neglect not be reported, where such a report is not mandated by law. With the patient's permission, other possible solutions may be sought.

Dentists should be aware that jurisdictional laws vary in their definitions of abuse and neglect, in their reporting requirements and the extent to which immunity is granted to good faith reporters. The variances may raise potential legal and other risks that should be considered, while keeping in mind the duty to put the welfare of the patient first. Therefore a dentist's ethical obligation to identify and report suspected cases of abuse and neglect can vary from one jurisdiction to another.

Dentists are ethically obligated to keep current their knowledge of both identifying abuse and neglect and reporting it in the jurisdiction(s) where they practice.

3.F. PROFESSIONAL DEMEANOR IN THE WORKPLACE.
Dentists have the obligation to provide a workplace environment that supports respectful and collaborative relationships for all those involved in oral health care.

ADVISORY OPINION

3.F.1. DISRUPTIVE BEHAVIOR IN THE WORKPLACE.
Dentists are the leaders of the oral healthcare team. As such, their behavior in the workplace is instrumental in establishing and maintaining a practice environment that supports the mutual respect, good communication, and high levels of collaboration among team members required to optimize the quality of patient care provided. Dentists who engage in disruptive behavior in the workplace risk undermining professional relationships among team members, decreasing the quality of patient care provided, and undermining the public's trust and confidence in the profession.

Section 4 PRINCIPLE: JUSTICE ("fairness"). The dentist has a duty to treat people fairly.

This principle expresses the concept that professionals have a duty to be fair in their dealings with patients, colleagues and society. Under this principle, the dentist's primary obligations include dealing with people justly and delivering dental care without prejudice. In its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.

CODE OF PROFESSIONAL CONDUCT

4.A. PATIENT SELECTION.
While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex or national origin.

ADVISORY OPINION

4.A.1. PATIENTS WITH BLOODBORNE PATHOGENS.
A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual is infected with Human

Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested should be made on the same basis as they are made with other patients. As is the case with all patients, the individual dentist should determine if he or she has the need of another's skills, knowledge, equipment or experience. The dentist should also determine, after consultation with the patient's physician, if appropriate, if the patient's health status would be significantly compromised by the provision of dental treatment.

4.B. EMERGENCY SERVICE.

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, the dentist, upon completion of treatment, is obliged to return the patient to his or her regular dentist unless the patient expressly reveals a different preference.

4.C. JUSTIFIABLE CRITICISM.

Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services. Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true.

ADVISORY OPINION

4.C.1. MEANING OF "JUSTIFIABLE."

Patients are dependent on the expertise of dentists to know their oral health status. Therefore, when informing a patient of the status of his or her oral health, the dentist should exercise care that the comments made are truthful, informed and justifiable. This should, if possible, involve consultation with the previous treating dentist(s), in accordance with applicable law, to determine under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would unjustly imply mistreatment. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable. Therefore, this section is phrased to address the discretion of dentists and advises against unknowing or unjustifiable disparaging statements against another dentist. However, it should be noted that, where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements.

4.D. EXPERT TESTIMONY.

Dentists may provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

ADVISORY OPINION

4.D.1. CONTINGENT FEES.

It is unethical for a dentist to agree to a fee contingent upon the favorable outcome of the litigation in exchange for testifying as a dental expert.

4.E. REBATES AND SPLIT FEES.
Dentists shall not accept or tender "rebates" or "split fees."

ADVISORY OPINION

4.E.1. SPLIT FEES IN ADVERTISING AND MARKETING SERVICES.
The prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists. Thus, a dentist who pays for advertising or marketing services by sharing a specified portion of the professional fees collected from prospective or actual patients with the vendor providing the advertising or marketing services is engaged in fee splitting. The prohibition against fee splitting is also applicable to the marketing of dental treatments or procedures via "social coupons" if the business arrangement between the dentist and the concern providing the marketing services for that treatment or those procedures allows the issuing company to collect the fee from the prospective patient, retain a defined percentage or portion of the revenue collected as payment for the coupon marketing service provided to the dentist and remit to the dentist the remainder of the amount collected.

Dentists should also be aware that the laws or regulations in their jurisdictions may contain provisions that impact the division of revenue collected from prospective patients between a dentist and a third party to pay for advertising or marketing services.

Section 5 PRINCIPLE: VERACITY ("truthfulness"). The dentist has a duty to communicate truthfully.

This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people. Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.

CODE OF PROFESSIONAL CONDUCT

5.A. REPRESENTATION OF CARE.
Dentists shall not represent the care being rendered to their patients in a false or misleading manner.

ADVISORY OPINIONS

5.A.1. DENTAL AMALGAM AND OTHER RESTORATIVE MATERIALS.
Based on current scientific data, the ADA has determined that the removal of amalgam restorations from the non-allergic patient for the alleged purpose of removing toxic substances from the body, when such treatment is performed solely at the recommendation of the dentist, is improper and unethical. The same principle of veracity applies to the dentist's recommendation concerning the removal of any dental restorative material.

5.A.2. UNSUBSTANTIATED REPRESENTATIONS.
A dentist who represents that dental treatment or diagnostic techniques

ADA American Dental Association®

211 East Chicago Avenue
Chicago, Illinois 60611

T 312.440.2500
F 312.440.7494
www.ada.org

Date: October 7, 2011

To: ADA Constituent Executive Directors

From: ADA Legal Division

Subject: Legal Issues in Marketing a Dental Practice: Referral Gifts and Groupon Discounts[1]

QUESTION PRESENTED

Whether a dentist's adoption of any of the following practices creates potential legal concerns:

(a) Offering and awarding gifts[2] to existing patients in exchange for new patient referrals ("referral gifts")?

(b) Offering and awarding Groupon[3] discounts to new or existing patients?

(c) Advertising Groupon or other discounts in connection with dental services?

EXECUTIVE SUMMARY

Depending on (a) the state in which the dentist practices and (b) whether the dentist provides services payable under a federal health care program such as Medicare or Medicaid, a dentist may be prohibited under state and/or federal law from (i) offering and/or awarding referral gifts or (ii) offering and/or awarding Groupon discounts. Many states have regulations that prohibit or restrict the award of gifts as a means of soliciting patients, or prohibit fee splitting between a dentist and a third party. (A dentist utilizing Groupon to offer discounts to new patients will split a portion of the revenue generated from the Groupon promotion with Groupon.) In addition, the federal anti-kickback statute generally prohibits a dentist from offering or paying remuneration to induce a person to refer a patient that may be eligible for services under a federal health care program, including Medicare or Medicaid.

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[1] This memo is not intended to provide or offer legal or other advice and should not be relied upon for that purpose. To get appropriate legal advice, one should consult directly with a properly qualified attorney.

[2] For purposes of this memo, "gifts" include cash, gift cards, or other tangible items of value. It does not include discounts for services, for which different rules may apply.

[3] The analysis provided herein would be applicable to any company that provides similar services under a similar fee structure (e.g., LivingSocial).

A violation of the state regulations could result in the dentist's facing censure and reprimand, fines, suspension, and even license revocation, while a dentist violating federal law could be charged with a felony and subject to fines, imprisonment, and exclusion from federal health care programs.

The advertising of discounts may also raise concerns. Many states have dental advertising regulations that restrict the method of advertising discounts in connection with dental services. Some restrictions involve the form of the advertisement, while others involve the manner in which the discount and other fees are applied to a patient.

In addition, the terms of the dentist's contracts with third party payors may give rise to issues with the offer and award of referral gifts or Groupon discounts to patients. These contracts sometimes contain provisions requiring that fees submitted to the insurer reflect any rebates or reductions in the fees (or co-pays) charged to the patient, or that the dentist grant the insurer the best price that the dentist charges for a particular service (a "most favored nations" clause). In the first instance, giving a rebate to a patient after the service has been billed to the insurer may violate the contract; in the second, providing a discounted price to Groupon customers may breach the most favored nation provision (or perhaps require the dentist to offer the same discount to the insurer's patients, and perhaps even to rebate an equivalent per patient discount to the insurer).

Finally, the offer and award of referral gifts or Groupon discounts to patients may violate certain ADA ethical rules, including the rule prohibiting dentists from giving rebates and splitting fees.

ANALYSIS

1. Referral Gifts

A dentist may be prohibited under state and/or federal law from offering or awarding referral gifts to existing patients.

a. State Law

Many states have regulations that directly or indirectly prohibit or restrict the award of gifts as a means of soliciting dental patients. Some of these laws, such as those in Illinois and Texas, have a broad prohibition against such gifts. The Illinois Dental Practice Act (the "Illinois Act") makes it unlawful for any dentist to "advertise or offer gifts as an inducement to secure dental patronage",[4] and the rules of the Texas State Board of Dental Examiners (the "Texas Board Rules") make it illegal for a dentist to "offer, give, dispense, distribute or make available to any third party...any cash, gift, premium, chance, reward, ticket, item or thing of

[4] 225 ILCS 25/45.

value for securing or soliciting patients".[5] Under these regulations, even nominal gifts made to existing patients may be prohibited.[6]

Other state regulations have a more narrow prohibition against referral gifts. For example, while the New Jersey Board of Dentistry regulations include a general prohibition on offering or paying remuneration to third parties in exchange for a referral, that provision is tempered by the statement that "[n]othing contained in this section shall prohibit a dentist from providing a gift to a patient, or from providing a credit for dental services to a patient, provided the gift or credit does not exceed $25.00 in value".[7] Hence, referral gifts to existing patients having of value of $25.00 or less may be allowed under the New Jersey regulations.

In addition, some state regulations may be read to bar referral gifts to existing patients even though the regulations do not specifically mention "gifts" or "consideration". Under the Arizona Dental Practice Act, "unprofessional conduct" is defined to include the "giving or receiving . . . of rebates, either directly or indirectly".[8] While a referral gift such as movie tickets or a gift card may not typically be thought of as a rebate, a broad interpretation of the statute might treat such a gift as a means of helping to offset the patient's fees. Similarly, some statutes prohibit "fee splitting" for the referral of patients.[9] If a referral gift to an existing patient is interpreted as a method of dividing fees received from a new patient between the dentist and the existing patient, such gift would be prohibited under the fee-splitting laws.

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[5] Rule §108.60.

[6] See also, §29.1.b.3 and §29.1.b.12(e) of the New York Rules of the Board of Regents (unprofessional conduct includes "directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services" and "offer[ing] bonuses or inducements in any form other than a discount or reduction in an established fee or price for a professional service or product"); Section 650(a) of the California Business and Professions Code ("the offer, delivery, receipt, or acceptance by any person licensed under this division ... of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful").

[7] Chapter 13:30-8.13(d).

[8] Chapter 32-1201.21(k).

[9] See Section 23(5) of the Illinois Act (prohibiting the "[d]ivision of fees or agreeing to split or divide the fees received for dental services with any person for bringing or referring a patient"); Section 776.A(9) of the Louisiana Dental Practice Act (prohibiting the "[d]ivision of fees or other remuneration or consideration with any person not licensed to practice dentistry in Louisiana, or an agreement to divide and share fees received for dental services with any non-dentists in return for referral of patients to the licensed dentists, whether or not the patient or legal representative is aware of the arrangement"); Section 333.16221(d)(ii) of the Michigan Public Health Code (prohibiting "[d]ividing fees for referral of patients").

Accordingly, a dentist should carefully consider and seek guidance as to the application of state laws before offering and awarding referral gifts to patients. A violation by a dentist of the state dental board statute and regulations could result in the dentist's facing censure and reprimand, fines, suspension, and even license revocation. Note that compliance with state law would not absolve a dentist of exposure under federal law (and vice versa).

b. Federal Law

The federal anti-kickback statute ("AKS") prohibits any person from:

> " ... knowingly and willfully offer[ing] and pay[ing] any remuneration (including any kickback, bribe or rebate)...to any person to induce such person...to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program".[10]

The AKS can apply if even one purpose of the transaction is to generate referral(s) for such item or service. Prior to the enactment of the Patient Protection and Affordable Care Act in 2010 (the "Affordable Care Act"), some courts held that the AKS only applied if the defendant *knew* that the AKS prohibited offering or paying remuneration to induce referrals, and did so with the specific intent to disobey the law. However, the Affordable Care Act amended the AKS to make clear that the AKS does not require the government to prove actual knowledge of a "known legal duty" that was being breached, but only that the dentist intended to perform the act that violated the law.[11] In addition, the statute refers to payments that "may be" made under a federal health care program, so it is possible that a dentist who accepts Medicare or Medicaid patients may be found to have violated the AKS even if the payment for services at issue is not in fact made by a Medicare or Medicaid patient or out of Medicare or Medicaid funds.

Accordingly, a dentist who provides services payable by a federal health care program including Medicare or Medicaid should carefully consider the application of the AKS before offering and awarding referral gifts to patients.[12] A violation by the dentist of the AKS could result in the dentist being charged with a felony and subject to fines and imprisonment, in

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[10] 42 U.S.C. §1320a-7b(b).
[11] 42 U.S.C. §1320a-7b.
[12] There may also be an issue under the Civil Monetary Penalties Law (the "CMP") if the patient receiving the referral gift is a Medicare or state health care patient. Section 1128A(a)(5) of the CMP provides for the imposition of civil monetary penalties against any person who "gives something of value to a Medicare or state health care program beneficiary, including Medicaid, that the benefactor knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a state health care program, including Medicaid". However, "nominal" gifts of between $10 and $50 annually are generally allowed under the CMP.

addition to being excluded from federal health care programs, such as Medicare and Medicaid.

2. Groupon

Offering and awarding Groupon discounts by a dentist to new or existing patients may be prohibited under state or federal law.

a. State Law

As noted above, many states have regulations that prohibit fee splitting between a dentist and a third party. For example, the Michigan Public Health Code prohibits "[d]ividing fees for referral of patients".[13] When a dentist utilizes Groupon to offer discounts to new patients, the dentist generally splits the revenue generated from the promotion with Groupon (in fact, the fees are paid directly to Groupon, with Groupon then paying the dentist a percentage of the fees collected). This arrangement could be seen to violate state regulations prohibiting fee-splitting.

In addition, Groupon-type arrangements may also violate the other rules and regulations that prohibit dentists from providing referral gifts to existing patients. For example, as noted in Paragraph 1.a. above, under the Texas Board Rules a dentist may not offer or give cash to a third party for securing or soliciting patients. While the Texas Board Rules do have a "safe harbor" for remuneration for advertising, marketing or other services if the remuneration "is set in advance, is consistent with the fair market value of the services, and is not based on the volume or value of any patient referrals", the Groupon arrangement most likely would not meet the safe harbor requirements because Groupon's fees are not set in advance and are based on the volume or value of patient referrals. Accordingly, if Groupon is viewed under the rules as having secured or solicited patients for the dentist in exchange for cash, the Groupon arrangement may constitute a violation of such rules.[14]

A dentist may argue of course that Groupon is simply advertising or promoting the dentist's services, and is thus not referring or soliciting patients on behalf of the dentist. However, a dentist considering participation in Groupon may wish to wait until further guidance is provided by the states regarding this type of arrangement. In fact, the Oregon Board of Dentistry recently released a "Newsflash" announcing it "had preliminarily determined that [voucher systems for potential patients] may violate Oregon's unprofessional conduct rule which prohibits offering rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee or employer". The Board further advised that "until [such arrangements] can be fully reviewed by the Board, licensees proceed with caution and if they feel necessary seek legal counsel on this matter or contact the Board..."

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[13] Section 333.16221(d)(ii). See footnote 9 above for additional state regulations prohibiting fee splitting.

[14] See footnote 6 above for additional examples of state regulations prohibiting the payment of remuneration to third parties in exchange for patient referrals.

Accordingly, a dentist should carefully consider and seek appropriate guidance as to the application of state law before offering and awarding Groupon discounts to new or existing patients. A violation by a dentist of the state dental statutes and regulations might risk the possibility of censure and reprimand, fines, suspension, and even license revocation.

b. Federal Law

As described in Paragraph 1.b. above, the AKS prohibits any person from knowingly and willfully offering or paying cash to any person to induce the person to refer a patient for services for which payment may be made under a federal health care program. While the AKS does provide a safe harbor for payments by physicians to referral services such as professional societies or other consumer-oriented groups, the Groupon-type arrangement may not fit within the safe harbor, which requires that any payment from a participant to a referral service not be based on the volume or value of any referrals and must be based on the cost of operating the referral service.[15] On the other hand, the AKS should not be applicable if the Groupon discount is being offered solely for services that would not be covered by a federal health care program.

As under state law, a dentist may claim that Groupon is not referring patients on behalf of the dentist, but is instead simply advertising or promoting the dentist's services. Once again, however, the more prudent approach may be simply to wait to participate in Groupon until clear guidance is provided, by the federal government or the courts.

Accordingly, a dentist who provides services payable under a federal health care program should carefully consider the application of the AKS before offering Groupon discounts for covered services to new or existing patients. A violation of the AKS can be a felony and can subject an offender to fines, imprisonment, and exclusion from federal health care programs, such as Medicare and Medicaid.

3. Discount Advertising Regulations

Many states have regulations restricting the advertising of discounts in connection with dental services. Florida, for example, imposes the following disclosure requirements with respect to advertising of dental service discounts:

> (1) An appropriate disclosure regarding advertised fees is necessary to protect the public since there is no uniform code available which would enable a fair and rational selection based upon advertised fees.
> (2) Any advertisement containing fee information shall contain a disclaimer that the fee is a minimum fee only.
> (3) Any advertised fee for a dental service shall state a specified period during which the fee is in effect or that service shall remain available at or below the advertised fee for at least 90 days following the final advertisement for that service.

[15] 42 C.F.R. §1001.952(f).

> (4) Any dental service for which a fee is advertised shall be accompanied either by a description of that service using the exact wording for that service contained in the American Dental Association's "Code on Dental Procedures and Nomenclature"... or by the specific ADA Code number or numbers which accurately and fully describes the advertised dental service.[16]

In addition, Florida requires that the following statement be included in advertisements for discounted services in capital letters and clearly distinguishable from the rest of the text in the advertisement:

> THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT THAT IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT.

Similarly, in Indiana, advertisements of discount offers by dentists must disclose "the non-discounted or full price and the final discounted price", as well as the period during which the discount will be available.[17] Accordingly, a Groupon or other discount ad that does not contain the requisite language for satisfying applicable state dental advertising regulations may be in violation of the law.

In addition to restrictions on the form of the advertisement under state law, there may also be restrictions on the manner in which the discount and other fees are charged to a patient. The Illinois Act, for example, provides that "[d]entists may advertise or offer free examinations or free dental services; it shall be unlawful, however, for any dentist to charge a fee to any new patient for any dental service provided at the time that such free examination or free dental services are provided."[18] And New Jersey law states that "[s]ervices advertised as complimentary, free of charge or for a discounted fee shall be offered equally to all patients identified as eligible in the advertisement (for example "new patients"), regardless of the patient's third-party coverage."[19]

Accordingly, a dentist should carefully consider the application of, and seek appropriate guidance as to, the state dental advertising regulations before advertising for Groupon or

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[16] Fla. Admin. Code Ann. R. 64B5-4.003.
[17] 828 Ind. Admin. Code 1-1-18(d). See also Cal. Code Regs. Tit. 16 Section 1051 (advertising of discounted dental services must disclose the dollar amount of the non-discounted fee, the dollar amount of the discount fee (or the percentage of the discount), the length of time the discount is available, the specific groups who qualify for the discount, and any other applicable terms and conditions).
[18] 225 ILCS 25/45.
[19] N.J.A.C. 13:30-6.2.

other dental discounts. As in the case of the previously discussed statutes or regulations, a violation of the state dental statutes and regulations could result in censure and reprimand, fines, suspension, and even license revocation.

4. Insurance Contracts

The provision of referral gifts or discounts may also be problematic under the terms of the dentist's contracts with third party payors. These contracts may require that fees submitted to the insurer reflect any rebates or reductions in the fees (or co-pays) charged to the patient. In such case, if a rebate is given to a patient after the service has been billed to the insurer, the insurer may contend that the rebate effectively reduced the fees for the service and thus that the dentist's a claim is in violation of his or her contract (or even fraudulent). The rebate may also be viewed as violating Section 5.B. of the ADA Ethics Code, which provides that "[d]entists shall not represent the fees being charged for providing care in a false or misleading manner".

Further, if the insurance contract contains a "most favored nation" clause, that clause may be violated by referral gifts and Groupon discounts. A "most favored nation" clause generally provides that the dentist must grant the insurer the best price that the dentist charges for a particular service. The insurer could invoke such a clause to compel a dentist who has given a rebate or Groupon discount for a particular service to charge the reduced price for that service to all patients covered by the insurer, and even to rebate to the insurer amounts previously charged by the dentist in excess of the Groupon rate.

Accordingly, a dentist who has entered into a contract with a third party payor should carefully review the terms and conditions in the contract to determine whether offering and awarding referral gifts or Groupon discounts to patients would impact such third party payor contract.

5. Ethical Implications: ADA Ethics Code

Finally, the provision of referral gifts and Groupon discounts may also raise ethical issues. For example, under Section 4.E. of the ADA Principles of Ethics and Code of Professional Conduct (the "ADA Ethics Code"), a dentist may not "accept or tender 'rebates' or 'split fees.'" For the reasons described above, the referral gifts and Groupon fee arrangement may violate this provision. Moreover, a rebate paid to a patient after a claim for the service has been submitted to an insurer may violate Section 5.B. of the ADA Ethics Code, which provides that "[d]entists shall not represent the fees being charged for providing care in a false or misleading manner". Although compliance with the ADA Ethics Code is not mandatory for all dentists, members of the ADA voluntarily agree to abide by the ADA Ethics Code as a condition of their membership. At the time of writing this memo, it is understood that the ADA Council on Ethics, Bylaws and Judicial Affairs is investigating this issue.

CONCLUSION

There are numerous legal issues for a dentist to consider before offering and awarding referral gifts or Groupon discounts to patients. Hence, a dentist is advised to consult with an attorney familiar with such issues in the state in which the dentist is located prior to proceeding.

Due to Groupon's popularity, it may be that state and federal agencies will soon provide general guidance as to whether the Groupon arrangement violates state and federal laws (indeed, as previously noted, the Oregon Dental Board has recently provided preliminary guidance). If such guidance provides that the Groupon arrangement may under certain circumstances violate state and federal laws, enforcement of such laws may not be far behind.

If general guidance from state agencies is not yet available, the dentist may have the option of seeking an opinion letter from the applicable state dental board as to whether the dentist's marketing plan would run afoul of the state's dental regulations. Doing so, however, would provide no guidance with respect to the federal statute. While a dentist may seek an advisory opinion under the AKS, the process may be costly and time-consuming, and may involve certain risks, particularly if an opinion is sought for past behavior (for which criminal penalties may apply). Legal advice should be sought prior to seeking an advisory opinion either under state law or under the AKS.

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HEALTH LAW

Expert Analysis

Internet Discounts On Health Care Services: Strictly Illegal

Millions of consumers now use coupon and discount websites to access deals on everything from groceries to jewelry to car repairs. The Groupon, Living Social, and other websites are hugely successful cutting-edge innovations in the marketing of goods and services. By all indications, they are a boon to retailers and consumers alike.

A recent article in a Florida newspaper[1] reported that some doctors and dentists are using coupon and discount websites to offer deals on their professional services in order to attract new patients. The article cited a cosmetic surgery center offering a $3,500 laser liposuction surgery for $999; a dental practice charging $129 for a $595 package of services including dental exam, X-rays, cleaning and whitening; and a dermatology practice charging $699 for face-tightening ultrasound therapy that normally costs $1,650. The article also mentioned that the websites advertising these services keep up to half of the payments made by the purchasers. A check on any of a number of coupon and discount websites on any given day will turn up a variety of such offers. Licensed, certified or registered providers of medical, podiatric, chiropractic, dental, and other professional health care services in New York (and for that matter most other states) who offer these kinds of discounted services could find themselves in serious trouble, as could the websites advertising these deals.

Prohibitions

The police powers of the states have historically included licensure and regulation of providers of health care services including medicine, dentistry, podiatry, physical therapy, chiropractic, acupuncture, and other health services (hereinafter referred to as health care services). In New York, the controlling statutes are the Education Law,[2] which governs professional practice by individual practitioners such as physicians, dentists, podiatrists and chiropractors, and the Public Health Law,[3] which governs entities providing health care services such as hospitals, diagnostic and treatment centers and nursing homes. Even if a provider is physically located in another state (such as a clinical laboratory or a mail-order pharmacy), it must be licensed by New York State if it is providing health care services or items to patients located in New York State.

By Francis J. Serbaroli

> With very few exceptions, business corporations that are not licensed may not provide health care services or employ licensed practitioners to provide health care services.

For well over a century, New York has had a prohibition on the corporate practice of medicine and other professions. The prohibition seeks to assure that medical decisions about what health care services a patient needs are made only by licensed medical professionals, and to prevent interference by business corporations and laypersons in medical judgments or the provision of medical care.

Physicians and other health care practitioners who are licensed to practice by the Education Department can practice their profession in a private office or offices, either individually or with other practitioners (e.g., physicians with other physicians, dentists with other dentists). They may do so in a professional partnership, as a professional corporation,[4] in an employer-employee relationship, and so on. They may become employees or contractors to licensed entities such as hospitals, clinics, laboratories and the like. With very few exceptions, however, business corporations that are not licensed may not provide health care services, or employ licensed practitioners to provide health care services, or hold themselves out to the general public as a provider or purveyor of health care services.

The penalties for engaging in the corporate practice of medicine are severe. The unlicensed practice of a health care profession or aiding or abetting same is a Class E felony,[5] and is further subject to injunctive relief.[6] Operation of an unlicensed facility for the provision of health care is a violation of the Public Health Law punishable by a fine of up to $10,000 per violation,[7] injunctive relief,[8] and presumably forfeiture of any moneys earned by the unlicensed facility.

New York and most states also prohibit the splitting or sharing of professional fees by licensed health care practitioners with other individuals (licensed or unlicensed) outside of their practice. Education Law §6530 includes among the definitions of professional misconduct:

> 18. Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or in connection with the performance of professional services;
>
> 19. Permitting any person to share in the fees for professional services, other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice medicine, or a legally authorized trainee practicing under the supervision of a licensee....

Education Law §6530(17) also classifies as professional misconduct:

> Exercising undue influence on the patient, including the promotion of the sale of services, goods, appliances, or drugs in such manner as to exploit the patient for the financial gain of the licensee or of a third party.

Education Law §6531 authorizes the suspension, revocation or annulment of a health care practitioner's license and other penalties if such professional:

> directly or indirectly requested, received or participated in the division, transference, assignment, rebate, splitting or refunding of a fee for, or has directly requested, received or profited by means of a credit or other valuable consideration as a commission, discount or gratuity, in connection with the furnishing of professional care or service....

Fee-splitting and exercising undue influence on patients are also prohibited by the regulations of the Department of Education at 8 N.Y.C.R.R. §29.1(b).

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Fee-splitting constitutes unprofessional conduct[9] and is punishable by revocation, suspension or annulment of the practitioner's license, and up to a $10,000 fine for each violation.[10] There are a few narrow exceptions to this rule (e.g., a licensed hospital can share in the professional fees generated by a hospital-employed practitioner).

As a general rule, licensed health care practitioners can set their own fees, advertise their fees and any discounts or special offers, or pay a third party to do advertising on their behalf. They may pay on a per advertisement basis, or a flat monthly or yearly fee for advertising. But they may not pay a website or advertiser on the basis of a percentage of either their gross or net income, or a percentage of the fees earned per patient.

New York law also has long prohibited the operation of for-profit medical referral services. Public Health Law §4501(1) reads:

> No person, firm, partnership, association or corporation, or agent or employee thereof, shall engage in for profit any business or service which in whole or in part includes the referral or recommendation of persons to a physician, dentist, hospital, health related facility, or dispensary for any form of medical or dental care or treatment of any ailment or physical condition. The imposition of a fee or charge for any such referral or recommendation shall create a presumption that the business or service is engaged in for profit.

The law also prohibits health care providers from accepting patients referred from these referral sources whether the sources are located within or outside New York State. Sec. 4501(2) reads:

> No physician, dentist, hospital, health related facility or dispensary shall enter into a contract or other form of agreement to accept for medical or dental care or treatment by a medical or dental referral service business located in or doing business in another state if the medical or dental referral service business would be prohibited under this section if the business were located in or doing business in this state.

A violation of this law is a misdemeanor punishable by up to a year in prison and/or a fine of up to $5,000. The Attorney General is authorized to seek injunctive relief against repeated fraudulent illegal acts,[11] and is further authorized to bring an action to dissolve a corporation inter alia for exceeding its legal authority, or conducting or transacting its business in a persistently fraudulent or illegal manner.[12]

Where referrals of patients and Medicare or Medicaid money are involved, federal law provides severe criminal and civil penalties. The federal Anti-Kickback Law, 42 U.S.C. §1320a-7b(b) makes it a felony for anyone to solicit or receive:

> any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind—
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program...

The crime is punishable by up to five years in prison and/or up to a $25,000 fine.

The Civil Monetary Penalties statute at 42 U.S.C. §1320a-7a(a)(5) prohibits any person, organization, agency or other entity from offering or transferring to any Medicare or Medicaid beneficiary any remuneration "likely to influence such individual in order to receive from a particular provider, practitioner or supplier any item or service" paid in whole or in part by Medicare or Medicaid. The law imposes a penalty of up to $10,000 for each item or service provided in violation of this prohibition. Offering discounts also implicates Medicare and Medicaid payment rules, and depending upon the arrangement, can violate the contracts and policies of private health insurance carriers and managed care organizations.

Policy Issues

Historically, there have been important public policy justifications for the corporate practice, fee-splitting and referral prohibitions, centered on protecting consumers of health care services. Employment of professionals by a business corporation was thought to encourage inappropriate lay interference in a licensed professional's exercise of independent medical judgment, and to place financial concerns above the patient's best interests.

Unless and until there are significant changes in the law, discount coupons or advertising for the services of physicians, dentists, and other licensed health care practitioners that involve sharing any portion of a practitioner's fee with the Internet coupon site or advertiser are illegal under the laws of New York and most other states.

The rationale behind the fee-splitting prohibition is somewhat similar: that sharing fees would corrupt the professional's judgment and encourage unnecessary treatments and procedures based upon the expectation of financial rewards, rather than what was actually needed by or in the best interests of the patients. Offering discount coupons for health care services presents related issues, including concerns over patient-steering, encouraging patients to undergo procedures that are not medically indicated or necessary, and encouraging patients to choose price over quality.

In summary, unless and until there are significant changes in the law, discount coupons or advertising for the services of physicians, dentists, and other licensed health care practitioners that involve sharing any portion of a practitioner's fee with the Internet coupon site or advertiser are illegal under the laws of New York and most other states. Where Medicare or Medicaid patients are involved, it can violate both federal and state laws.

As we have noted in the past, lawyers who represent providers should be aware that the laws and regulations governing the provision of health care services and payment for those services make up a field strewn with many extremely dangerous legal landmines. Business activities and marketing practices that are perfectly legal in other sectors of the economy turn into everything from felonies to grounds for license revocation or suspension, and exclusion from the Medicare and Medicaid programs in the health care sector. Proceed only with full knowledge and utmost caution.

1. La Mendola, "Are Groupon Discounts for Medical Treatments Illegal?" Florida Sun Sentinel, Sept. 25, 2011.
2. N.Y. Education Law (Ed.L.) Articles 130-131.
3. N.Y. Public Health Law (PHL) Article 28, §2801-a.
4. N.Y. Business Corporation Law (BCL) Article 15.
5. Ed.L. §6512.
6. Ed.L. §6512; N.Y. Executive Law (Exec.L.) §63(12); see *Nassau Neuropsychiatric Society Inc. v. Adelphi University*, 18 NY2d 370, 275 NYS2d 511 (1966).
7. P.H.L.§12.
8. P.H.L.§2801-c.
9. See citations at note §12 supra.
10. Ed.L. §6511.
11. N.Y. Exec.L. §63(12); see *State v. Abortion Information Agency Inc.*, 323 NYS2d 597 (Sup. Ct. N.Y. Co. 1971); *State by Lefkowitz*, 299 NYS2d 739 (1st Dept. 1969).
12. BCL §1101; see *State v. Abortion Information Agency Inc.*, supra.

BUSINESS AND PROFESSIONS CODE SECTION 650-657

650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services, donations, loans, or a combination thereof to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be permitted only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility, provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56632 and 56644), and subsequently amended versions.

(f) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate

Fee Splitting:

Regarding the legality of fee splitting, each state has its own laws which vary one from another.

The Dental Practice Act in Illinois states:

Sec. 23. Refusal, revocation or suspension of dental licenses. The Department may refuse to issue or renew, or may revoke, suspend, place on probation, reprimand or take other disciplinary action as the Department may deem proper, including fines not to exceed $10,000 per violation, with regard to any license for any one or any combination of the following causes: . . .

5. Division of fees or agreeing to split or divide the fees received for dental services with any person for bringing or referring a patient, except in regard to referral services as provided for under Section 45, or assisting in the care or treatment of a patient, without the knowledge of the patient or his legal representative. Nothing in this item 5 affects any bona fide independent contractor or employment arrangements among health care professionals, health facilities, health care providers, or other entities, except as otherwise prohibited by law. Any employment arrangements may include provisions for compensation, health insurance, pension, or other employment benefits for the provision of services within the scope of the licensee's practice under this Act. Nothing in this item 5 shall be construed to require an employment arrangement to receive professional fees for services rendered.

Standards for Professional Conduct In The Practice of Dentistry

Preamble

The Standards for Professional Conduct for licensees of the Virginia Board of Dentistry establishes a set of principles to govern the conduct of licensees in the profession of dentistry. Licensees must respect that the practice of dentistry is a privilege which requires a high position of trust within society. The Board maintains that adherence to these standards will safeguard patients, uphold the laws and regulations governing practice and maintain the public trust. The standards are an expression of types of conduct that are either required or encouraged and that are either prohibited or discouraged to provide further guidance on the requirements for practice set out in the Code of Virginia and the Regulations Governing the Practice of Dentistry and Dental Hygiene.

Scope of Practice

- Keep knowledge and skills current. The privilege, professional status, and a license to practice derive from the knowledge, skill, and experience needed to safely serve the public and patients.
- Seek consultation, if possible whenever the welfare of patients will be safeguarded or advanced by utilizing the knowledge and skills of those who have special skills, knowledge and experience, or advanced training.
- Do not prescribe treatment or use diagnostic techniques or diagnose, cure, or alleviate diseases, infections or other conditions that are not within the scope of the practice of dentistry or that are not based upon accepted scientific knowledge or research.
- Do not treat or prescribe for yourself.

Treating or Prescribing for Family

- Only treat and prescribe based on a bona-fide practitioner-patient relationship, and prescribe by criteria set forth in §54.1-3303 of the Code of Virginia.
- Do not prescribe to a family member a controlled substance or a medicine outside the scope of dentistry.
- When treating a family member or a patient maintain a patient record documenting a bona-fide practitioner-patient relationship.

Staff Supervision

- Protect the health of patients by only assigning to qualified auxiliaries those duties which can be legally delegated.
- Prescribe and supervise the patient care provided by all auxiliary personnel in accordance with the correct type of supervision.
- Maintain documentation that staff has current licenses, certificates for radiology, up-to-date vaccinations, CPR training, HIPPA training, and OSHA training in personnel files.

- Display documents that are required to be posted in the patient receiving area so that all patients might see and read them.
- Be responsible for the professional behavior of staff towards patients and the public at all times.
- Avoid unprofessional behavior with staff
- Provide staff with a safe environment at all times.
- Provide staff with opportunities for continuing education that will keep treatment and services up-to-date and allow staff to meet continuing education requirements
- Supervise staff in dispensing, mixing and following the instruction for materials to be used during treatment.
- Instruct the staff to inform the dentist of any event in the office concerning the welfare of the patient regarding exposures or blood borne pathogens

Practitioner-Patient Communications

- Before performing any dental procedure, accurately inform the patient or the guardian of a minor patient of the diagnoses, prognosis and the benefits, risks, and treatment alternatives to include the consequences of doing nothing.
- Inform the patient of proposed treatment and any reasonable alternatives, in understandable terms to allow the patient to become involved in treatment decisions.
- Acquire informed consent of a patient prior to performing any treatment.
- Refrain from harming the patient and from recommending and performing unnecessary dental services or procedures.
- Specialists must inform the patient that there is a need for continuing care when they complete their specialized care and refer patients to a general dentist or another specialist to continue their care.
- Immediately inform any patient who may have been exposed to blood or other infectious material in the dental office or during a procedure about the need for post exposure evaluation and follow up and to immediately refer the patient to a qualified health care professional
- Do not represent the care being provided in a false or misleading manner
- Inform the patient orally and note in the record any deviation in a procedure due to the dentist's discretion or a situation that arises during treatment that could delay completion of treatment or affect the prognosis for the condition being treated.
- Inform the patient about the materials used for any restoration or procedure such as crowns, bridges, restorative materials, ingestibles, and topicals as to risks, alternatives, benefits, and costs, as well as describing the materials, procedures, or special circumstances in the patient's notes.
- Refrain from removing amalgam restorations from a non-allergic patient for the alleged purpose of removing toxic substances from the body. The same applies to removing any other dental materials.

Patient of Record

- A patient becomes a patient of record when the patient is seated in the dental chair and examination and diagnosis of the oral cavity is initiated.
- In §54.1-2405(B) of the Code of Virginia, "current patient" means a patient who has had a patient encounter with the provider or his professional practice during the two-year period immediately preceding the date of the record transfer.

Patient Records

- Maintain treatment records that are timely, accurate, legible and complete.
- Note all procedures performed as well as substances and materials used.
- Note all drugs with strength and quantity administered and dispensed.
- Safeguard the confidentiality of patient records.
- Upon request of a patient or an authorized dental practitioner, provide any information that will be beneficial for the welfare and future treatment of that patient.
- On request of the patient or the patient's new dentist timely furnish gratuitously or at a reasonable cost, legible copies of all dental and financial records and readable copies of x-rays. This obligation exists whether or not the patient's account is paid in full.
- Comply with §32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.
- Post information concerning the time frame for record retention and destruction in the patient receiving area so that all patients might see and read it.
- Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.
- Maintain records for not less than three years from the last date of treatment as required by the Board of Dentistry and maintain records for longer periods of time to meet contractual obligations or requirements of federal law.
- When closing, selling or relocating a practice, meet the requirements of §54.1-2405 of the Code of Virginia for giving notice and providing records.

Financial Transactions

- Do not accept or tender "rebates" or split fees with other health professionals.
- Maintain a listing of customary fees and represent all fees being charged clearly and accurately.
- Do not use a different fee without providing the patient or third party payers a reasonable explanation which is recorded in the record.
- Return fees to the patient or third party payers in a timely manner if a procedure is not completed or the method of treatment is changed.
- Do not accept a third party payment in full without disclosing to the third party that the patient's payment portion will not be collected.
- Do not increase fees charged to a patient who is covered by a dental benefit plan.

- Do not incorrectly describe a dental procedure in order to receive a greater payment or reimbursement or incorrectly make a non-covered procedure appear to be a covered procedure on a claim form.
- Do not certify in a patient's record or on a third party claim that a procedure is completed when it is not completed.
- Do not use inaccurate dates that are to benefit the patient; false or misleading codes; change the procedure code to justify a false procedure; falsify a claim not having done the procedure, or expand the claim.
- Avoid exploiting the trust a patient has in the professional relationship when promoting or selling a product by: advising the patient or buyer if there is a financial incentive for the dentist to recommend the product; providing the patient with written information about the product's contents and intended use as well as any directions and cautions that apply to its use; and, informing the patient if the product is available elsewhere.
- Do not misrepresent a product's value or necessity or the dentist's professional expertise in recommending products or procedures.

Relationships with Practitioners

- Upon completion of their care, specialists or consulting dentists are to refer back to the referring dentist, or if none, to the dentist of record for future care unless the patient expresses a different preference.
- A dentist who is rendering a second opinion regarding a diagnosis or treatment plan should not have a vested interest in the patient's case and should not seek to secure the patient for treatment unless selected by the patient for care.

Practitioner Responsibility

- Once a course of treatment is undertaken, the dentist shall not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Emergency care must be provided during the notice period to make sure that the patient's oral health is not jeopardized or to stabilize the patient's condition.
- Only prescribe, dispense, and utilize those devices, drugs, dental materials and other agents accepted for dental treatment.
- Make reasonable arrangements for the emergency care of patients of record.
- Exercise reasonable discretion in the selection of patients. Dentists may not refuse patients because of the patient's race, creed, color, sex, or national origin.
- Do not refuse to treat a patient because the individual has AIDS, is HIV positive, or has had hepatitis. Use a proper protocol in the office to protect the public and staff.
- Follow the rules and regulations of HIPPA, OSHA, FDA, and the laws governing health practitioners in the Code of Virginia.
- Be knowledgeable in providing emergency care and have an acceptable emergency plan with delegated duties to the staff in written form, maintain accurate records and be current in basic CPR.

- Avoid interpersonal relationships with patients and staff that could impair professional judgment or risk the possibility of exploiting the veracity and confidence placed in the doctor-patient relationship.

Advertising Ethics

- Do not hold out as exclusive any devise agent, method, or technique if that representation would be false or misleading in any material respect to the public or patients.
- When you advertise, fees must be included stating the cost of all related procedures, services and products which to a substantial likelihood are necessary for the completion of the service as it would be understood by an ordinarily prudent person.
- Disclose the complete name of a specialty board or other organization which conferred certification or another form of credential.
- Do not claim to be a specialist or claim to be superior in any dental specialty or procedure unless you have attained proper credentials from an advanced postgraduate education program accredited by the Commission on Dental Accreditation of the American Dental Association.

Reports and Investigations

- Cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board and timely provide information and records as requested.
- Allow staff to cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board.
- Report the adverse reaction of a drug or dental device to the appropriate medical and dental community and in the case of a serious event to the Food and Drug Administration or Board of Dentistry.
- Provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.
- Become familiar with the special signs of child abuse and report suspected cases to the proper authorities.
- Report to the Board of Dentistry instances of gross or continually faulty treatment by other dentists.

Notice

This guidance document does not address every law and regulation which governs the practice of dentistry. To fully understand your legal responsibilities you should periodically review the laws, regulations, notices and guidance documents provided on the Board of Dentistry webpage, www.dhp.virginia.gov/dentistry.

Law and Regulation on Fee-Splitting

Virginia Board of Medicine

Code of Virginia

§ 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.

A. The Board may refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; impose a monetary penalty or terms as it may designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct:

9. Violating provisions of this chapter on division of fees or practicing any branch of the healing arts in violation of the provisions of this chapter;

§ 54.1-2962. Division of fees between physicians and surgeons prohibited.

No surgeon or physician shall directly or indirectly share any fee charged for a surgical operation or medical services with a physician who brings, sends or recommends a patient to such surgeon for operation, or such physician for such medical services; and no physician who brings, sends, or recommends any patient to a surgeon for a surgical operation or medical services shall accept from such surgeon or physician any portion of a fee charged for such operation or medical services. This chapter shall not be construed as prohibiting the members of any regularly organized partnership of such surgeons or physicians from making any division of their total fees among themselves as they may determine or a group of duly licensed practitioners of any branch or branches of the healing arts from using their joint fees to defray their joint operating costs. Any person violating the provisions of this section shall be guilty of a Class 1 misdemeanor.

§ 54.1-2962.1. Solicitation or receipt of remuneration in exchange for referral prohibited.

No practitioner of the healing arts shall knowingly and willfully solicit or receive any remuneration directly or indirectly, in cash or in kind, in return for referring an individual or individuals to a facility or institution as defined in § 37.2-100 or a hospital as defined in § 32.1-123. The Board shall adopt regulations as necessary to carry out the provisions of this section. Such regulations shall exclude from the definition of "remuneration" any payments, business arrangements, or payment practices not prohibited by Title 42, Section 1320a-7b (b) of the United States Code, as amended, or any regulations promulgated pursuant thereto.

§ 54.1-2964. Disclosure of interest in referral facilities and clinical laboratories.

A. Any practitioner of the healing arts shall, prior to referral of a patient to any facility or entity engaged in the provision of health-related services, appliances or devices, including but not limited to physical therapy, hearing testing, or sale or fitting of hearing aids or eyeglasses provide the patient with a notice in bold print that discloses any known material financial interest of or ownership by the practitioner in such facility or entity and states that the services,

appliances or devices may be available from other suppliers in the community. In making any such referral, the practitioner of the healing arts may render such recommendations as he considers appropriate, but shall advise the patient of his freedom of choice in the selection of such facility or entity. This section shall not be construed to permit any of the practices prohibited in § 54.1-2914 or Chapter 24.1 (§ 54.1-2410 et seq.) of this title.

In addition, any practitioner of the healing arts shall, prior to ordering any medical test from an independent clinical laboratory for a patient, provide the patient with notice in bold print that discloses any known material financial interest or ownership by the practitioner in such laboratory unless the independent clinical laboratory is operated by a publicly held corporation. The practitioner shall inform the patient about the accreditation status and credentials of the laboratory.

B. The Attorney General, an attorney of the Commonwealth, the attorney for a city, county or town, or any aggrieved patient may cause an action to be brought in the appropriate circuit court in the name of the Commonwealth, of the county, city or town, or of any aggrieved patient, to enjoin any violation of this section. The circuit court having jurisdiction may enjoin such violations, notwithstanding the existence of an adequate remedy at law. When an injunction is issued, the circuit court may impose a civil fine to be paid to the Literary Fund not to exceed $1,000. In any action under this section, it shall not be necessary that damages be proven.

Regulations

18VAC85-20-80. Solicitation or remuneration in exchange for referral.

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia. Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.

Discussion Draft – Prohibition on Fee-Splitting or Rebates

No dentist shall directly or indirectly accept or tender a rebate or split a fee with any third party, including another dentist, for bringing, sending or recommending a patient for dental services. Advertising or marketing dental services by sharing a specified portion of the professional fees collected from prospective or actual patients with the entity providing the advertising or marketing shall constitute fee splitting.

Agenda item: Practice Ownership

The Board charged the Regulatory/Legislative Committee to develop a proposal to address concerns advanced through public comment and through disciplinary case to address who might own a practice and to consider policies to address the accountability of corporate owners. The Committee is charged to work with a Regulatory Advisory Panel (RAP) to develop a proposal.

Ms. Yeatts and Ms. Reen have begun researching this topic and exploring the expertise needed on the RAP. An historical provision of law, excerpts from the Code of Virginia, a policy statement adopted by the Tennessee Board of Dentistry, the Department of Taxation's listing of business entity types, and the State Corporation Commission's listing of entity types and categories are provide to facilitate discussion.

Action Options:

- Articulate the goals and objectives to be discussed with the RAP
- Give directions to staff for researching the topic further

PRACTICE OWNERSHIP
1987 Code Provision

General Provisions.

§54-146. What constitutes practice of dentistry. – Any person shall be deemed to be practicing dentistry, who uses the words dentist, or dental surgeon, the letters D.D.S., D.M.S., or any letters or title in connection with his mane, which in any way, represents him as engaged in the practice of dentistry, or any branch thereof; or who holds himself out, advertises or permits to be advertised by sign, card, circular, handbill, newspaper or otherwise that he can or will attempt to perform dental operations of any kind; or who shall diagnose, profess to diagnose, or treat or profess to treat any of the diseases or lesions of the oral cavity, its contents or contiguous structures, or shall extract teeth, or shall correct malpositions of the teeth or jaws, or shall take impressions, or shall supply or repair artificial teeth as substitutes for natural teeth, or shall place in the mouth and adjust such substitutes, or do any practice included in the curricula of recognized dental colleges, or administer or prescribe such remedies, medicinal or otherwise, as shall be needed in the treatment of dental or oral diseases or shall use a X-ray or administer local or general anesthetic agents for dental treatment or dental diagnostic purposes.

And any person shall be deemed to be practicing dentistry who is a manager, proprietor, operator, or conductor of a place for performing dental operations of any kind, or who for a fee, salary, or other reward paid or to be paid either to himself or to another person, performs or advertises to perform dental operations of any kind, diagnoses or treats diseases or lesions of human teeth or jaws, mechanically, medicinally, or by means of radiograms, or attempts to correct malpositions thereof.

Practice Ownership – Code of Virginia

Chapter 27 of Title 54.1

§ 54.1-2711. Practice of dentistry.

Any person shall be deemed to be practicing dentistry who (i) uses the words dentist, or dental surgeon, the letters D.D.S., D.M.D., or any letters or title in connection with his name, which in any way represents him as engaged in the practice of dentistry; (ii) holds himself out, advertises or permits to be advertised that he can or will perform dental operations of any kind; (iii) diagnoses, treats, or professes to diagnose or treat any of the diseases or lesions of the oral cavity, its contents or contiguous structures, or (iv) extracts teeth, corrects malpositions of the teeth or jaws, takes impressions for the fabrication of appliances or dental prosthesis, supplies or repairs artificial teeth as substitutes for natural teeth, or places in the mouth and adjusts such substitutes.

No dentist shall be supervised within the scope of the practice of dentistry by any person who is not a licensed dentist.

(Code 1950, § 54-146; 1972, c. 805; 1988, c. 765.)

§ 54.1-2715. Temporary permits for certain clinicians.

A. The Board may issue a temporary permit to a graduate of a dental school or college or the dental department of a college or university, who (i) has a D.D.S. or D.M.D. degree and is otherwise qualified, (ii) is not licensed to practice dentistry in Virginia, and (iii) has not failed an examination for a license to practice dentistry in the Commonwealth. Such temporary permits may be issued only to those eligible graduates who serve as clinicians in dental clinics operated by (a) the Virginia Department of Corrections, (b) the Virginia Department of Health, (c) the Virginia Department of Behavioral Health and Developmental Services, or (d) a Virginia charitable corporation granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code and operating as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services: (i) as a federal qualified health center designated by the Centers for Medicare and Medicaid Services or (ii) at a reduced or sliding fee scale or without charge.

B. Applicants for temporary permits shall be certified to the executive director of the Board by the Director of the Department of Corrections, the Commissioner of Health, the Commissioner of Behavioral Health and Developmental Services, or the chief executive officer of a Virginia charitable corporation identified in subsection A. The holder of such a temporary permit shall not be entitled to receive any fee or other compensation other than salary. Such permits shall be valid for no more than two years and shall expire on the June 30 of the second year after their issuance, or shall terminate when the holder ceases to serve as a clinician with the certifying agency or charitable corporation. Such permits may be reissued annually or may be revoked at

any time for cause. Reissuance or revocation of a temporary permit is in the discretion of the Board.

C. Dentists licensed pursuant to this chapter may practice as employees of the dental clinics operated as specified in subsection A.

(Code 1950, § 54-152; 1968, c. 604; 1970, c. 639; 1972, c. 805; 1975, c. 479; 1976, c. 327; 1985, c. 373; 1988, c. 765; 2002, c. 549; 2004, c. 48; 2005, cc. 505, 587; 2006, c. 176; 2009, cc. 813, 840.)

§ 54.1-2716. Practicing in a commercial or mercantile establishment.

It shall be unlawful for any dentist to practice his profession in a commercial or mercantile establishment, or to advertise, either in person or through any commercial or mercantile establishment, that he is a licensed practitioner and is practicing or will practice dentistry in such commercial or mercantile establishment. This section shall not prohibit the rendering of professional services to the officers and employees of any person, firm or corporation by a dentist, whether or not the compensation for such service is paid by the officers and employees, or by the employer, or jointly by all or any of them. Any dentist who violates any of the provisions of this section shall be guilty of a Class 1 misdemeanor.

For the purposes of this section, the term "commercial or mercantile establishment" means a business enterprise engaged in the selling of commodities or services unrelated to the practice of dentistry or the other healing arts.

(Code 1950, § 54-147.1; 1988, c. 765.)

§ 54.1-2717. Practice of dentistry by professional business entities.

A. No corporation shall be formed or foreign corporation domesticated in the Commonwealth for the purpose of practicing dentistry other than a professional corporation as permitted by Chapter 7 (§ 13.1-542 et seq.) of Title 13.1.

B. No limited liability company shall be organized or foreign limited liability company domesticated in the Commonwealth for the purpose of practicing dentistry other than a professional limited liability company as permitted by Chapter 13 (§ 13.1-1100 et seq.) of Title 13.1.

C. Notwithstanding the provisions of subsections A and B, dentists licensed pursuant to this chapter may practice as employees of the dental clinics operated as specified in subsection A of § 54.1-2715.

(Code 1950, § 54-183; 1988, c. 765; 1992, c. 574; 2004, c. 48.)

§ 54.1-2718. Practicing under firm or assumed name.

A. No person shall practice, offer to practice, or hold himself out as practicing dentistry, under a name other than his own. This section shall not prohibit the practice of dentistry by a partnership under a firm name, or a licensed dentist from practicing dentistry as the employee of a licensed dentist, practicing under his own name or under a firm name, or as the employee of a professional corporation, or as a member, manager, employee, or agent of a professional limited liability company or as the employee of a dental clinic operated as specified in subsection A of § 54.1-2715.

B. A dentist, partnership, professional corporation, or professional limited liability company that owns a dental practice may adopt a trade name for that practice so long as the trade name meets the following requirements:

1. The trade name incorporates one or more of the following: (i) a geographic location, e.g., to include, but not be limited to, a street name, shopping center, neighborhood, city, or county location; (ii) type of practice; or (iii) a derivative of the dentist's name.

2. Derivatives of American Dental Association approved specialty board certifications may be used to describe the type of practice if one or more dentists in the practice are certified in the specialty or if the specialty name is accompanied by the conspicuous disclosure that services are provided by a general dentist in every advertising medium in which the trade name is used.

3. The trade name is used in conjunction with either (i) the name of the dentist or (ii) the name of the partnership, professional corporation, or professional limited liability company that owns the practice. The owner's name shall be conspicuously displayed along with the trade name used for the practice in all advertisements in any medium.

4. Marquee signage, web page addresses, and email addresses are not considered to be advertisements and may be limited to the trade name adopted for the practice.

(Code 1950, § 54-184; 1970, c. 639; 1975, c. 479; 1988, c. 765; 1992, c. 574; 2004, c. 48; 2005, cc. 505, 587.)

Professional Corporations

§ 13.1-542.1. Practice of certain professions by corporations.

Unless otherwise prohibited by law or regulation, the professional services defined in subsection A of § 13.1-543 may be rendered in this Commonwealth by:

1. A corporation organized as a professional corporation pursuant to the provisions of this chapter;

2. A foreign corporation that has obtained a certificate of authority pursuant to the provisions of this chapter;

3. A corporation organized pursuant to the provisions of Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of this title; or

4. A foreign corporation that has obtained a certificate of authority pursuant to the provisions of Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of this title.

§ 13.1-543. Definitions.

A. As used in this chapter:

"Eligible employee stock ownership plan" means an employee stock ownership plan as such term is defined in § 4975(e)(7) of the Internal Revenue Code of 1986, as amended, sponsored by a professional corporation and with respect to which:

1. All of the trustees of the employee stock ownership plan are individuals who are duly licensed or otherwise legally authorized to render the professional services for which the professional corporation is organized under this chapter; however, if a conflict of interest exists for one or more trustees with respect to a specific issue or transaction, such trustees may appoint a special independent trustee or special fiduciary, who is not duly licensed or otherwise legally authorized to render the professional services for which the professional corporation is organized under this chapter, which special independent trustee shall be authorized to make decisions only with respect to the specific issue or transaction that is the subject of the conflict;

2. The employee stock ownership plan provides that no shares, fractional shares, or rights or options to purchase shares of the professional corporation shall at any time be issued, sold, or otherwise transferred directly to anyone other than an individual duly licensed or otherwise legally authorized to render the professional services for which the professional corporation is organized under this chapter, unless such shares are transferred as a plan distribution to a plan beneficiary and subject to immediate repurchase by the professional corporation, the employee stock ownership plan or another person authorized to hold such shares; however:

a. With respect to a professional corporation rendering the professional services of public accounting or certified public accounting:

(1) The employee stock ownership plan may permit individuals who are not duly licensed or otherwise legally authorized to render these services to participate in such plan, provided such individuals are employees of the corporation and hold less than a majority of the beneficial interests in such plan; and

(2) At least 51% of the total of allocated and unallocated equity interests in the corporation sponsoring such employee stock ownership plan are held (i) by the trustees of such employee stock ownership plan for the benefit of persons holding a valid CPA certificate as defined in § 54.1-4400, with unallocated shares allocated for these purposes pursuant to § 409(p) of the Internal Revenue Code of 1986, as amended, or (ii) by individual employees holding a valid CPA certificate separate from any interests held by such employee stock ownership plan; and

b. With respect to a professional corporation rendering the professional services of architects, professional engineers, land surveyors, landscape architects, or certified interior designers, the employee stock ownership plan may permit individuals who are not duly licensed to render the services of architects, professional engineers, land surveyors, or landscape architects, or individuals legally authorized to use the title of certified interior designers to participate in such plan, provided such individuals are employees of the corporation and together hold not more than one-third of the beneficial interests in such plan, and that the total of the shares (i) held by individuals who are employees but not duly licensed to render such services or legally authorized to use a title and (ii) held by the trustees of such employee stock ownership plan for the benefit of individuals who are employees but not duly licensed to render such services or legally authorized to use a title, shall not exceed one-third of the shares of the corporation; and

3. The professional corporation, the trustees of the employee stock ownership plan, and the other shareholders of the professional corporation comply with the foregoing provisions of the plan.

"Professional business entity" means any entity as defined in § 13.1-603 that is duly licensed or otherwise legally authorized under the laws of the Commonwealth or the laws of the jurisdiction under whose laws the entity is formed to render the same professional service as that for which a professional corporation or professional limited liability company may be organized, including, but not limited to, (i) a professional limited liability company as defined in § 13.1-1102, (ii) a professional corporation as defined in this subsection, or (iii) a partnership that is registered as a registered limited liability partnership registered under § 50-73.132, all of the partners of which are duly licensed or otherwise legally authorized to render the same professional services as those for which the partnership was organized.

"Professional corporation" means a corporation whose articles of incorporation set forth a sole and specific purpose permitted by this chapter and that is either (i) organized under this chapter for the sole and specific purpose of rendering professional service other than that of architects, professional engineers, land surveyors, or landscape architects, or using a title other than that of certified interior designers and, except as expressly otherwise permitted by this chapter, that has as its shareholders or members only individuals or professional business entities that are duly licensed or otherwise legally authorized to render the same professional service as the corporation, including the trustees of an eligible employee stock ownership plan or (ii) organized under this chapter for the sole and specific purpose of rendering the professional services of

architects, professional engineers, land surveyors, or landscape architects, or using the title of certified interior designers, or any combination thereof, and at least two-thirds of whose shares are held by persons duly licensed within the Commonwealth to perform the services of an architect, professional engineer, land surveyor, or landscape architect, including the trustees of an eligible employee stock ownership plan, or by persons legally authorized within the Commonwealth to use the title of certified interior designer; or (iii) organized under this chapter or under Chapter 10 (§ 13.1-801 et seq.) of this title for the sole and specific purpose of rendering the professional services of one or more practitioners of the healing arts, licensed under the provisions of Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1, or one or more nurse practitioners, licensed under Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1, or one or more optometrists licensed under the provisions of Chapter 32 (§ 54.1-3200 et seq.) of Title 54.1, or one or more physical therapists and physical therapist assistants licensed under the provisions of Chapter 34.1 (§ 54.1-3473 et seq.) of Title 54.1, or one or more practitioners of the behavioral science professions, licensed under the provisions of Chapter 35 (§ 54.1-3500 et seq.), 36 (§ 54.1-3600 et seq.) or 37 (§ 54.1-3700 et seq.) of Title 54.1, or one or more practitioners of audiology or speech pathology, licensed under the provisions of Chapter 26 (§ 54.1-2600 et seq.) of Title 54.1, or one or more clinical nurse specialists who render mental health services licensed under Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 and registered with the Board of Nursing, or any combination of practitioners of the healing arts, optometry, physical therapy, the behavioral science professions, and audiology or speech pathology, and all of whose shares are held by or all of whose members are individuals or professional business entities duly licensed or otherwise legally authorized to perform the services of a practitioner of the healing arts, nurse practitioners, optometry, physical therapy, the behavioral science professions, audiology or speech pathology or of a clinical nurse specialist who renders mental health services, including the trustees of an eligible employee stock ownership plan; however, nothing herein shall be construed so as to allow any member of the healing arts, optometry, physical therapy, the behavioral science professions, audiology or speech pathology or a nurse practitioner or clinical nurse specialist to conduct his practice in a manner contrary to the standards of ethics of his branch of the healing arts, optometry, physical therapy, the behavioral science professions, audiology or speech pathology, or nursing, as the case may be.

"Professional service" means any type of personal service to the public that requires as a condition precedent to the rendering of such service or use of such title the obtaining of a license, certification, or other legal authorization and shall be limited to the personal services rendered by pharmacists, optometrists, physical therapists and physical therapist assistants, practitioners of the healing arts, nurse practitioners, practitioners of the behavioral science professions, veterinarians, surgeons, dentists, architects, professional engineers, land surveyors, landscape architects, certified interior designers, public accountants, certified public accountants, attorneys-at-law, insurance consultants, audiologists or speech pathologists, and clinical nurse specialists. For the purposes of this chapter, the following shall be deemed to be rendering the same professional service:

1. Architects, professional engineers, and land surveyors; and

2. Practitioners of the healing arts, licensed under the provisions of Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; nurse practitioners, licensed under the provisions of Chapter 29 (§ 54.1-2900

et seq.) of Title 54.1; optometrists, licensed under the provisions of Chapter 32 (§ 54.1-3200 et seq.) of Title 54.1; physical therapists and physical therapist assistants, licensed under the provisions of Chapter 34.1 (§ 54.1-3473 et seq.) of Title 54.1; practitioners of the behavioral science professions, licensed under the provisions of Chapters 35 (§ 54.1-3500 et seq.), 36 (§ 54.1-3600 et seq.), and 37 (§ 54.1-3700 et seq.) of Title 54.1; and one or more clinical nurse specialists who render mental health services, licensed under Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 and are registered with the Board of Nursing.

B. Persons who practice the healing art of performing professional clinical laboratory services within a hospital pathology laboratory shall be legally authorized to do so for purposes of this chapter if such persons (i) hold a doctorate degree in the biological sciences or a board certification in the clinical laboratory sciences and (ii) are tenured faculty members of an accredited medical college or university that is an "educational institution" within the meaning of § 23-14.

§ 13.1-544. Who may organize and become shareholder.

A. An individual or group of individuals (i) duly licensed or otherwise legally authorized to render the same professional services other than those of architects, professional engineers or land surveyors, or to use a title other than those of certified landscape architects or certified interior designers, of which at least one is duly licensed or otherwise legally authorized to render such professional services within the Commonwealth, or (ii) complying with the provisions of § 13.1-549 and duly licensed to render within the Commonwealth the professional services of architects, professional engineers or land surveyors, or legally authorized to use within the Commonwealth the title of certified landscape architects or certified interior designers, or any combination thereof, may organize a professional corporation for pecuniary profit under the provisions of Chapter 9 (§ 13.1-601 et seq.) of this title or organize a professional corporation as a nonstock corporation under the provisions of Chapter 10 (§ 13.1-801 et seq.) of this title, for the sole and specific purpose of rendering the same and specific professional service, subject to any laws, not inconsistent with the provisions of this chapter, which are applicable to the practice of that profession in the corporate form.

B. An eligible employee stock ownership plan or any individual or group of individuals described in clause (i) or (ii) of subsection A may become a shareholder or shareholders of a professional corporation for pecuniary profit under the provisions of Chapter 9 (§ 13.1-601 et seq.) of this title, for the sole and specific purpose of rendering the same and specific professional service, subject to any laws, not inconsistent with the provisions of this chapter, that are applicable to the practice of that profession in the corporate form.

C. Any individual or group of individuals described in clause (i) or (ii) of subsection A may become a member or members of a professional corporation organized as a nonstock corporation under the provisions of Chapter 10 (§ 13.1-801 et seq.) of this title for the sole and specific purpose of rendering such professional services, subject to any laws, not inconsistent with the provisions of this chapter, that are applicable to the practice of that profession in the corporate form.

§ 13.1-1101.1. Practice of certain professions by limited liability companies.

Unless otherwise prohibited by law or regulation, the professional services defined in subsection A of § 13.1-1102 may be rendered in this Commonwealth by:

1. A limited liability company organized as a professional limited liability company pursuant to the provisions of this chapter;

2. A foreign limited liability company that has obtained a certificate of authority pursuant to the provisions of this chapter;

3. A limited liability company organized pursuant to the provisions of Chapter 12 (§ 13.1-1000 et seq.) of this title; or

4. A foreign limited liability company that has obtained a certificate of authority pursuant to the provisions of Chapter 12 (§ 13.1-1000 et seq.) of this title.

§ 13.1-1102. Definitions.

A. As used in this chapter:

"Professional business entity" means any entity as defined in § 13.1-603 that is duly licensed or otherwise legally authorized under the laws of the Commonwealth or the laws of the jurisdiction under whose laws the entity is formed to render the same professional service as that for which a professional corporation or professional limited liability company may be organized, including, but not limited to, (i) a professional limited liability company as defined in this subsection, (ii) a professional corporation as defined in subsection A of § 13.1-543, or (iii) a partnership that is registered as a registered limited liability partnership under § 50-73.132, all of the partners of which are duly licensed or otherwise legally authorized to render the same professional services as those for which the partnership was organized.

"Professional limited liability company" means a limited liability company whose articles of organization set forth a sole and specific purpose permitted by this chapter and that is either (i) organized under this chapter for the sole and specific purpose of rendering professional service other than that of architects, professional engineers, land surveyors, or landscape architects, or using a title other than that of certified interior designers and, except as expressly otherwise permitted by this chapter, that has as its members only individuals or professional business entities that are duly licensed or otherwise legally authorized to render the same professional service as the professional limited liability company or (ii) organized under this chapter for the sole and specific purpose of rendering professional service of architects, professional engineers, land surveyors, or landscape architects or using the title of certified interior designers, or any combination thereof, and at least two-thirds of whose membership interests are held by persons

duly licensed within the Commonwealth to perform the services of an architect, professional engineer, land surveyor, or landscape architect, or by persons legally authorized within the Commonwealth to use the title of certified interior designer; or (iii) organized under this chapter for the sole and specific purpose of rendering the professional services of one or more practitioners of the healing arts, licensed under the provisions of Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1, or one or more nurse practitioners, licensed under Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1, or one or more optometrists licensed under the provisions of Chapter 32 (§ 54.1-3200 et seq.) of Title 54.1, or one or more physical therapists and physical therapist assistants licensed under the provisions of Chapter 34.1 (§ 54.1-3473 et seq.) of Title 54.1, or one or more practitioners of the behavioral science professions, licensed under the provisions of Chapter 35 (§ 54.1-3500 et seq.), 36 (§ 54.1-3600 et seq.) or 37 (§ 54.1-3700 et seq.) of Title 54.1, or one or more practitioners of audiology or speech pathology, licensed under the provisions of Chapter 26 (§ 54.1-2600 et seq.) of Title 54.1, or one or more clinical nurse specialists who render mental health services licensed under Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 and registered with the Board of Nursing, or any combination of practitioners of the healing arts, of optometry, physical therapy, the behavioral science professions, and audiology or speech pathology and all of whose members are individuals or professional business entities duly licensed or otherwise legally authorized to perform the services of a practitioner of the healing arts, nurse practitioners, optometry, physical therapy, the behavioral science professions, audiology or speech pathology or of a clinical nurse specialist who renders mental health services; however, nothing herein shall be construed so as to allow any member of the healing arts, optometry, physical therapy, the behavioral science professions, audiology or speech pathology or a nurse practitioner or clinical nurse specialist to conduct that person's practice in a manner contrary to the standards of ethics of that person's branch of the healing arts, optometry, physical therapy, the behavioral science professions, or audiology or speech pathology, or nursing as the case may be.

"Professional services" means any type of personal service to the public that requires as a condition precedent to the rendering of that service or the use of that title the obtaining of a license, certification, or other legal authorization and shall be limited to the personal services rendered by pharmacists, optometrists, physical therapists and physical therapist assistants, practitioners of the healing arts, nurse practitioners, practitioners of the behavioral science professions, veterinarians, surgeons, dentists, architects, professional engineers, land surveyors, landscape architects, certified interior designers, public accountants, certified public accountants, attorneys at law, insurance consultants, audiologists or speech pathologists and clinical nurse specialists. For the purposes of this chapter, the following shall be deemed to be rendering the same professional services:

1. Architects, professional engineers, and land surveyors; and

2. Practitioners of the healing arts, licensed under the provisions of Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1, nurse practitioners, licensed under Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1, optometrists, licensed under the provisions of Chapter 32 (§ 54.1-3200 et seq.) of Title 54.1, physical therapists, licensed under the provisions of Chapter 34.1 (§ 54.1-3473 et seq.) of Title 54.1, practitioners of the behavioral science professions, licensed under the provisions of Chapters 35 (§ 54.1-3500 et seq.), 36 (§ 54.1-3600 et seq.), and 37 (§ 54.1-3700 et seq.) of Title

54.1, and clinical nurse specialists who render mental health services licensed under Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 and registered with the Board of Nursing.

B. Persons who practice the healing art of performing professional clinical laboratory services within a hospital pathology laboratory shall be legally authorized to do so for purposes of this chapter if such persons (i) hold a doctorate degree in the biological sciences or a board certification in the clinical laboratory sciences and (ii) are tenured faculty members of an accredited medical college or university that is an "educational institution" within the meaning of § 23-14.

C. Except as expressly otherwise provided, all terms defined in § 13.1-1002 shall have the same meanings for purposes of this chapter.

§ 13.1-1103. Who may become a member.

One or more individuals or professional business entities (i) duly licensed or otherwise legally authorized to render the same professional services other than those of architects, professional engineers or land surveyors, or to use a title other than those of certified landscape architects or certified interior designers, of which at least one is duly licensed or otherwise legally authorized to render such professional services within the Commonwealth or (ii) complying with the provisions of § 13.1-1111 and duly licensed to render within the Commonwealth the professional services of architects, professional engineers or land surveyors, or legally authorized to use within the Commonwealth the title of certified landscape architects or certified interior designers, or any combination thereof, may become members of a limited liability company for pecuniary profit under the provisions of Chapter 12 (§ 13.1-1000 et seq.) of this title, for the sole and specific purpose of rendering the same and specific professional service, subject to any laws, not inconsistent with the provisions of this chapter, which are applicable to the practice of that profession in the limited liability company form.

§ 13.1-1104. Use of initials "P.L.C.," "PLC," "P.L.L.C." or "PLLC" in company name.

Any professional limited liability company as defined in § 13.1-1102 may, but is not required to, use the initials "P.L.C.," "PLC," "P.L.L.C." or "PLLC," or the phrase "professional limited company," "a professional limited company," "professional limited liability company," or "a professional limited liability company," at the end of its limited liability company name. Such initials or phrase may be used in the place of any words or abbreviation required by subsection A of § 13.1-1012.

§ 13.1-1105. Certificate of authority for foreign professional limited liability company.

A. Notwithstanding any other provision of this chapter, a foreign professional limited liability company, organized under the laws of a jurisdiction other than the Commonwealth of Virginia to perform a professional service of the type defined in § 13.1-1102, may apply for and obtain a certificate of authority to render those professional services in Virginia on the following terms and conditions:

1. Only members, managers, employees, and agents licensed or otherwise legally qualified by this Commonwealth may perform the professional service in Virginia.

2. The professional limited liability company must meet every requirement of this chapter except for the requirement that all of its members and managers be licensed to perform the professional service in this Commonwealth.

3. The powers of any foreign professional limited liability company admitted under this section shall not exceed the powers permitted to domestic professional limited liability companies under this chapter.

B. In order to qualify, a foreign professional limited liability company shall make application to the Commission as provided in § 13.1-1052 and shall make the application for and secure any certificate of authority, registration or registration certificate may be required by §§ 13.1-1111, 13.1-1112 or § 13.1-1113 and, in addition, shall be required to set forth the name and address of each member, manager, employee, and agent of the limited liability company who will be providing the professional service in this Commonwealth and whether those members, managers, employees, and agents are licensed, or otherwise legally qualified, to perform the professional service in Virginia.

§ 13.1-1107. How limited liability company may render professional services; nonprofessional employees and agents; members and managers need not be employees, etc.

No limited liability company organized under this chapter may render professional services except through its members, managers, employees, independent contractors, and agents who are duly licensed or otherwise legally authorized to render those professional services, and only members, managers, employees, independent contractors, and agents licensed or otherwise legally qualified by this Commonwealth may perform the professional service in Virginia. However, this provision shall not be interpreted to preclude clerks, secretaries, bookkeepers, technicians and other assistants who are not usually and ordinarily considered by custom and practice to be rendering professional service to the public for which a license or other legal authorization is required from acting as employees, managers and agents of a professional limited liability company and performing their usual duties or from acting as employees, independent contractors, managers or agents of a professional limited liability company. Nothing contained in this chapter shall be interpreted to require that the right of an individual to be a member or manager of a limited liability company organized under this chapter, or to organize that limited liability company, is dependent upon the present or future existence of an employment relationship between that individual and that limited liability company, or that individual's present or future active participation in any capacity in the production of the income of that limited liability company or in the performance of the services rendered by that limited liability company.

§ 13.1-1118. Management.

Unless the articles of organization or an operating agreement provides for management of a professional limited liability company by a manager or managers, management of a professional

limited liability company shall be vested in its members. If the articles of organization or an operating agreement provides for management of a professional limited liability company by a manager or managers, the manager shall be an individual or professional business entity duly licensed or otherwise legally authorized to render the same professional services within this Commonwealth that the professional limited liability company was organized for the purpose of rendering. Only members or managers duly licensed or otherwise legally authorized to render the same professional services within this Commonwealth shall supervise and direct the provision of professional services within this Commonwealth, or delegate to their agents, officers, and employees or delegate by a management agreement or another agreement with, or otherwise to, other persons managerial duties and tasks related to the professional limited liability company's operations.

TENNESSEE BOARD OF DENTISTRY

POLICY STATEMENT

OWNERSHIP OF DENTAL PROFESSIONAL CORPORATIONS AND DENTAL PROFESSIONAL LIMITED LIABILITY COMPANIES

The Board votes to issue this policy regarding the definition of "owner" under Rule 0460-01-.08. In addition to issuance of the policy, it is the Board's wish to review this language at a properly noticed rulemaking hearing for a possible amendment to the referenced rule.

For the purpose of Rule 0460-01-.08 (1) regarding Dental Professional Corporations (D.P.C.), "owner" means a stockholder dentist with an active Tennessee license issued pursuant to Tennessee Code Annotated Title 63, Chapter 5.

For the purpose of Rule 0460-01-.08 (2) regarding Dental Professional Limited Liability Companies (D.P.L.L.C.), "owner" means a member dentist with an active Tennessee license issued pursuant to Tennessee Code Annotated Title 63, Chapter 5.

Adopted by the Board on January 28, 2011.

Tennessee Board of Dentistry
Acting Chairperson

0460-01-.08 DENTAL PROFESSIONAL CORPORATIONS AND DENTAL PROFESSIONAL LIMITED LIABILITY COMPANIES.

(1) Dental Professional Corporations (D.P.C.) – Except as provided in this rule Dental Professional Corporations shall be governed by the provisions of Tennessee Code Annotated, Title 48, Chapter 101, Part 6.

(a) Filings – A D.P.C. need not file its Charter or its Annual Statement of Qualifications with the Board.

(b) Ownership of Stock – Only the following may form and own shares of stock in a foreign or domestic D.P.C. doing business in Tennessee:

1. Dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5; and/or

2. A foreign or domestic general partnership, D.P.C. or Dental Professional Limited Liability Company (D.P.L.L.C.) in which all partners, shareholders, members or holders of financial rights are dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5 to practice dentistry in Tennessee, or composed of entities which are directly or indirectly owned by such licensed dentists.

(c) Officers and Directors of Dental Professional Corporations -

1. All, except the following officers, must be persons who are eligible to form or own shares of stock in a dental professional corporation as limited by T.C.A. § 48-101-610 (d) and subparagraph (1) (b) of this rule:

(i) Secretary;

(ii) Assistant Secretary;

(iii) Treasurer; and

(iv) Assistant Treasurer.

2. With respect to members of the Board of Directors, only persons who are eligible to form or own shares of stock in a dental professional corporation as limited by T.C.A. § 48-101-610 (d) and subparagraph (1) (b) of this rule shall be directors of a D.P.C.

(d) Practice Limitations

1. Engaging in, or allowing another dentist incorporator, shareholder, officer, or director, while acting on behalf of the D.P.C., to engage in, dental practice in any area of practice or specialty beyond that which is specifically set forth in the charter may be a violation of the unprofessional conduct enumerated in Rule 0460-01-.12 and/or Tennessee Code Annotated, Section 63-5-124 (a) (1).

2. Nothing in these rules shall be construed as prohibiting any health care professional licensed pursuant to Tennessee Code Annotated, Title 63 from being an employee of or a contractor to a D.P.C.

3. Nothing in these rules shall be construed as prohibiting a D.P.C. from electing to incorporate for the purposes of rendering professional services within two (2) or

(Rule 0460-01-.08, continued)

more professions or for any lawful business authorized by the Tennessee Business Corporations Act so long as those purposes do not interfere with the exercise of independent dental judgment by the dentist incorporators, directors, officers, shareholders, employees or contractors of the D.P.C. who are practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.

4. Nothing in these rules shall be construed as prohibiting a dentist from owning shares of stock in any type of professional corporation other than a D.P.C. so long as such ownership interests do not interfere with the exercise of independent dental judgment by the dentist while practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.

(2) Dental Professional Limited Liability Companies (D.P.L.L.C.) - Except as provided in this rule Dental Professional Limited Liability Companies shall be governed by either the provisions of Tennessee Code Annotated, Title 48, Chapters 248 or 249.

(a) Filings - Articles filed with the Secretary of State shall be deemed to be filed with the Board and no Annual Statement of Qualifications need be filed with the Board.

(b) Membership - Only the following may be members or holders of financial rights of a foreign or domestic D.P.L.L.C. doing business in Tennessee:

1. Dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5; and/or

2. A foreign or domestic general partnership, D.P.C. or D.P.L.L.C. in which all partners, shareholders, members or holders of financial rights are either dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5 to practice dentistry in Tennessee or composed of entities which are directly or indirectly owned by such licensed dentists.

(c) Managers, Directors or Governors of a D.P.L.L.C.

1. All, except the following managers, must be persons who are eligible to form or become members or holders of financial rights of a dental professional limited liability company as limited by T.C.A. § 48-248-401 (d) and subparagraph (2) (b) of this rule:

(i) Secretary

(ii) Treasurer

2. Only persons who are eligible to form or become members or holders of financial rights of a dental professional limited liability company as limited by T.C.A. § 48-248-401 (d) and subparagraph (2) (b) of this rule shall be allowed to serve as a director, or serve on the Board of Governors of a D.P.L.L.C.

(d) Practice Limitations

1. Engaging in, or allowing another dentist member or holder of financial rights, officer, manager, director, or governor, while acting on behalf of the D.P.L.L.C., to engage in, dental practice in any area of practice or specialty beyond that which is specifically set forth in the articles of organization may be a violation of the unprofessional conduct enumerated in Rule 0460-01-.12 and/or Tennessee Code Annotated, Section 63-5-124 (a) (1).

(Rule 0460-01-.08, continued)

2. Nothing in these rules shall be construed as prohibiting any health care professional licensed pursuant to Tennessee Code Annotated, Title 63 from being an employee of or a contractor to a D.P.L.L.C.

3. Nothing in these rules shall be construed as prohibiting a D.P.L.L.C. from electing to form for the purposes of rendering professional services within two (2) or more professions or for any lawful business authorized by the Tennessee Limited Liability Company Act or the Tennessee Revised Limited Liability Company Act so long as those purposes do not interfere with the exercise of independent dental judgment by the dentist members or holders of financial rights, governors, officers, managers, employees or contractors of the D.P.L.L.C. who are practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.

4. Nothing in these rules shall be construed as prohibiting a dentist from being a member or holder of financial rights of any type of professional limited liability company other than a D.P.L.L.C. so long as such interests do not interfere with the exercise of independent dental judgment by the dentist while practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.

5. All D.P.L.L.C.s formed in Tennessee pursuant to Tennessee Code Annotated, Sections 48-248-104 or 48-249-1104 to provide services only in states other than Tennessee shall annually file with the Board a notarized statement that they are not providing services in Tennessee.

(3) Dissolution - The procedure that the Board shall follow to notify the attorney general that a D.P.C. or a D.P.L.L.C. has violated or is violating any provision of Title 48, Chapters 101, 248 and/or 249, shall be as follows but shall not terminate or interfere with the secretary of state's authority regarding dissolution pursuant to Tennessee Code Annotated, Sections 48-101-624, 48-248-409, or 48-249-1122.

(a) Service of a written notice of violation by the Board on the registered agent of the D.P.C. and/or D.P.L.L.C. or the secretary of state if a violation of the provisions of Tennessee Code Annotated, Title 48, Chapters 101, 248, and/or 249 occurs.

(b) The notice of violation shall state with reasonable specificity the nature of the alleged violation(s).

(c) The notice of violation shall state that the D.P.C. and/or D.P.L.L.C. must, within sixty (60) days after service of the notice of violation, correct each alleged violation or show to the Board's satisfaction that the alleged violation(s) did not occur.

(d) The notice of violation shall state that, if the Board finds that the D.P.C. and/or D.P.L.L.C. is in violation, the attorney general will be notified and judicial dissolution proceedings may be instituted pursuant to Tennessee Code Annotated, Title 48.

(e) The notice of violation shall state that proceedings pursuant to this section shall not be conducted in accordance with the contested case provisions of the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5 but that the D.P.C. and/or D.P.L.L.C., through its agent(s), shall appear before the Board at the time, date, and place as set by the Board and show cause why the Board should not notify the attorney general and reporter that the organization is in violation of the Act or these rules. The Board shall enter an order that states with reasonable particularity the facts describing each violation and the statutory or rule reference of each violation. These proceedings shall constitute the conduct of administrative rather than disciplinary business.

(Rule 0460-01-.08, continued)

(f) If, after the proceeding the Board finds that a D.P.C. and/or D.P.L.L.C. did violate any provision of Title 48, Chapters 101, 248, and/or 249 or these rules, and failed to correct said violation or demonstrate to the Board's satisfaction that the violation did not occur, the Board shall certify to the attorney general and reporter that it has met all requirements of Tennessee Code Annotated, Sections 48-101-624 (1)-(3), and/or 48-248-409 (1)-(3) and/or 48-249-1122 (1)-(3).

(4) Violation of this rule by any dentist individually or collectively while acting as a D.P.C. or as a D.P.L.L.C. may subject the dentist(s) to disciplinary action pursuant to Tennessee Code Annotated, Sections 63-5-124 (a)(1).

(5) The authority to own shares of stock or be members or holders of financial rights in a D.P.C. or a D.P.L.L.C. granted by statute or these rules to professionals not licensed in this state shall in no way be construed as authorizing the practice of any profession in this state by such unlicensed professionals.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 48-101-605, 48-101-608, 48-101-610, 48-101-618, 48-101-624, 48-101-628, 48-101-629, 48-101-630, 48-248-104, 48-248-202, 48-248-401, 48-248-404, 48-248-409, 48-248-501, 48-248-601, 48-248-602, 48-248-603, 48-249-101, et seq., 63-5-105, 63-5-107, 63-5-108, 63-5-110, 63-5-121, and 63-5-124.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed September 4, 1998; effective November 18, 1998. Amendment filed June 13, 2003; effective August 27, 2003. Repeal and new rule filed April 5, 2006; effective June 19, 2006. Amendment filed September 25, 2008; effective December 9, 2008.*

0460-01-.09 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, and 63-5-105.* ***Administrative History:*** *New rule filed September 4, 1998; effective November 18, 1998. Amendment filed June 13, 2003; effective August 27, 2003. Repeal filed April 5, 2006; effective June 19, 2006*

0460-01-.10 CLINICAL TECHNIQUES-TEETH WHITENING. All teeth whitening formulations, except those sold over-the-counter, shall be prescribed and dispensed by a licensed dentist. Licensed dental hygienists or registered dental assistants are authorized to apply teeth whitening formulations, but only under the direct supervision of a licensed dentist.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, and 63-5-115.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed August 21, 2002; effective November 4, 2002.*

0460-01-.11 INFECTION CONTROL.

(1) The dentist shall ensure that at least one (1) of the following sterilization procedures is utilized daily for instruments and equipment:

(a) Steam autoclave

(b) Dry-heat

(c) Chemical vapor

(d) Disinfectant/chemical sterilant. U.S. Environmental Protection Agency (EPA) approved disinfectant shall be used in dilution amounts and specified time periods.

(e) Any procedure listed in MMWR, Vol 41, No. RR8, pp. 1-12, May 28, 1993 or successor publications.

Form R-1

Virginia Department of Taxation
Business Registration Form

It's faster and easier to register your business online at www.tax.virginia.gov. If you prefer to register by paper, please read the instructions carefully as you complete this form.

For assistance with this form, or for information about taxes not listed in this form, please call (804) 367-8057.

Fax the completed form to (804) 367-2603 or mail it to: Virginia Department of Taxation
Registration Unit
PO Box 1114
Richmond, VA 23218-1114

Reason for Submitting this Form:

☐ **New Business Registration** – *Complete pages 2-5.*

☐ **Add an additional tax responsibility to your existing account** – For example you are currently registered for Sales Tax and you now need to register for Employer Withholding tax. *Complete the information below and pages 4-8 as applicable.*

Business Name _____

Federal Employer Identification Number (FEIN) _____

☐ **Add a new business location to your existing account** – *Complete the information below and pages 4-5 as they pertain to Sales and Use Tax.*

Business Name _____

Account Number or Federal Employer Identification Number (FEIN) _____

This Registration Form must be signed by the owner or an officer of the business who is authorized to sign on behalf of the organization.

_____ _____
Print Name Title

_____ _____ _____
Signature Date Contact Phone Number

NEW BUSINESS REGISTRATION

BUSINESS PROFILE INFORMATION

1. **Business Name** _____
   Enter the legal name of your business.

2. **Federal Employer Identification Number (FEIN)** _____
   If you do not have a FEIN go to irs.gov to obtain one.

3. **Business Entity Type** - *Check the one that best describes the type of ownership of your business as reported to the IRS and/or State Corporation Commission.*

   ☐ **Sole Proprietor** - An unincorporated business owned and operated by one person. This person receives all the profits and is personally liable for all the losses and taxes.

Corporations

☐ Corporation – An entity with a legal existence separate from its owners.

☐ Non-profit Corporation – A corporation with a nonprofit, tax-exempt status under Section 501(c) of the IRS Code that is incorporated as a non-stock entity.

☐ Limited Liability Company (LLC) reporting as a Corporation – An LLC is an unincorporated association having one or more members. It is a separate legal entity that limits the personal liability of its owners.

Pass Through Entities

☐ Sub Chapter S Corporation – An entity with a legal existence separate from its owners. The corporation does not pay any income tax but passes its income and expenses through to its shareholders to be included on their separate returns.

☐ General Partnership - A relationship existing between two or more persons joined together to carry on a trade or a business.

☐ Limited Partnership - A Limited Partnership has two classifications of partners. *General partners* retain control over the management of the partnership and are liable for all debts. *Limited partners* invest money or property in the business and are entitled to share in the profits. The limited partners' liability is limited to the extent of their investment.

☐ Limited Liability Partnership (LLP) - A limited liability partnership is formed under a state limited liability partnership law. Generally, a partner in an LLP is not personally liable for the debts of the LLP or any other partner, nor is a partner liable for the acts or omissions of any other partner, solely by reason of being a partner.

☐ Limited Liability Company (LLC) reporting as a Partnership – An LLC is an unincorporated association having one or more members. It is a separate legal entity that limits the personal liability of its owners.

Other Entities

☐ Non-Profit Organization – An entity that meets the requirements under Section 501(c) (3) of the Internal Revenue Code and is not incorporated.

☐ Cooperative – An entity designated by the Virginia State Corporation Commission based on Section 13.1-301 of the *Code of Virginia*.

☐ Credit Union – An entity defined in Section 6.1-225.2 of the *Code of Virginia* as a cooperative, nonprofit corporation, organized to do business for the purposes of encouraging thrift among its members and, also, providing an opportunity for its members to use and control their own money on a democratic basis to improve their economic and social condition.

☐ Bank - A corporation authorized under Section 6.104 of the *Code of Virginia* to accept deposits and to hold itself out to the public as engaged in the banking business.

☐ Savings and Loan – An entity as defined in Section 6.1-194.2 of the *Code of Virginia* authorized to accept deposits and to hold itself out to the public as engaged in the savings institution business (such as a Savings and Loan Association, a Building and Loan Association, Building Association, Savings Bank).

☐ Public Service Corporation - An entity that conducts a business of a public service nature as defined in Section 58.1-2600 and Section 13.1-620 of the *Code of Virginia*.

Government Entities

☐ Federal Government

☐ Virginia State Government

☐ Virginia Local Government

☐ Other Government

4. **Trading As Name (or Doing Business as Name)** _____
This is the name that would be known to the public.

5. **Sole Proprietor (if applicable):**

Owner's Name _____

Owner's SSN _____

6. **Primary Business Activity** _____
Describe the specific product line or service your business provides.

☐ **Check if you will be selling any tobacco products?**

7. **Primary Business Address** - *Enter the physical address of your business.*

Street Address _____

City _____ State _____ ZIP Code _____

8. **Primary Mailing Address** – *enter a mailing address if different from your* ***Primary Business Address.***

Address or PO Box _____

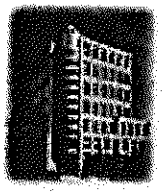
City _____ State _____ ZIP Code _____

9. **Primary Business Contact Information** – *identify the contact person most knowledgeable about your business.*

Name _____

Phone Number _____ Fax Number _____

Commonwealth of Virginia
State Corporation Commission



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Entity Types and Categories

The following Definitions provide basic, general information about the Entity Types and Categories listed. It is recommended that you consult with an attorney or a tax professional in order to determine the entity type that is most appropriate for your anticipated business activities.

Entity Type	Definition
Business Trust	A business trust is an unincorporated association whose governing instrument, sometimes referred to as a declaration of trust, provides that one or more trustees will manage property or conduct for-profit business activities on behalf of one or more beneficial owners. A business trust is a separate legal entity and, generally, its trustees and beneficial owners are not liable for the obligations of the business trust.
Corporation	A corporation is an artificial person or legal entity managed by a board of directors, consisting of one or more individuals, who collectively elect officers to run the corporation's day-to-day business activities. There are two types of corporations in Virginia, **stock corporations**, which are authorized to issue shares to persons who become shareholders, the owners of the corporation, and **nonstock corporations**, which may have members, but not owners. Stock corporations are usually formed to generate a profit for the shareholders. Nonstock corporations are usually organized for not-for-profit purposes, such as a tax-exempt, charitable organization or a property owners' association. Generally, officers, directors, shareholders and members are not liable for the obligations of the corporation.

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General Partnership	A general partnership (sometimes simply referred to as a "partnership") is an association of two or more persons to carry on, as co-owners, a business for profit. Each partner contributes money, property and/or services in return for an interest in the general partnership, shares in the profits and losses of the general partnership's business, and has equal rights in the management and conduct of the partnership's business. A general partnership is an entity distinct from its partners, but unless the general partnership is registered as a registered limited liability partnership (see this category, below), each partner is liable for the obligations of the general partnership.
Limited Liability Company	A limited liability company is an unincorporated association of one or more members (the owners) who share in the profits and losses of the company's business. It is managed in accordance with an operating agreement by one or more members (member-managed) or by one or more managers (manager-managed). A limited liability company is a separate legal entity and, generally, the members and managers are not liable for the obligations of the limited liability company.
Limited Partnership	A limited partnership, which is a type of partnership distinct from a general partnership, is formed by two or more persons with at least one general partner and one limited partner. The general partners exercise control over the management of the limited partnership's business. The limited partners contribute money, property and/or services in return for an interest in the partnership, and share in the profits and losses of the limited partnership with the general partners in accordance with a written partnership agreement or, if there is none, the value of the unreturned contributions made by each partner. A limited partnership is an entity distinct from its partners. Generally, the limited partners are not liable for the obligations of the limited partnership. Unless the limited partnership is registered as a registered limited liability partnership (see this category, below), however, each general partner is liable for the obligations of the limited partnership.

The following are categories within and across various business entity types.

Category	Definition
Benefit Corporation	A benefit corporation is a Virginia stock corporation whose articles of incorporation provide that it is a benefit corporation and that has, as one of its purposes, the purpose of creating a general public benefit on society and/or the environment.
Cooperative	A cooperative is a stock or nonstock corporation that is organized to conduct, on a cooperative plan for the mutual benefit of its members, any housing, agricultural, fishing, dairy, mercantile, merchandise, brokerage, water, sewer, manufacturing, service or mechanical business, or to represent or provide financing for cooperative associations, societies, companies or exchanges.
Foreign Business Entity	A foreign business entity is a business trust, corporation, general partnership, limited liability company or limited partnership that has been incorporated, organized or formed under the laws of a state or jurisdiction other than Virginia.
Professional Corporation	A professional corporation is a stock or nonstock corporation that is organized for the sole and specific purpose of rendering the professional service of pharmacists, optometrists, physical therapists, physical therapist assistants, practitioners of the healing arts, nurse practitioners, practitioners of the behavioral science professions, veterinarians, surgeons, dentists, architects, professional engineers, land surveyors, certified landscape architects, certified interior designers, public accountants, certified public accountants, attorneys-at-law, insurance consultants, audiologists, speech pathologists or clinical nurse specialists.
Professional Limited Liability Company	A professional limited liability company is a limited liability company that is organized for the sole and specific purpose of rendering a professional service that can be performed by a professional corporation.
Public Service Company	A public service company is a business entity that conducts business as a gas, pipeline, electric light, heat, power, water supply, sewer, telephone or telegraph company, or as a common carrier of

	passengers or property. Generally, the business activities of a public service company are subject to regulation by a Virginia and/or federal governmental agency.
Registered Limited Liability Partnership	A registered limited liability partnership (sometimes referred to as a limited liability partnership) is a status granted to a general partnership or a limited partnership that has registered for such status in the jurisdiction of its formation. Upon registration, the partners of a general partnership and the general partners of a limited partnership are not liable for the obligations of the general partnership or limited partnership that arise after registration.
Registered Limited Liability Limited Partnership	A registered limited liability limited partnership is the term that applies to a limited partnership that has registered for status as a registered limited liability partnership.

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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

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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]

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[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-

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[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.

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[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

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[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.

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[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 0236092/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

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[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

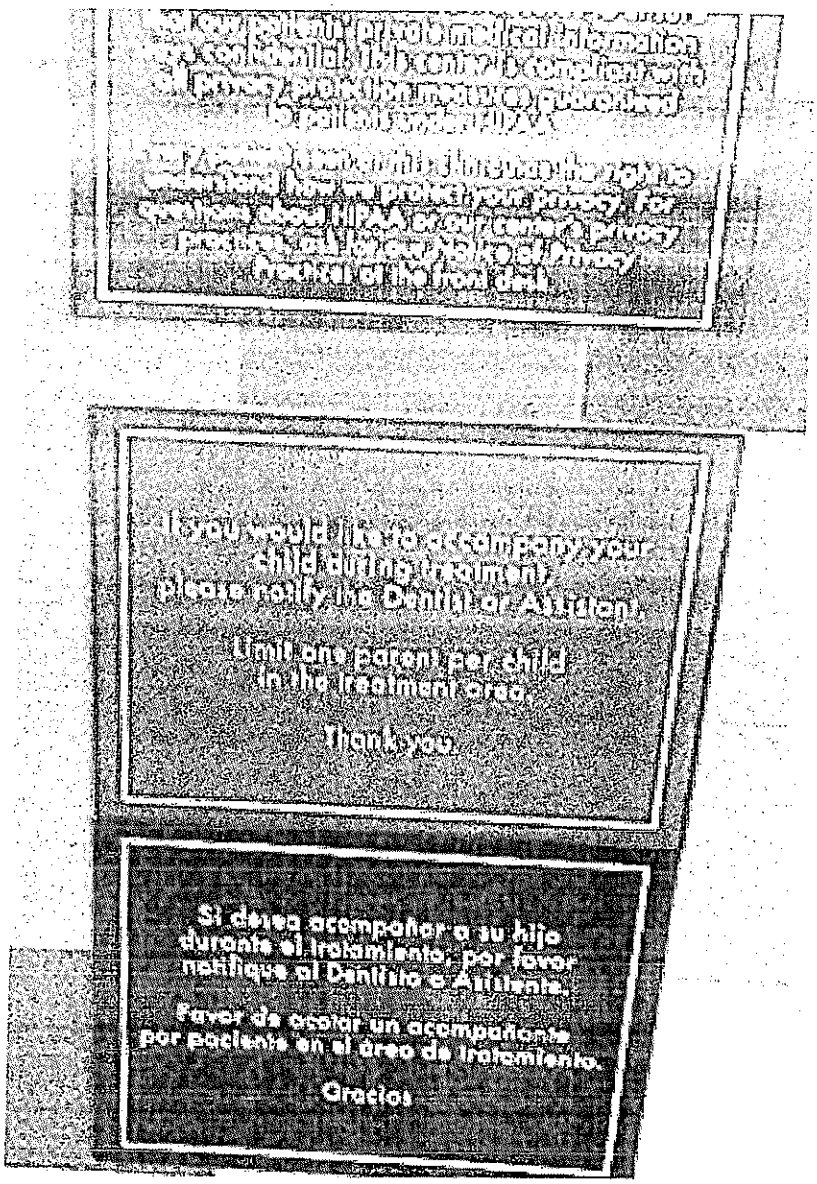
On March 7, 2012, Committee staff arranged a site visit at a Small Smiles Dental Center in Oxon Hill, Maryland, during an audit by the Independent Monitor.[72] The center was large, reasonably well kept, and clinic employees were friendly and welcoming. Signs informing parents of their right to join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


Si desea acompañar a su hijo
durante el tratamiento, por favor
notifique al Dentista o Asistente.
Favor de escoger un acompañante
por paciente en el área de tratamiento.
Gracias
Thank you.

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

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[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.

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[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

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[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]

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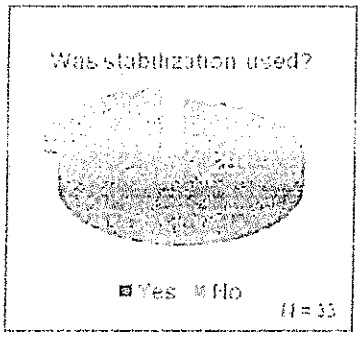
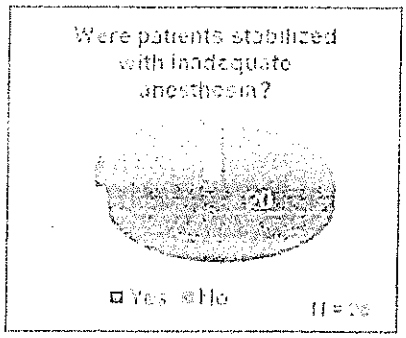
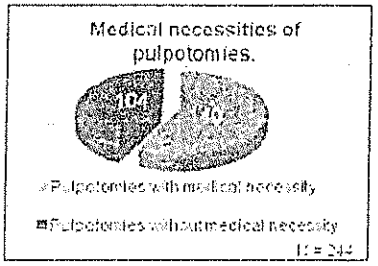
[99] IMR Phoenix, Ariz. at 17 (Exhibit 20).
[100] *Id.* at 18.
[101] *Id.* at 17.
[102] *Id.* at 17–18.
[103] Independent Monitor Report Manassas, Va. at 2 (Sept. 22, 2011) (Exhibit 23).
[104] Independent Monitor Report, Worcester, Mass. at 5 (Jan. 4, 2011) (Exhibit 46); Independent Monitor Report, Thornton, 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).



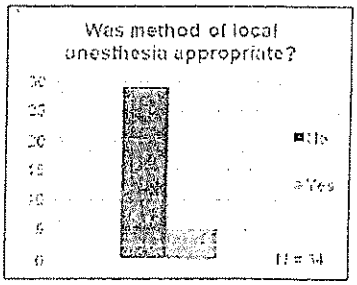


Source: IMR Manassas, Va. at 32 (Exhibit 23).

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

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[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]

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[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]

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[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]

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[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-denial-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

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[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=pIoMaw4xC9Q* (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.

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[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.

Agenda item: Permit Holder Office Inspections

With the final sedation and anesthesia permit regulations in final form and soon to be in effect, it is time to institute the planned periodic inspections. The Regulatory/Legislative Committee is asked to review the revised inspection form and proposed guidance document and to provide guidance to staff on development of these document for consideration by the Board during the June 13, 2014 business meeting. These documents were developed by Ms. Reen with guidance from the Director of Enforcement, Ms. Lemon, and her two deputies and the Deputy Director of the Board of Pharmacy, Mr. Johnson.

Action Options:

- Give direction to staff for developing the documents for presentation to the Board

Virginia Board of Dentistry Dental Inspection Form Date Hours Case#
Commonwealth of Virginia
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-367-4538

PERMIT HOLDER INSPECTIONS DISCUSSION DRAFT

TYPE OF INSPECTION
_____COMPLAINT INVESTIGATION _____COMPLIANCE _____PERIODIC FOR PERMIT HOLDER
Permit #: _____
Facility #: _____

PRACTICE NAME SPECIALTY PRACTICE

STREET ADDRESS CITY STATE ZIP CURRENT ADDRESS OF RECORD

PHONE: FAX: HOURS OF OPERATION:

STAFF: (Identify dentists, hygienists and assistants)	POSITION	LICENSE	EXP.DATE	Assists in Sedation GA
Any staff not listed in previous section?	Position			

C NC	18VAC60-20-200	Utilization of Dental Hygienists and Dental Assistants II No more than 4 dental hygienists or dental assistants II in any combination practicing under direction at one and the same time.
C NC NA	18VAC60-20-210	Requirements for Dental Hygienists to practice under general supervision. Y N Written orders are in the patient record. Y N The services on the original order are to be rendered within a specific time period not to exceed 10 months. Y N The dental hygienist has consented in writing to providing services under general supervision. Y N The patient is informed before the appointment that he will be treated under general supervision. Y N Written basic emergency procedures are established and the hygienist is capable of implementing those procedures.

Posting of Current Licenses, Certificates, and Registrations

C NC NA	54.1-2720	Display of Name of Practitioner. Every person practicing dentistry ...shall display his name at the entrance of the office.
C NC NA	54.1.2721	Dental Licenses are posted in plain view of patients.
C NC NA	54.1-2727	Dental Hygiene Licenses are posted in plain view of patients.
C NC NA	18VAC60-20-16	Dental Assistant II Registrations are posted in plain view of patients.
C NC NA	18VAC60-20-195	Radiation Certificate posted for those who expose dental x-ray and not otherwise licensed.
C NC NA	12VAC5-481-370.A (1) B	Certificate of certification of x-ray machine is posted near the x-ray machine.
C NC NA	18VAC60-20-110(D)	Deep Sedation/General Anesthesia Permit or AAOMS certificate AND DEA registration are posted in plain view of patients.
C NC NA	18VAC60-20-120(G)	Conscious/Moderate Sedation Permit or AAOMS certificate AND DEA registration is posted in plain view of patients.

Education

C NC NA	18VAC60-20-50	Dentists must hold current certification in basic life support or cardiopulmonary resuscitation with hands-on airway training for healthcare providers OR 18VAC60-20-110(C)(2) and 18VAC60-20-120(F) Dentists who administers conscious/moderate sedation, deep sedation or general anesthesia must hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers including basic electrocardiographic interpretation
C NC NA	18VAC60-20-50	Dental hygienists must hold current certification of completion of a hands-on course in basic cardiopulmonary resuscitation for health care providers
C NC NA	18VAC60-20-50	Dental assistants II must hold current certification of completion of a hands-on course in basic cardiopulmonary resuscitation for health care providers
C NC NA	18VAC60-20-107(I)	Dentists who administers conscious/moderate sedation, deep sedation or general anesthesia has completed at least four hours of continuing education directly related to such administration within the past 2 years

C	NC	NA	18VAC60-20-107(I)	Dental hygienists who monitor patients under conscious/moderate sedation, deep sedation or general anesthesia has completed at least four hours of continuing education directly related to such monitoring within the past 2
C	NC	NA	18VAC60-20-107 (G)(2)	Written basic emergency procedures are readily accessible when any level of sedation or general anesthesia is administered
C	NC	NA	18VAC60-20-107(G)(2)	Record of staff training to carry out emergency procedures when any level of sedation or general anesthesia is administered NOTE THE MOST RECENT DATE OF TRAINING:_____
C	NC	NA	18VAC60-20-135	Personnel, i.e. dental assistants, who assist in the administration and monitoring of conscious/moderate sedation or deep sedation and general anesthesia, must hold current certification in basic resuscitation techniques with hands-on airway training for health care providers.

18VAC60-20-15 and 18VAC60-20-107 Recordkeeping

Records include the following:

C	NC	NA	Patient's name and date of treatment
C	NC	NA	Health history Dates:_____
C	NC	NA	Written Informed Consent for any level of sedation
C	NC	NA	Written Informed Consent for the dental treatment to be performed when conscious/moderate sedation, deep sedation or general anesthesia is to be administered
C	NC	NA	Notation of patient's ASA classification: Class I to V when conscious/moderate sedation, deep sedation or general anesthesia is to be administered
C	NC	NA	For Class III patients, notation of consultation with patient's medical doctor for risks and special monitoring requirements or an OMS can document performing the evaluation and risk assessment and noting special monitoring requirements
C	NC	NA	Pre-operative vital signs when conscious/moderate sedation, deep sedation or general anesthesia is to be administered
C	NC	NA	Monitoring record of vital signs and physiologic measures recorded every five minutes
C	NC	NA	Diagnosis and treatment rendered
C	NC	NA	List of drugs prescribed, administered, dispensed and the route of administration, the quantity, dose and strength including local anesthetics
C	NC	NA	Radiographs/Digital Images/Pictures
C	NC	NA	Patient financial records
C	NC	NA	Name of dentist , dental hygienist and dental assistant providing treatment services, or monitoring patient specifying assigned duties
C	NC	NA	Patient records maintained for not less than three years from the most recent date of service
C	NC	NA	Number of records reviewed: _____
C	NC	NA	List patient records with noted deficiencies and attach copy:
C	NC	NA	§54.1-2719 Laboratory Work Orders Include: (attach example) Y N Name and address of the person, firm or corporation. Y N Patient's name or initials or an ID number. Y N Date work order was written. Y N Description of work to be done; Specifications of the type and materials to be used Y N Signature and address of the dentists

Environmental Conditions

C	NC	Facility appears neat and clean
C	NC	Describe any equipment with broken or missing part; oil/grease on any equipment; and any dirty suction hoses
C	NC	Describe sterilization process to include equipment use (should include heat and/or spore indicators.)
C	NC	Who processes spore indicators and are results maintained?
C	NC	What is office protocol when sterilization equipment indicates equipment is not working properly?
C	NC	How are sterilized instruments maintained?
C	NC	How are clinical surfaces disinfected and sanitized? Frequency? Solutions used?
C	NC	Are sharps containers available? When disposing of sharps/biohazard waste, is there a current contract, bill or receipt to document service?
C	NC	Appropriate personal protective equipment including gloves, face protection, eye protection and lead aprons
C	NC	Safe and accessible building exits in case of fire or other emergency

C NC	Additional inspection comments:	

Drug Security, Inventory and Records

C NC	CFR 1301.75 (b)	Sch II-V controlled substances are stored in a securely locked, substantially constructed cabinet
C NC	CFR 1304.04 (f)	Inventories and records of Sch II controlled substances are maintained separately from all other records and are readily retrievable
C NC	CFR 1304.04 (f)	Inventories and records of Sch III-V controlled substances are maintained either separately from all of records or in such a form that the information is readily retrievable
C NC		Records of Sch II-V controlled substances are maintained in chronological order
C NC	54.1- 3404. F	Required records are maintained completely and accurately for two years from the date of the transaction
C NC	54.1-3404. C	Records of receipt include the actual date of receipt, name and address of the person from whom received, and the name, strength and quantity of drug received
C NC	54,1-3404. D	Records of drugs sold, administered, dispensed or disposed of include the date of the transaction, name of patient, drug name, quantity of drug, and signature of person making the transaction
C NC	54.1-3404. A& B	Biennial inventory of Sch II-V drugs available was taken on a date within two years of the previous biennial inventory
C NC	54.1-3404. A & B	Biennial inventory is dated and indicates whether it was taken at the opening or close of business. Specify.
C NC	54.1-3404. E	Theft or unusual loss of drugs in Sch II-V is reported to the board of Pharmacy and an inventory taken if the registrant is unable to determine the exact kind and quantity of drug loss
C NC		Expired drugs are stored separate from the working stock of drugs until properly disposed

Equipment Requirements for Anesthesia, Sedation and Analgesia

18VAC60-20-108 (B) A dentist who administers anxiolysis or inhalation analgesia shall maintain the following operational equipment and be trained in its use	18VAC60-20-110(F) A dentist who administers deep sedation/general anesthesia shall maintain the following operational equipment in sizes for adults or children as appropriate for the patient being treated	18VAC60-20-120(I) A dentist who administers conscious sedation shall maintain the following operational equipment in sizes for adults or children as appropriate for the patient being treated
C NC Blood Pressure Monitoring	C NC Full face mask	C NC Full face masks
C NC Positive Pressure Oxygen	C NC Oral and Nasopharyngeal airway management adjuncts	C NC Oral and Nasopharyngeal airway management adjuncts
C NC Mechanical (hand) respiratory bag	C NC ET tubes with appropriate connectors or airway adjuncts such as a laryngeal mask	C NC ET tubes with appropriate connectors or airway adjuncts such as a laryngeal mask
	C NC Laryngoscope with reserve batteries and bulbs and appropriately sized blades	C NC Pulse Oximetry and BP Monitoring
	C NC Source of delivery of oxygen under controlled positive pressure	C NC Pharmacological antagonist agents unexpired
	C NC Mechanical (hand) respiratory bag	C NC Positive Pressure Oxygen
	C NC Pulse Oximetry and BP monitoring	C NC Emergency drugs for resuscitation
	C NC Emergency drugs for resuscitation	C NC Mechanical (hand) resp bag
	C NC EKG/ Temp monitoring equipment	C NC Suction apparatus
	C NC Pharmacological antagonist agents	C NC Throat Pack
	C NC External defibrillator (manual or automatic)	C NC External defibrillator (manual or automatic)
	C NC An end-Tidal CO2 monitor for intubated patients	C NC Precordial or pretracheal sthethoscope
	C NC Suction apparatus	C NC Temp measuring device
	C NC Throat Pack	C NC Electrocardiographic monitor
	C NC Precordial or pretracheal sthethoscope	

Staffing Requirements for Anesthesia, Sedation, & Analgesia

18VAC60-20-108 A dentist who administers anxiolysis or inhalation analgesia shall maintain the following:	18VAC60-20-110 A dentist who administers deep sedation/general anesthesia shall maintain the following:	18VAC60-20-120 A dentist who administers conscious sedation shall maintain the following:

C NC Treatment team: dentist & a second person to assist, monitor & observe the patient	C NC Treatment team: Operating dentist, a second person to monitor & observe the patient, & a third person to assist the operating dentist	C NC Treatment team: Operating dentist & a second person to assist, monitor, & observe the patient.
	C NC Post educational certificate in plain view of the patient	

Oral and Maxillofacial Surgeons

Y N 18VAC60-20-250 Has Board Registration
Y N 18VAC60-20-260 Has updated practitioner profile. Attach Profile.
Y N 18VAC60-20-290 Performs cosmetic procedures and is certified by the Board according to §54.1-2709.

Please check all certifications for cosmetic procedures.

A. [ ] Rhinoplasty/similar procedures
B. [ ] Blepharoplasty/similar procedures
C. [ ] Rhytidectomy/similar procedures
D. [ ] Submental liposuction/similar procedures
E. [ ] Browlift/either open or endoscopic technique/similar procedures
F. [ ] Otoplasty/similar procedures
G. [ ] Laser resurfacing or dermabrasion/similar procedures
H. [ ] Platysmal muscle plication/similar procedures

Compliant (C) Non Compliant (NC) Not Applicable (NA)

Type of Inspection: _____ **Case No.:** _____

_____ _____

Signature of Inspector **Date** **Signature of Licensee** **Date**

Guidance Document Discussion Draft

Virginia Board of Dentistry

Periodic Office Inspections for Administration of Sedation and Anesthesia

Purpose

The purpose of instituting periodic office inspections is to foster and verify compliance with regulatory requirements by dentists who hold a permit to administer sedation or general anesthesia (permit holders). Verifying compliance with the requirements will assure that appropriate protections are in place for the health and safety of patients who undergo conscious/moderate sedation, deep sedation, or general anesthesia for dental treatment.

Excerpts of Applicable Laws and Regulation

- **Employees of the Department of Health Professions, when properly identified, shall be authorized, during ordinary business hours, to enter and inspect any dental office or dental laboratory for the purpose of enforcing the provisions of this chapter as provided by §54.1-2703 of the Code of Virginia.**
- **The Board shall establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of sedation and anesthesia to patients in a dental office as provided by §54.1-2709.5 of the Code.**
- **Part IV of the Regulations Governing Dental Practice addresses the administration of anesthesia, sedation and analgesia beginning at 18VAC60-20-107.**

Scope of Periodic Inspections

- **Dentists who do not provide any level of sedation and those that only provide minimal sedation do not require a permit and are not subject to periodic inspections.**
- **Oral and maxillofacial surgeons (OMSs) who maintain membership in AAOMS and who provide the Board with the reports which result from the periodic office examinations required by AAOMS do not require a permit and are not subject to periodic inspections by the Board so long as each Virginia office an OMS practices in has undergone an AAMOS periodic office examination within five years and the reports of the examinations are provided to the Board upon request.**
- **Every OMS who does not maintain AAOMS membership or who cannot or will not provide an AAOMS report to the Board is required to hold a**

permit to administer sedation or general anesthesia and are subject to periodic inspections by the Board.

- Every dentist who holds a permit to administer conscious/moderate sedation, enteral conscious/moderate sedation, or deep sedation and general anesthesia is subject to periodic office inspections.
- Permit holders who practice in multiple offices shall identify each location for inspection. Each office will be inspected concurrently and will be addressed in one inspection report.
- Practices with multiple permit holders will be inspected for general compliance at least once in an inspection cycle. These inspections will also address the compliance of each permit holder at the practice so that a complete inspection report is issued for each permit holder.
- Permit holders practicing on an itinerant basis shall identify a primary practice location for a periodic inspection and shall report and provide information about the arrangements in place for control of itinerant practice to facilitate inspection of those arrangements.

Inspection Cycle

The standard inspection cycle is to inspect each permit holder's practice once every three years. This cycle will be followed when an inspection finds that all requirements have been met or that only a few minor violations have been identified for correction through either a confidential consent agreement or pre-hearing consent order. Significant findings of violations may result in disciplinary action and more frequent inspections.

Initiation of Inspections

The Board will conduct a pre-inspection survey of all permit holders. The purpose of this survey will be to collect information about the level of sedation practiced, practice locations and staffing. This information will facilitate planning for inspections. Permit holders will receive a copy of the inspection form with the survey.

Beginning on Month/Date/Year, the Enforcement Division of the Department of Health Professions will initiate inspections of the offices of permit holders.

- The inspections for current permit holders as of Month/Date/Year will be conducted so that inspections will be completed within three years.
- Permit holders who receive their permit on or after Month/Date/Year shall be inspected within 1 year of issuance of the permit.

After Month/Date/Year, the Board will send an e-mail request to each OMS for submission of the most recent reports which resulted from the periodic office

examinations required by AAOMS. This request will include a form to be completed and returned to the Board with the name of the primary contact person and the name, address, and phone number of each office where the OMS practices.