IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ROANNE J. WICZER, D.M.D.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 11101	*	**Case Number: 2018-232**

* * * * * * * * * * * * *

CONSENT ORDER

On September 30, 2020, the Maryland State Board of Dental Examiners (the "Board") charged **ROANNE J. WICZER, D.M.D.,** (the "Respondent"), License Number 11101, with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. § 4-315 and Md. Code Regs. ("COMAR") 10.44 *et seq.*:

> **Health Occ. § 4-315. Denials, reprimand, probations, suspension, and revocations— Grounds.**
>
> (a) *License to practice dentistry.* -- Subject to the hearing provisions of § 4-318 of this subtitle, the Board may . . . reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the applicant or licensee:
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> . . . .
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]
>
> . . . .
>
> (20) Violates any rule or regulation adopted by the Board[.]

COMAR 10.44.30.02 General Provisions for Handwritten, Typed and Electronic Health Records.[1]

. . . .

B. Dental records shall include:

(1) A patient's clinical chart as described in Regulation .03 of this chapter; . . .

. . . .

K. Dental records shall:

(1) Be accurate;

(2) Be detailed;

. . . .

(5) Document all data in the dentist's possession pertaining to the patient's dental health status;

. . . .

U. Dentists are responsible for the content of the dental records.

COMAR 10.44.30.03 Clinical Charts.[2]

A. Each patient's clinical chart shall include at a minimum the following:

. . . .

(5) Diagnosis and treatment notes;

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[1] COMAR 10.44.30.02 was adopted effective June 11, 2012. Effective April 29, 2013, COMAR 10.44.30.02 was amended to reflect minor revisions to the regulatory language. Specifically, the language formerly found in COMAR 10.44.30.02(V) was transferred to COMAR 10.44.30.02(U) without any revisions. Accordingly, the provisions from COMAR 10.44.30.02 are applicable, as listed, to the Respondent's conduct committed on or after June 11, 2012.

[2] COMAR 10.44.30.03 was adopted effective June 11, 2012. Effective April 29, 2013, COMAR 10.44.30.03 was amended to reflect a renumbering of the paragraphs listed in COMAR 10.44.30.03. Accordingly, COMAR 10.44.30.03, as listed herein, is applicable to the Respondent's conduct committed on or after June 11, 2012.

(6) Progress notes;

. . . .

(12) Radiographs of diagnostic quality;

(13) Periodontal charting; [and]

. . . .

(15) Informed consent[.]

COMAR 10.44.30.05 Violations

> Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law [.]

On January 6, 2020, a Case Resolution Conference was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter into this public Consent Order consisting of the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on August 16, 1991, under License Number 11101. The Respondent's dental license is scheduled for renewal on or before June 30, 2021.

2. At all times relevant, the Respondent maintained an office for the practice of dentistry in Montgomery County, Maryland.

II. COMPLAINT

3. On or about May 16, 2018, the Board received a complaint from a the father ("Father")[3] of the Respondent's patient ("Patient A") who alleged that the Respondent failed to perform periodontal charting on Patient A, performed procedures on Patient A without the Father's consent and excessively billed for treatment provided.

4. After receiving the complaint, the Board initiated an investigation of the Respondent's dental practices under Case Number 2018-232.

III. INVESTIGATION

5. As part of its investigation into the complaint regarding Patient A, the Board subpoenaed a total of five (5) additional patient charts from the Respondent (Patients B through F) and forwarded all six (6) patient charts to a licensed dentist (the "Expert") who specializes in periodontics for an expert review. Based on his review, the Expert found that the Respondent's treatment and recordkeeping practices of five (5) out of six (6)[4] of the patients under review constituted gross incompetency, behaving dishonorably or unprofessionally, violating the standard of care, and violating the Board's regulations related to recordkeeping.

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[3] To ensure confidentiality and privacy, the names of individuals and healthcare facilities involved in this case are not disclosed in this document.

[4] The Expert's review of the records the Respondent maintained for Patient F revealed Patient F only saw the Respondent on October 18, 2017 for swelling and discomfort. The Respondent prescribed the patient Penicillin and referred the patient to an endodontist. The Expert noted that the Respondent's treatment and record for this visit was adequate however the Expert did express concerns that there was no follow up with the patient or the endodontist.

IV. PATIENT-SPECIFIC FINDINGS

PATIENT A

6. Patient A, born in 1982, initially saw the Respondent on January 29, 2018, for a new patient examination and prophylaxis. The Respondent document that at this visit he observed "tremendous build up of calculus" and that Patient A "should have thirds out" and needed fillings of teeth #s 4, 5, 12, 13, and 18. The Respondent further documented that he conducted full mouth debridement, a panoramic x-ray, bitewing radiographs, and periapical radiographs.

7. Patient A returned to the Respondent on February 1, 2018, at which time, Patient A signed a "Dental Treatment Consent Form"[5] and the Respondent filled teeth #s 4, 13 and 14 with composite fillings,[6] and placed indirect pulp caps on each of the teeth he filled. After the Respondent performed the fillings, the hygienist immediately performed root planing on two quadrants and documented that antibiotics were placed. The chart however fails to indicate the location of the antibiotics placed.

8. The dental records revealed that the Respondent failed to ever document evidence of Patient A's pre-treatment status including findings from a clinical exam or documentation of a clinical tooth charting or a restorative examination being performed,

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[5] The Father did not sign a consent form for procedures performed on Patient A. As part of the complaint, the Father alleged that on January 29, 2018, the Father explained to the Respondent that Patient A was disabled and "needed [the Father's] assistance in making any and all decisions."

[6] The Respondent documented that he advised the patient "to put amalgam in molars, he insisted on composite."

or even a medical/dental history form.[7] There was no record of a diagnosis and based upon the diagnosis a treatment plan with options being developed and provided to the patient. Treatment was performed without documentation as to the rationale for the need for the treatment. The Expert noted that his review of the radiographs provided does not support the need for the restorations performed or the indirect pulp capping performed. (The Respondent subsequently located perio-charting for the visit of February 1, 2018, in addition to an insurance claim form.)

PATIENT B

9. Patient B, a male born in 2000, was seen by the Respondent twice in 2017. Patient B initially saw the Respondent on August 2, 2017, for a comprehensive oral examination and panoramic radiograph. The Respondent documented that the "decay [was] minimal" at this visit.

10. The next time Patient B returned was on August 11, 2017, at which time, the Respondent placed fillings and indirect pulp caps on teeth #s 18, 19, and 30.[8]

11. The dental records revealed that the Respondent failed to ever document a periodontal or restorative examination being performed. There was no record of a diagnosis and based upon the diagnosis a treatment plan with options being developed and provided to the patient. The panoramic radiograph included in the file is not dated or labeled left versus right. The Respondent documented that the fillings were administered,

[7] The only periodontal chart in the Respondent's file for Patient A is dated February 1, 2018.

[8] The Respondent failed to document in the clinical chart which teeth received fillings and indirect pulp caps. The teeth numbers were obtained from the patient ledger listing the date of service, code number, tooth number, description of service, and charges.

but the Respondent failed to provide any information about the amount of anesthesia utilized.

12. Treatment was performed without documentation as to the rationale for the need for the treatment. The Expert noted that his review of the radiographs provided does not support the need for the restorations performed or the indirect pulp capping performed.

PATIENT C

13. Patient C, a male born in 1963, with a history of an enlarged heart, heart problems, diabetes, obesity and a history of "[e]xcessive bleeding with surgery/extractions," initially saw the Respondent on September 28, 2006, for a new patient examination, full set of radiographs, panoramic radiograph, and a filling on tooth # 6.

14. From September 28, 2006 until the last chart note dated February 15, 2018, Patient C was seen by the Respondent on a sporadic basis to receive treatment as immediately needed "rather than establishing and following a plan."[9]

15. The dental records revealed that the Respondent failed to maintain adequate documentation including dental or periodontal charting as part of a new patient evaluation or on a regular basis.[10] The Respondent frequently documented that he obtained radiographs, however, those radiographs were not provided to the Board upon request. And the Respondent's documentation demonstrated notable treatment

[9] For example, Patient C experienced lengthy gaps in treatment from April 15, 2008 to February 3, 2010 and from February 4, 2016 to January 18, 2018.

[10] There was documentation of documentation of periodontal charting in 2010.

discrepancies, for example, the August 29, 2015 treatment note documents that tooth # 22 was extracted, but then the January 6, 2016 treatment note documents that tooth # 22 needed a filling.

PATIENT D

16. Patient D, a female born in 1952, received several treatments from the Respondent including prophylaxis, evaluations and re-evaluations, crown insertions, and build ups of all crowns inserted.

17. According to the "Patient Ledger" provided by the Respondent listing the service dates, codes, and charges for Patient D, Patient D received treatment from the Respondent from February 4, 2009 until March 2, 2018. However, the Respondent did not provide the Board with any clinical notes from prior to November 13, 2012. (The records of the patient prior to November 2012 had been stored in a box in the lower level of Respondent's office and were located.)

18. According to the "Patient Ledger" the Respondent inserted a crown for tooth # 31 on July 22, 2009, however, the only readable radiographs for this tooth provided by the Respondent were from November 13, 2012; February 14, 2014; and August 21, 2017 all of which, according to the Expert revealed distal decay under the crown on # 30 which was left undiagnosed and untreated by the Respondent.

19. On November 28, 2012, the Respondent documented that the reason for visit was "filling #21-B" and then in the treatment area the Respondent only documented that tooth "#21-B [was] with decay." The Respondent failed to document that the filling was performed or what was utilized for the filling.

20. Then on February 25, 2014, the Respondent documented that he conducted a dental examination on Patient D which revealed the patient "needs crown," but the Respondent failed to document which tooth needs a crown.

21. At the final visit documented in the chart notes on March 2, 2018, the Respondent documented that he conducted a dental examination, prophylaxis, a panoramic radiograph, and a bitewing radiograph. The Respondent further documented his examination findings as "tissue: mod bleeding, upper left side has 4mm pocket with bleeding (rec root planing for upper left side)" and see an endodontist for # 13. The Respondent however failed to document which tooth or side of the tooth contained the 4 mm pocket. The Expert's review of the bitewing radiograph obtained by the Respondent at this visit revealed bone loss on the distal of # 12 and the mesial of # 13 which was evident on earlier films and an open margin on the distal of # 20 all of which were undiagnosed and untreated by the Respondent. The Expert's review of the film also revealed no deposits on the root or evidence from this film that would provide a rationale for why the patient was referred to an endodontist for # 13.

22. The dental records revealed that the Respondent failed to maintain adequate documentation including any dental or periodontal charting for the entire nine years the patient saw the Respondent and failed to include complete and accurate clinical notes for each visit. Specifically, the Respondent failed to maintain any clinical notes for prior to November 13, 2012, and then even in the clinical notes he did provide, they include missing information such as the tooth number treated and the findings of examinations and re-evaluations the Respondent documented he performed.

23. The records maintained by the Respondent also included radiographs that were not of diagnostic quality including a panoramic radiograph that has the date handwritten on it and is not labeled left versus right, as well as radiographs on the initial visit (February 4, 2009) which were too dark to read; a radiograph from March 3, 2011 which was improperly handled resulting in the films being too dark to read; and radiographs mistakenly labeled February 18, 2018[11] which were also dark.

PATIENT E

24. Patient E a male born in 1962 was first seen by the Respondent on February 15, 2017, at which time the Respondent documented that his examination revealed moderate to heavy calculus and heavy plaque, however, the Respondent never documented conducting a cleaning or oral hygiene instruction at this visit or at any of the subsequent visits. The Respondent also documented that he obtained "oral facial images," however, those radiographs were not provided to the Board upon request. In fact, upon the Board's second request for the records, the Respondent submitted a written response stating he could not retrieve the images and "it did not save maybe."

25. At the next appointment on February 21, 2017, the Respondent documented that he performed fillings on teeth #s 19 and 13, and that "patient came into our office toxic! Cannot have him here under those circumstances."[12]

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[11] Based on the entries on the "Patient Ledger" the radiographs were most likely obtained on February 18, 2010. According to the Expert, while the radiographs were dark, they did reveal significant bone loss in the lower anterior which is undiagnosed and untreated.

[12] The chart provided by the Respondent included a "Dental Treatment Consent Form" signed by Patient E for fillings and was dated February 16, 2017. According to the instructions on the consent form the patient was required to initial the items checked off. Despite listing that the treatment being performed

26. The next visit was an emergency examination on June 14, 2017, where the Respondent documented that Patient E is "handicapped, wants pain pills." The Respondent further documented that he obtained two periapical radiographs, referred the patient to an oral surgeon for extraction of # 30, and wrote the patient a prescription for a non-storidal anti-inflammatory medication. According to the ledger the patient was also charged for two panoramic radiographs at this visit, which were credited back on December 6, 2017, but then one of the credits was reversed on September 6, 2018. According to the written statement submitted to the Board by the Respondent, no panoramic radiographs were taken of this patient and "credit [was] given to [the] patient, [and there was a] mistake in ledger." Despite documenting in the clinical notes that the patient would be referred to an oral surgeon for extraction of # 30, the actual referral slip completed by the Respondent states that the patient was referred to an endodontist for "eval [and] treat # 31 [and] possibly # 30 as well." (The Respondent subsequently located two bite wings of this patient taken on June 14, 2017.) The Expert's review of the two periapical radiographs obtained by the Respondent at this visit revealed no evidence of a need for extraction of # 30 or endodontic treatment of # 30 or # 31. Moreover, the file contains a letter dated September 28, 2017, from the endodontist stating the patient schedule their appointment with the endodontist for June 23, 2017, but then the patient canceled the appointment and failed to reschedule with the endodontist. The records

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were fillings, the patient was still required to sign this generic consent form which had disclosures for all procedures listed checked off including alternatives to removal of teeth had been explained to the patient and "I authorize the Dentist to remove the following teeth [blank];" disclosures pertaining to crowns, bridges and caps; disclosures pertaining to dentures; disclosures pertaining to root canals; and disclosures pertaining to periodontal loss.

maintained by the Respondent failed to demonstrate that the Respondent followed up regarding the cancelled appointment or documented the cancelled appointment or the supposedly needed treatment in the clinical chart.

27. The next visit Patient D attended with the Respondent is dated as October 19, 2017 on the clinical chart however it is dated as October 18, 2017 on the patient ledger.

28. According to the patient ledger the final visit was on December 6, 2017, when a crown buildup was conducted on tooth # 19 however the Respondent failed to provide the Board with any clinical notes for this date or treatment.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's recordkeeping practices of Patients A through E, as set forth in detail above, constitute: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.30.02, and COMAR 10.44.30.03, in violation of Health Occ. § 4-315(a)(20).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 20TH day of JANUARY, 2021, by a majority of the Board considering this case:

ORDERED that the Respondent be and hereby is **REPRIMANDED;** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **EIGHTEEN (18) MONTHS.** During the probationary period, the Respondent must comply with the following terms and conditions:

1. Within six (6) months of the date of this Consent Order, the Respondent shall successfully complete the following Board-approved courses: 1) a six (6) credit hour equivalent course in dental record keeping; and 2) a two (2) credit hour equivalent course in ethics. The Respondent shall be responsible for submitting written documentation to the Board of her successful completion of these courses. The Respondent understands and agrees that she may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that she has completed the courses according to the terms set forth herein.

2. Within sixty (60) days of the date of this Consent Order, the Respondent shall pay a fine in the amount of **One Thousand dollars ($1,000)** payable to the Maryland Board of Dental Examiners.

3. The Respondent is subject to chart reviews by the Board. The Board, at its discretion, may conduct chart review to ensure that the Respondent is in compliance with record keeping standards.

4. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining thereof.

AND IT IS FURTHER ORDERED that after the conclusion of **EIGHTEEN (18) MONTHS** from the date of this Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, may grant the termination if the Respondent has fully and satisfactorily complied with all of the

probationary terms and conditions and there are no pending investigation or outstanding complaints of similar violations against her; and it is further

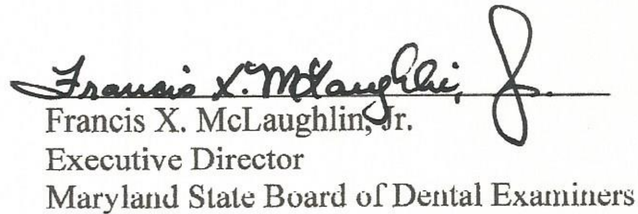
ORDERED that if the Board has reason to believe that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).



Francis X. McLaughlin, Jr.
Executive Director
Maryland State Board of Dental Examiners

CONSENT

I, Roanne J. Wiczer, D.M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

1-18-2021
Date

Roanne J. Wiczer, D.M.D.
Roanne J. Wiczer, D.M.D.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 18 day of January, 2021, before me, a Notary Public of the foregoing State and City/County personally appear Roanne J. Wiczer, D.M.D., and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: May 1, 2023