BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

IN THE MATTER OF:

PAUL E. WATKINS, D.D.S. License No. 5757)	)	FINAL AGENCY DECISION

THIS MATTER came on to be heard and was heard on September 14 – 15 and October 4 – 6, 2007 before the North Carolina State Board of Dental Examiners (the Board) pursuant to G.S. §§ 90-41.1 and 150B-38 and 21 N.C.A.C. 16N .0504 of the Board's Regulations. The hearing panel of the Board consisted of Board members Dr. Ronald K. Owens, presiding; Dr. C. Wayne Holland, Dr. Joseph Burnham and Dr. Clifford Feingold. Board members Dr. Brad C. Morgan, Dr. W. Stan Hardesty, Jr., Ms. Neplus Hall and Ms. Zannie Efird did not participate in the hearing, deliberations or decision of this matter. Freddie Lane, Jr., represented the Respondent, Paul E. Watkins, D.D.S. Carolin Bakewell represented the Investigative Panel.

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

FINDINGS OF FACT

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

2. The Respondent, Paul E. Watkins (Respondent) was licensed to practice dentistry in North Carolina on June 10, 1988. His license was duly renewed through the current year.

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

4. The Respondent was properly served with the Second Amended Notice of Hearing and had proper notice of the hearing dates.

DENTAL LICENSE APPLICATION

5. Following his graduation from dental school in May 1987, Respondent worked for a dentist named Dr. Charles Hall ("Dr. Hall") in Nashville, Tennessee.

6. On October 5, 1987, Respondent was licensed to practice dentistry in the state of Tennessee by examination.

7. For two months in late 1987 or early 1988, Respondent was employed at Madison Dental Center, a dental laboratory owned by a non-dentist, Harold Richardson ("Richardson"). While employed at Madison Dental Center, Respondent engaged in the practice of dentistry by performing dental services for members of the public.

8. On March 2, 1988, a Notice of Charges ("Tennessee Notice of Charges") was filed against Respondent by the Tennessee Department of Health and Environment, alleging that Respondent's employment at Madison Dental Center violated a Tennessee law prohibiting dentists from working for non-dentists.

9. On March 2, 1988, a copy of the Tennessee Notice of Charges was deposited in the U.S. Mail for service upon Respondent by the Tennessee Department of Health and Environment.

10. Thereafter, Respondent retained counsel to represent him regarding the Tennessee Notice of Charges.

11. On July 22, 1988, the Tennessee disciplinary proceeding against Respondent was resolved by the entry of a Consent Order. Respondent's attorney signed the Consent Order on Respondent's behalf. The Consent Order found that Respondent had violated Tennessee law by working as an employee of Madison Dental Center. Pursuant to the Consent Order, the Respondent's Tennessee dental license was suspended for three months, and the suspension was stayed for three years.

12. On April 1, 1988, after the Tennessee Notice of Charges had been filed and mailed, but before the Consent Order was entered, Respondent filled out and signed a verified application for licensure as a dentist in North Carolina ("North Carolina application"). Respondent submitted the North Carolina application to the Board shortly thereafter.

13. Despite the fact that he was aware of the Tennessee disciplinary proceeding, Respondent falsely stated on his North Carolina application that no charges or informal or formal complaints had ever been made or filed against him and that no proceedings had ever been instituted against him as a member of any profession.

14. Respondent also falsely represented on his North Carolina application that his only work as a dentist had been as an associate with Dr. Hall. Respondent failed to disclose his employment at Madison Dental Center.

15. On June 27, 1988, Respondent filed a verified application for a temporary dental license in the state of New York ("temporary New York application"). Respondent filed the temporary New York application less than one month before the Tennessee disciplinary case was resolved by entry of the Consent Order.

16. Although he was aware of the pending Tennessee disciplinary case, Respondent falsely indicated on his temporary New York application that he was not the subject of pending disciplinary charges in any state.

17. On June 1, 1989, Respondent filed a verified application for a permanent dental license in New York. ("permanent New York application").

18. Although the permanent New York application was filed approximately 11 months after Respondent had agreed to entry of the Consent Order in the Tennessee disciplinary case, Respondent falsely indicated on his permanent New York application that he had never been professionally disciplined in any jurisdiction.

19. On his permanent New York application Respondent also falsely stated that North Carolina was the only state in which he had ever been licensed as a dentist by examination.

JEREMY HYLER

20. On July 29, 2003, Jeremy Hyler ("Hyler") presented to Respondent's orthodontic practice for an initial examination and consultation regarding possible orthodontic treatment. Orthodontic treatment was recommended and initial radiographs and study models were taken.

21. Hyler, who was a Medicaid recipient, was taken to all of his appointments with Respondent by his grandfather, Charles Markham ("Markham").

22. On September 4, 2003, Hyler and Markham returned to Respondent's practice, at which time Respondent reviewed Hyler's treatment plan and the records.

23. Neither Respondent nor his staff ever submitted Hyler's case to the North Carolina Department of Medical Assistance (DMA) for approval.

24. Respondent and his staff falsely represented to Markham that Hyler's case had been submitted to DMA for approval.

25. In reliance upon these false representations, Hyler and Markham appeared for appointments at Respondent's office on various occasions between November 2003 and March 2004, which required them to take time from school and other pursuits.

26. As of 2003 and 2004, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists who treated Medicaid patients to submit their cases to DMA for approval on a timely basis.

27. Hyler's last appointment with Respondent's office was scheduled for March 30, 2004.

28. In April 2004, Hyler's grandmother, Joanne Markham, discovered from another source that Hyler's case had never been submitted to DMA for approval. Hyler later transferred to another orthodontist, who completed his treatment.

29. There was no legitimate medical or dental reason for Respondent to delay submitting Hyler's case to DMA for approval.

30. Neither Respondent nor his staff informed the Markhams of the expected timeline for submitting and receiving DMA approval or denial, nor did they provide the Markhams with adequate information regarding the procedure that should be followed if DMA failed to approve or deny Hyler's case within eight weeks after the case was submitted.

MARA ADDISON

31. Between September 11, 2003 and August 19, 2004, Mara Addison ("Mara") was a dental patient under Respondent's care. She was a Medicaid recipient.

32. On September 11, 2003, Mara presented to Respondent's orthodontic practice for an initial examination and consultation regarding possible orthodontic treatment. Orthodontic treatment was recommended and initial radiographs and study models were taken.

33. On January 15, 2004, Mara presented to Respondent's practice for initial banding. Respondent placed ceramic brackets at an additional charge of $600.00.

34. Mara's mother, Donna Addison ("Ms. Addison") paid Respondent a total of $400 in two installments toward the $600 charge for the ceramic brackets.

35. In the summer of 2004, Respondent's office manager, Roya Tooloian ("Ms. Tooloian"), advised Ms. Addison that Respondent had refused to treat Mara until the $200 balance for the ceramic brackets was paid.

36. Mara Addison did not receive orthodontic treatment from Respondent at any time following this conversation.

37. In 2004, the standard of care for dentists licensed to practice dentistry in North Carolina forbade dentists to refuse treatment merely because a patient had an outstanding balance.

JUDY TONEY

38. Between April 30, 2003 and August 14, 2004, Judy Toney ("Judy") was a dental patient under Respondent's case.

39. On April 30, 2003, Judy presented to Respondent's orthodontic practice for an initial examination.

40. On May 28, 2003 Judy returned to the practice and orthodontic records were taken. Respondent's orthodontic records consisted of a Panorex, a lateral head film and study models. Respondent later had cephalometric tracings done.

41. In 2003, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to take or have available intraoral and facial photographs before initiating orthodontic treatment.

42. Respondent failed to take, or have available, intraoral or facial photographs before initiating orthodontic treatment for Judy.

43. In 2003, the standard of care for dentists licensed in North Carolina required dentists to take or have available study models of diagnostic quality before initiating orthodontic treatment.

44. Study models are used to establish a patient's "baseline" condition and determine a treatment plan.

45. The model that Respondent prepared for Judy was not of diagnostic quality. The maxillary anterior teeth of the model were distorted and the impression was not deep enough to reveal all of the soft tissue adequately. These defects adversely affected the model's usefulness.

46. On June 13, 2003, Respondent placed brackets on Judy's anterior teeth.

47. On July 9, 2003, Respondent installed separators in preparation for inserting Judy's molar bands. Judy was not scheduled for an additional appointment until August 6, 2003.

48. Delaying banding appointments beyond one or two weeks after separators are placed creates a significant risk that the separators will fall out and the spaces between the teeth will close back up, thereby delaying treatment.

49. When Judy returned for the August 6, 2003 appointment, her separators had in fact fallen out and had to be replaced. As a result, molar banding was delayed until Judy's September 3, 2003 appointment.

50. Judy's remaining banding was completed on October 8, 2003. There was no legitimate reason for spreading out Judy's banding over three visits and a period of four months.

51. Although he was aware that Judy had a thumbsucking habit when she first presented for an evaluation, Respondent did not install an appliance to deal with the habit until April 14, 2004, approximately ten months after Judy's orthodontic treatment began.

52. The appliance did not fit and was removed by a dentist at the Surry County Health Department because the appliance was causing discomfort and hygiene problems.

53. Judy was not seen by Respondent between April 14 and July 16, 2004. During 60 days of this period, Respondent's license was suspended by the Dental Board for violations of the Dental Practice Act unrelated to his treatment of Judy Toney.

54. Respondent failed to refer Judy to another orthodontist for interim treatment during the suspension of his dental license.

55. As of October 2004, when Judy was first seen by Dr. James Wilson ("Dr. Wilson"), the orthodontist who completed her orthodontic work, Judy's anterior teeth had not undergone any retraction.

56. In 2003 and 2004, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to proceed with treatment in a timely manner.

57. Respondent did not proceed with Judy's orthodontic treatment in a timely manner.

JACKIE TONEY

58. Between April 30, 2003 and August 14, 2004, Jackie Toney ("Jackie") was a dental patient under Respondent's care. Jackie, who was a Medicaid recipient during this period of treatment, is the sister of Judy Toney.

59. On April 30, 2003, Jackie presented to Respondent's orthodontic practice for an initial examination.

60. Jackie returned to Respondent's practice on May 28, 2003, and orthodontic records were taken. Respondent's orthodontic records consisted of a Panorex and a lateral head film. Respondent later had cephalometric tracings made.

61. In 2003, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to take or have available intraoral and facial photographs before initiating orthodontic treatment.

62. Respondent failed to take, or have available, intraoral or facial photographs before initiating orthodontic treatment for Jackie.

63. The standard of care applicable to North Carolina dentists in 2003 required dentists to take or have available radiographs and study models of diagnostic quality before initiating orthodontic treatment.

64. The cephalometric radiograph Respondent took in Jackie's case was not of diagnostic quality. The cephalostat was about 10 mm off and this

defect would likely skew the measurements used to determine the orthodontic plan.

65. At the time Jackie began orthodontic treatment, she still had a number of deciduous teeth.

66. Respondent did not take steps to ensure that Jackie's remaining deciduous teeth were extracted in a timely fashion. The presence of remaining deciduous teeth delayed Jackie's treatment.

67. The initial banding for Jackie occurred on September 3, 2003. Although Respondent placed a continuous ligature tie, it did not create tooth movement.

68. Respondent inserted separators on October 8, 2003, but did not schedule another appointment for Jackie until November 15, 2003.

69. By the time of Jackie's November 15, 2003 appointment, the separators had fallen out and had to be replaced. This delayed molar banding until Jackie's December 14, 2003 appointment.

70. Although he was aware of Jackie's thumbsucking habit at her initial appointment, Respondent did not insert an appliance to address Jackie's habit until May 2004, more than seven months after her treatment began.

71. The thumbsucking appliance did not fit and was removed by a general dentist at the Surry County Health Department because it was causing discomfort and hygiene problems.

72. Jackie was not seen by Respondent between April 19 and July 6, 2004. During 60 days of this period, Respondent's license was suspended by

the Dental Board for violations of the Dental Practice Act unrelated to his treatment of Jackie.

73. Respondent failed to refer Jackie to another orthodontist for interim treatment for the term of his suspension.

74. No tooth movement was accomplished for Jackie between April 19 and July 6, 2004. As of October 2004, when Jackie was seen by Dr. Wilson, her overjet had not been reduced.

75. In 2003 and 2004, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to proceed with treatment in a timely manner.

76. Respondent failed to proceed with Jackie Toney's orthodontic treatment in a timely manner.

HEATHER BRINSON

77. Between November 9, 2002 and December 13, 2004, Heather Brinson ("Ms. Brinson") was a dental patient under Respondent's care. Ms. Brinson was a Medicaid recipient and lived in a group home.

78. On November 9, 2002, Ms. Brinson presented to Respondent's orthodontic practice for an initial examination.

79. Ms. Brinson returned to the practice on January 31, 2003, and orthodontic records were taken. Respondent's orthodontic records consisted of a Panorex, study models and a lateral head film. Respondent later had cephalometric tracings made.

80. In 2003, the standard of care for dentists licensed to practice in North Carolina required dentists to take or have available intraoral and facial photographs before initiating orthodontic treatment.

81. Respondent failed to take, or have available, intraoral or facial photographs before initiating orthodontic treatment for Ms. Brinson.

82. In 2003, the standard of care for dentists licensed to practice in North Carolina required dentists to take or have available radiographs and study models of diagnostic quality before initiating orthodontic treatment.

83. Respondent's Panorex radiograph of Ms. Brinson was not of diagnostic quality. The panoramic radiograph was poorly processed and the images of the maxillary incisors were grossly distorted. The study models were not trimmed or articulated to reflect Ms. Brinson's occlusion.

84. In January 2005, Ms. Brinson's caseworker notified Respondent that Ms. Brinson was going to transfer to another orthodontist and asked Respondent for copies of Ms. Brinson's patient records.

85. On January 20, 2005, Respondent transferred Ms. Brinson's Panorex, lateral cephalogram, ADA form D8080 and a copy of the request for release of records to Ms. Brinson's caseworker. Respondent did not provide copies of Ms. Brinson's patient records or a transfer form to Ms. Brinson's caseworker.

86. In 2005, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to provide copies of patient records

or a transfer form to the patient or a subsequent treating dentist within 30 days of receiving a records request.

TRISTAN SPENCER

87. Between September 16, 1999 and February 23, 2005, Tristan Spencer ("Spencer") was a dental patient under Respondent's care. Spencer was a Medicaid recipient.

88. On September 16, 1999 Spencer presented to Respondent's orthodontic practice for an initial examination.

89. In 1999, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to take or have available intraoral and facial photographs before initiating orthodontic treatment.

90. Respondent failed to take, or have available, intraoral or facial photographs before initiating orthodontic treatment for Spencer.

DORINDA MCVAY

91. Between April 29, 2000 and November 25, 2003, Dorinda McVay ("Ms. McVay") was a dental patient under Respondent's care. Ms. McVay was a Medicaid recipient.

92. On April 29, 2000, Ms. McVay presented to Respondent's orthodontic practice for an initial examination. She was a minor at the time.

93. In 2000, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to take or have available intraoral and facial photographs before initiating orthodontic treatment.

94. Respondent failed to take, or have available, intraoral or facial photographs before initiating orthodontic treatment for Ms. McVay.

95. Respondent's treatment plan for Ms. McVay called for the extraction of lower first premolars, with routine orthodontic treatment to follow. This was a compromise treatment plan with a guarded prognosis.

96. The ideal treatment plan for Ms. McVay called for surgery to correct a skeletal deformity.

97. In 2000, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to fully inform the parents of a minor patient of the treatment alternatives available to the patient, the advantages and disadvantages of each alternative and the prognosis for each treatment option.

98. Respondent failed to advise Ms. McVay or her parents that surgery was the ideal treatment plan, nor did he tell them of the advantages and disadvantage of the various treatment alternatives or the guarded prognosis of the treatment plan that Respondent did present.

KENNETH NELSON

99. Between April 2, 2005 and February 3, 2006, Kenneth Nelson ("Nelson") was a dental patient under Respondent's care. Nelson was a Medicaid recipient.

100. On April 2, 2005, Nelson presented to Respondent's orthodontic practice for an initial examination.

101. In 2005, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to maintain patient records that clearly stated when and what orthodontic records were taken.

102. Respondent's patient records for Nelson failed to state when and what orthodontic records were taken.

103. In 2005, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to take or have available intraoral and facial photographs before initiating orthodontic treatment.

104. Respondent failed to take, or have available, intraoral or facial photographs before initiating orthodontic treatment for Nelson.

105. On February 3, 2006, Nelson presented for a scheduled appointment with Respondent. After waiting for some time, Nelson and his mother, Susan Perry ("Ms. Perry"), left the Respondent's dental office before Nelson had been treated.

106. The patient "sign in sheet" for Respondent's office for February 3, 2006, reflected that Nelson left before treatment and that he planned to reschedule the visit at a later time.

107. Despite the fact that Nelson left without being treated on February 3, 2006, Ms. Tooloian submitted a payment request on Respondent's behalf to DMA which represented that Nelson had been treated on February 3, 2006.

108. In reliance upon this representation, DMA paid Respondent for providing monthly maintenance services to Nelson on February 3, 2006.

109. In October 2006, Ms. Perry filed a complaint against Respondent with the Board which alleged, among other things, that Respondent had improperly billed DMA for the February 3, 2006 appointment. Although he was on notice of Ms. Perry's complaint, Respondent failed to refund the payment to DMA until February 24, 2007, after the Notice of Hearing herein was filed.

110. On February 24, 2006, Ms. Perry notified Respondent that she was transferring her son to another orthodontist. On the same date, Nelson's new orthodontist requested a copy of Nelson's records.

111. On March 3, 2006, Respondent transferred Nelson's Panorex, lateral cephalogram, ADA form D8080 and a copy of a request for release of records to Nelson's new orthodontist. Respondent did not send a copy of Nelson's treatment record or a completed transfer form to Nelson's new orthodontist.

112. In 2006, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to forward a copy of a patient's treatment record or a completed transfer form to a subsequent orthodontist within 30 days after receiving a records request.

OSCAR EASON

113. Between May 19, 2005 and November 12, 2005, Oscar Eason ("Eason") was a dental patient under Respondent's care. Eason was a Medicaid recipient.

114. On May 19, 2005, Eason presented to Respondent's orthodontic practice for an initial examination.

115. Eason remained a patient of record until November 12, 2005, when Eason's mother asked Respondent to transfer Eason's patient records to another orthodontist.

116. On November 29, 2005, Respondent's staff transferred Eason's Panorex, lateral cephalogram, ADA form D8080 and a copy of a request for release of records to Eason's new orthodontist. Respondent did not send a copy of Eason's treatment record or a completed transfer form to Eason's new orthodontist.

117. In 2005, the standard of care for dentists licensed to practice dentistry in North Carolina required dentists to forward a copy of a patient's treatment record or a completed transfer form to the subsequent orthodontist within 30 days of receiving a records request.

MEDICAID BILLING RULES

118. Respondent began providing treatment to Medicaid patients in 1992. As part of his contract with DMA, Respondent agreed that all billing submissions would be accurate and that he would take steps to correct any inaccurate submissions.

119. At all times relevant hereto, patients approved for orthodontic care by DMA were eligible to receive a one-in-a-lifetime banding service and 23 monthly maintenance visits at state expense. DMA also reimbursed participating orthodontists for taking initial dental records, such as radiographs and study models.

120. In 2004 and early 2005, DMA paid participating orthodontists $857.47 for the one-time banding service and $67.47 for each of the 23 monthly maintenance visits. The monthly maintenance fee was later increased to $75.

121. DMA deems banding to be complete only when all orthodontic appliances, including bands, brackets and arch wires, are placed on a patient's upper and lower arches.

122. The one-time banding service fee may not be billed or paid until banding is complete.

123. Charges for monthly maintenance visits may not be made before banding is completed.

124. DMA will pay for only one maintenance visit per month. No reimbursement is made for additional visits within the same month.

MEDICAID OVERBILLING/BANDING ABUSES

125. Ms. Tooloian was the employee who handled billing to and payments from DMA for Respondent at all times relevant hereto. Respondent trained Ms. Tooloian, was her immediate supervisor, and at all times had access to records documents reflecting how she was billing DMA.

126. Respondent personally benefited from the manner in which Ms. Tooloian billed DMA.

127. By no later than 2004, Respondent had developed a practice of spreading out patients' banding over several appointments for the purpose of maximizing the amount of fees collected from DMA.

128. Pursuant to this practice, Ms. Tooloian routinely billed DMA for the $857.47 banding fee after each patient's first banding appointment, although the appointment typically involved the placement of only six brackets, which meant that banding was incomplete.

129. At the same time, Respondent, through Ms. Tooloian, routinely billed later banding appointments as monthly maintenance visits.

130. Neither Respondent nor Ms. Tooloian revealed to DMA that some appointments that they billed as monthly maintenance visits were in fact follow up banding appointments.

131. DMA would not have paid Respondent for maintenance visits had it known that the work performed consisted of follow up banding work, such as insertion of separators, placement of bands and initial arch wire tie-ins.

132. Neither Respondent nor Ms. Tooloian telephoned DMA's helpline to ask for clarification of DMA's billing policy and neither attended any billing training seminars offered by DMA.

133. The American Dental Association's CDT manual did not authorize Respondent to bill follow up banding work as monthly maintenance visits.

134. On April 4, 2005, DMA notified Respondent in writing regarding a number of problems relating to his billing practices. The April 4, 2005 letter specifically advised Respondent that it was improper for him to bill visits for banding and placement of separators as monthly maintenance visits, since that work is part of the initial banding process.

135. At the latest, Respondent knew by early April 2005 that he was not authorized to bill follow up banding work as monthly maintenance visits.

136. Respondent did not file any appeal from or protest to the April 4, 2005 letter. In fact, he paid $4,539.98 in recoupment charges as directed in the letter.

137. Respondent did not take any disciplinary action against Ms. Tooloian for her billing practices after he received the April 4, 2005 letter from DMA, nor did he direct her to change her billing practices.

138. After April 4, 2005 Respondent, through Ms. Toolian, continued to bill DMA for monthly maintenance visits in cases in which the only work done constituted the completion of banding, for which Respondent had already been paid the $857.47 banding fee.

139. At the same time that Respondent was spreading out banding over several visits, billing DMA for the $857.47 banding fee after the first visit and routinely billing follow up visits as maintenance appointments to maximize payments from DMA, he also took steps to discourage patients from continuing treatment beyond a few visits. By doing so, Respondent had more time to devote to cases that had not yet been through the more profitable initial banding stage and, as a result, maximized the amount of money he received from DMA.

140. Pursuant to this scheme, Respondent scheduled as many as 60 – 70 Medicaid patients in a single day, thereby ensuring long waits and uncomfortable, crowded waiting rooms. Patients, some of whom had to drive

several hours to get to Respondent's office, reported waiting until 11 p.m. or midnight to receive treatment.

141. Parents were not allowed in the treatment rooms and rarely had any opportunity to speak to Respondent about their child's treatment plan or progress.

142. Patients who had problems with broken wires and brackets between appointments were typically required to wait until their next monthly visit to be seen.

143. Of a sample of 52 cases handled by Respondent in 2004 and 2005, approximately 2/3 of the patients failed to complete the entire 23 maintenance visits allowed by the state. Approximately 1/3 of the patients completed fewer than six visits.

BILLING WHEN NO SERVICE PROVIDED

144. On a number of occasions, Respondent also permitted Ms. Tooloian to bill DMA for orthodontic visits that had not occurred at all, as follows:

a) Respondent received payment from DMA for 10 visits in 2006 by Khadijah Akbarmotley when in fact Akbarmotley only appeared for eight monthly maintenance visits in 2006.

b) Respondent received payment from DMA for 11 visits in 2006 by Trayquan Bethea, when in fact Bethea only appeared for eight monthly maintenance visits in 2006.

c) Respondent received payment from DMA for four visits in 2005 by Kevisha Greene, when in fact Greene only appeared for three monthly maintenance visits in 2005.

145. Respondent, through Ms. Tooloian, billed and received payment from DMA for treating a number of patients in months in which the patients had no appointment and received no treatment as follows:

a) Respondent received payment from DMA for visits that he represented were made by Benjamin Chesney on January 4 and March 1, 2006, despite the fact that Chesney had no appointments and received no treatment at any time in January or March 2006.

b) Respondent billed and received payment from DMA for a visit that he represented had been made by David Calderon on October 12, 2005, despite the fact that Calderon had no appointments and received no treatment at any time in October 2005.

c) Respondent billed and received payment from DMA for service he represented was provided to Zainebe Ata on June 2, 2005, despite the fact that Ata had no appointments and received no treatment at any time in June 2005.

d) Respondent billed and received payment from DMA for service that he represented had been provided to Brittany Hall on February 11, 2005 and October 14, 2005, despite the

fact that Hall had no appointments and received no treatment at any time in February or October 2005.

e) Respondent billed and received payment from DMA for service that he represented was provided to Tiereke Jackson on November 2, 2004, despite the fact that Jackson had no appointments and received no treatment in November 2004.

f) Respondent billed and received payment from DMA for service that he represented was provided to Bobbi Sanders on November 30, 2006, despite the fact that Sanders had no appointments and received no treatment at any time in November 2006.

g) Respondent billed and received payment from DMA for service that he represented was provided to Erica Schoppers on October 20, 2005, despite the fact that Schoppers had no appointments and received no treatment at any time in October 2005.

h) Respondent billed and received payment from DMA for service that he represented had been provided to Gerardo Torres on October 20, 2005 and November 22, 2005, despite the fact that Torres had no appointments and received no treatment at any time in October or November 2005.

146. Respondent billed DMA and was paid for providing monthly maintenance services to Porshe Marable on June 1, 2006, despite the fact that Marable had no appointments and received no treatment in June 2006.

147. In fact, Marable was seen and treated by Respondent on May 18 and May 25, 2006. Respondent billed and was paid by DMA for the May 18, 2006 visit.

149. Respondent misrepresented to DMA that Marable's May 25, 2006 visit had occurred on June 1, 2006 for the purpose of obtaining payment to which Respondent was not entitled in light of DMA's rule that limited reimbursement to one maintenance visit per month.

MEDICAID OVERBILLING/SINGLE ARCH TREATMENT

150. Respondent was aware at all relevant times that DMA would neither approve cases in which a patient required treatment of only one arch ("single arch cases") nor provide payment for treating only a single arch.

151. Between November 2004 and May 27, 2005, Respondent, through Ms. Tooloian, billed DMA and was paid a full banding fee for Devricke Camack, Jordan Bryant, Brittany Word and Skyler Cannon, although each patient had only been banded on one arch.

152. Neither Respondent nor Ms. Tooloian disclosed to DMA that only a single arch had been banded for Camack, Bryant, Word and Cannon.

153. Neither Respondent nor Ms. Tooloian notified DMA when the patients failed to return for additional treatment. Respondent failed to refund the

banding payment he had received from DMA for Camack, Bryant, Word and Cannon.

VIOLATION OF CONSENT ORDER

154. On October 10, 2003, Respondent entered into a Consent Order with the Board that suspended the Respondent's dental license for one year, but stayed the suspension for two years on condition that:

a) Respondent shall not violate the Dental Practice Act codified at Chapter 90 of the North Carolina General Statutes or the rules adopted or promulgated by the Board;

b) Respondent shall neither direct nor knowingly permit any of his employees to violate any applicable law or rule of the Board during the term of the stay of the suspension of his license. "Knowingly permit" shall mean actual knowledge or conduct by employees that Respondent should have known about in the exercise of due diligence;

. . .

g) Respondent, in engaging in the practice of dentistry (including but not limited to orthodontics), shall not engage in any fraudulent, misleading, or deceptive practices;

h) For a period of two (2) years from the date of this order, Respondent shall not inform patients that Medicaid has not approved their treatment until he has written verification from Medicaid that Medicaid has not approved the treatment;

. . .

k) Respondent shall inform each Medicaid patient in his practice of the expected timeline for submitting and receiving approval/denial from Medicaid, record the date the case is mailed to Medicaid in the patient's chart, keep the patient informed as to the status of his/her pending Medicaid approval/denial, and provide the patient with adequate information as to what procedure should be followed should approval/denial not be received within eight (8) weeks of submission.

Based upon the foregoing Findings of Fact, the Board hereby enters the following:

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the Respondent's person and over the subject matter of this proceeding.

2. By falsely representing on his North Carolina dental licensure application that he had not been the subject of any formal or informal charges or proceedings and by omitting any reference to his employment by Harold Richardson, Respondent engaged in acts of fraud, deceit or misrepresentation in obtaining or attempting to obtain a license, in violation of N.C. Gen. Stat. § 90-41(a)(1).

3. By failing to provide the Markhams with adequate information regarding the procedure that should be followed if DMA did not approve or deny

Jeremy Hyler's case within eight weeks after submission, by failing to accurately inform the Markhams of the status of Hyler's submission to DMA and by failing to tell the Markhams of the expected timeline for submitting and receiving a response from DMA, Respondent violated decretal paragraph (k) of the October 10, 2003 Consent Order. By violating the October 10, 2003 Consent Order, Respondent engaged in unprofessional conduct as defined in 21 NCAC 16V.0101(4) and therefore violated N.C. Gen. Stat. §§ 90-41(a)(6) and (a)(26).

4. Respondent's conduct in misrepresenting the status of Hyler's submission to DMA and his failure to submit Hyler's case to DMA in a timely manner also violated the standard of care applicable to dentists licensed in North Carolina and thus violated N.C. Gen. Stat. § 90-41(a)(12).

5. Respondent violated N.C. Gen. Stat. § 90-41(a)(12) by refusing to treat Mara Addison because she had an outstanding balance on her account.

6. By failing to take, or have available, intraoral and facial photographs before initiating orthodontic treatment for Judy Toney, Jackie Toney, Tristan Spencer, Dorinda McVay, Heather Brinson and Kenneth Justin Nelson, Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina, in violation of N.C. Gen. Stat. § 90-41(a)(12).

7. Respondent's failure to proceed with treatment for Jackie and Judy Toney in a timely manner violated the standard of care for dentists licensed to practice dentistry in North Carolina, in violation of N.C. Gen. Stat. § 90-41(a)(12).

8. By using Panorex radiographs for Heather Brinson that were not of diagnostic quality, by using a cephalometric radiograph for Jackie Toney that was

not of diagnostic quality, and by using models for Judy Toney and Heather Brinson that were not of diagnostic quality, Respondent failed to comply with the standard of care for dentists licensed to practice dentistry in North Carolina and thus violated N.C. Gen. Stat. § 90-41(a)(12).

9. By failing to forward orthodontic transfer forms or treatment notes upon receiving requests for the records on behalf of Heather Brinson, Kenneth Nelson and Oscar Eason, Respondent violated the standard of care applicable to dentists licensed to practice dentistry in North Carolina and thus violated N.C. Gen. Stat. § 90-41(a)(12).

10. Respondent's failure to advise Ms. McVay's parents of all treatment alternatives, the advantages and disadvantages of those treatment alternatives and the guarded prognosis of the treatment plan that Respondent did present violated the standard of care applicable to dentists licensed to practice in North Carolina, and therefore violated N.C. Gen. Stat. § 90-41(a)(12).

11. By failing to maintain complete dental records for Kenneth Nelson that accurately and adequately reflected the treatment rendered, Respondent violated the standard of care for dentists licensed to practice in North Carolina, thereby violating N.C. Gen. Stat. § 90-41(a)(12) and Board Rule 21 NCAC 16T .0101(a).

12. By applying for and collecting a fee from DMA for dental services to Kenneth Nelson on February 3, 2006 when in fact Nelson did not receive treatment that day, Respondent collected a fee through fraud, misrepresentation or deceit in violation of N.C. Gen. Stat. § 90-41(a)(11).

13. By permitting Ms. Tooloian to bill DMA for banding work for Bryant, Camack, Cannon and Word, without disclosing that only a single arch had been banded and by receiving and retaining these fees, Respondent obtained fees through fraud, misrepresentation or deceit in violation of N.C. Gen. Stat. § 90-41(a)(11) and violated decretal paragraphs (a),(b) and (g) of the October 10, 2003 Consent Order. By violating the October 10, 2003 Consent Order, Respondent engaged in unprofessional conduct as defined in 21 NCAC 16V.0101(4) and therefore violated N.C. Gen. Stat. §§ 90-41(a)(6) and (a)(26).

14. By permitting Ms. Tooloian to bill DMA for services that had not provided and by receiving and retaining fees these fees, Respondent obtained fees through fraud, misrepresentation or deceit, in violation of G.S. § 90-41(a)(11) and violated decretal paragraphs (a),(b) and (g) of the October 10, 2003 Consent Order. By violating the October 10, 2003 Consent Order, Respondent engaged in unprofessional conduct as defined in 21 NCAC 16V.0101(4) and therefore violated N.C. Gen. Stat. §§ 90-41(a)(6) and (a)(26).

15. By permitting Ms. Tooloian to bill DMA for monthly maintenance visits without revealing that the work done at those visits entailed completion of the banding process, and by receiving and retaining these fees after he had already received the one-time banding fee for these patients, Respondent obtained fees through fraud, misrepresentation or deceit in violation of G.S. § 90-41(a)(11) and violated decretal paragraphs (a),(b) and (g) of the October 10, 2003 Consent Order. By violating the October 10, 2003 Consent Order,

Respondent engaged in unprofessional conduct as defined in 21 NCAC 16V.0101(4) and therefore violated N.C. Gen. Stat. §§ 90-41(a)(6) and (a)(26).

In addition to the foregoing Findings of Fact and Conclusions of Law regarding the violations charged in the Investigative Panel's Second Amended Notice of Hearing, the Board makes the following additional findings and conclusions regarding the evidence of mitigating and aggravating factors adduced at the hearing.

FINDINGS AND CONCLUSIONS REGARDING DISCIPLINE

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

   a) Respondent has been involved in several worthwhile civic organizations, including the Greensboro Medical Society, and he has appeared in local and national media on several occasions discussing matters of interest to the public health. Respondent has also been on mission trips to Jamaica and Africa.

   b) Respondent's misconduct regarding his application for licensure in North Carolina and New York is remote in time.

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

   a) Respondent has been disciplined by the Board on two prior occasions;

   b) Respondent has engaged in a pattern of misconduct;

   c) Respondent's misconduct occurred over a significant period of time;

d) Respondent failed to demonstrate remorse or any interim rehabilitation;

e) Patients and members of the public as well as DMA were harmed by Respondent's misconduct. The patient-victims of Respondent's misconduct were particularly vulnerable, as nearly all were from lower-income families, some had physical or mental disabilities and many were minors;

f) Respondent has substantial experience in the practice of dentistry and therefore cannot excuse his misconduct as the result of youth or inexperience;

g) Respondent engaged in a bad faith attempt to obstruct the disciplinary process by attempting to persuade Mary Eason to withdraw her complaint against him and by suggesting that others who had done so had received payments of money; and

h) Respondent failed to make timely, voluntary restitution to the victims of his misconduct.

3. The aggravating factors outweigh the mitigating factors.

Based upon the foregoing Findings of Fact and Conclusions of Law, the Board hereby enters the following

ORDER OF DISCIPLINE

In determining the appropriate discipline, the Board concluded that imposition of lesser discipline would not sufficiently protect the public for the following reasons:

a) some of the misconduct in which Respondent has engaged was the result of character flaws. Respondent offered no evidence that he has rehabilitated himself. Therefore, the Board has no assurance that Respondent will not engage in further misconduct.

b) past orders imposing a probationary term and a short suspension of license have proven insufficient to deter Respondent from committing additional violations of the Dental Practice Act.

c) the imposition of discipline short of revocation would be insufficient to protect the public from the risk of future harm by the Respondent.

WHEREFORE, Respondent's license to practice dentistry in North Carolina is hereby REVOKED.

This the 3 day of March, 2008.

Ronald K. Owens, DDS Secretary-Treasurer
The N.C. State Board of Dental Examiners