IN THE MATTER OF	*	**BEFORE THE MARYLAND**
OPHIR I. ALALOUF, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 12149	*	**Case Numbers: 2003-027, 2003 - 028 2006-075, 2006 - 100 2007-106**

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

CONSENT ORDER

On December 27, 2007, the Maryland State Board of Dental Examiners (the "Board") charged OPHIR I. ALALOUF, D.D.S ("Respondent"), license number 12149, under the Maryland Dentistry Act (the "Act"), Md. Health Occ. ("H.O.") Code Ann. §§ 4-101 *et seq.* (2005 & Supp. 2006). The pertinent provisions of H.O. § 4-315(a) provide:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> > (3) Obtains a fee by fraud or attempts to obtain a fee by fraud;
> >
> > (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
> >
> > (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
> >
> > (20) Willfully makes or files a false report or record in the practice of dentistry; and
> >
> > (23) Abrogates or forgives the copayment provisions of any insurance policy, insurance contract, health prepayment contract, health care plan, or nonprofit health service plan contract by accepting the payment received from a third party as full payment,

unless the dentist discloses to the third party that the patient's portion will not be collected.

As a result of negotiations with the Office of the Attorney General, by Kimberly S. Cammarata, Assistant Attorney General, the Respondent, by Kevin A. Dunne, Esquire, and the Board, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order, and with the terms and conditions set forth herein.

FINDINGS OF FACT

Background

1. The Respondent is and at all times relevant hereto was licensed to practice dentistry in the State of Maryland, initially receiving his license on 6/10/97.

2. On or about 7/24/02, the Board received complaints from 2 different parents who alleged that the Respondent may have recommended and/or performed unnecessary dental treatment for their child(ren). The Board referred the complaints to its investigative unit. The Board also elected to review 25 additional patient records.

3. On or about 9/5/05, the Board received another complaint alleging that the Respondent recommended unnecessary treatment.

4. On or about 10/15/05, the Board received another complaint alleging that the Respondent recommended and carried out unnecessary treatment and that he performed treatment beyond what the parents of the patient consented to.

5. On or about 10/23/06, the Board received another complaint alleging that the Respondent recommended unnecessary treatment.

6. The review of the records revealed, *inter alia,* that the Respondent: recommended and performed extensive dental treatment without clinical justification;

performed treatment beyond that which was recommended and informed consent obtained; failed to provide alternative treatment options; billed for services not rendered and/or up-coded the services; and waived co-pays. The Respondent also misrepresented the severity of the treatment needs to parents and to insurers.

Patient-Specific Findings

Case No. 2003-027

Patient A[1]

7. On or about 6/3/02, the mother of Patient A, a then 5 year old male, complained to the Board that the Respondent advised her that Patient A had 5 cavities and needed restorative treatment. Surprised by the Respondent's findings, Patient A was seen by another dentist who advised that Patient A did not have caries.

8. The patient records reveal that on or about 9/10/01, Patient A presented to the Respondent for routine check-up and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. Two bite-wing ("BW") radiographs were taken. The Respondent noted no caries but indicated that "d's" and "e's" were pitted and grooved and should be monitored or sealed. The record reflects that they would be monitored.

9. On or about 3/11/02, Patient A returned to the Respondent for a routine examination and prophylaxis. The records reflect that the Respondent performed an examination, prophylaxis and fluoride. No radiographs were taken. The Respondent noted positive caries and recommended that the patient have the following treatment:

[1] In order to protect patient confidentiality patient names are not disclosed in this document.

Tooth #	Treatment
A	Resin - MO
19	Sealant Resin – B5[2]
30	Sealant Resin – B5
K	Resin - B
T	Resin - B

10. Patient A did not return to the Respondent.

11. On or about 5/21/02, Patient A was seen at the Orthodontic Treatment Center and had an examination, prophylaxis and fluoride. Two radiographs were taken. No caries were found and no treatment was recommended.

12. On or about 7/15/05, Patient A was examined by Board expert James A. Coll, DMD. Dr. Coll examined Patient A and took 2 BW's and intraoral photographs. Dr. Coll noted that Patient A had occlusal caries in tooth A which had a dark stain but no cavitation and noted very shallow, facial caries in teeth # 19 and # 30. Dr. Coll did not find caries in the facial surfaces of teeth K or T. The BWs showed no mesial decay in tooth A. Dr. Coll concluded that the Respondent's plan to treat tooth A with an MO restoration and his recommendation to treat teeth K and T were unnecessary in 2002.

[2] It is unclear what "5" means.

Case No. 2003-028

Patient B

13. On or about 6/1/02, the mother of Patient B, a then 5 year old male, complained to the Board that the Respondent advised her that Patient B had a considerable number of cavities and that they should be restored in a hospital setting. She further advised that she was surprised as Patient B had had no prior findings by his previous dentist. She advised that she and her husband trusted the Respondent and Patient B had the restorations. She indicated that on a more recent visit Patient B presented to the Respondent with baby teeth so loose they were about to fall out. The Respondent recommended removing them and then charged the parents for the removal. The parents contested the charge and the Respondent agreed to waive the co-pay.

14. The patient records reveal that on or about 2/13/01, Patient B presented to the Respondent for routine check-up and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. Two BW's were taken. The Respondent noted caries and noted on the tooth charting form that the patient have the following treatment:

Tooth #	Treatment
A	Resin - O
J	Resin - O
K	Resin - O
T	Resin - O
B	Resin - DO
L	Resin - DO

S	Resin - DO

15. The Respondent noted that he discussed the treatment plan[3] with Patient B's mother and options for treatment with nitrous oxide or having the treatment in the OR.

16. The patient record reflects that an OR consult was carried out with the mother and father on 5/7/01. On that same date the mother signed a proposed treatment plan and authorized the following treatment:

Tooth #	**Treatment**
A	Resin - MO *original plan noted only O*
J	Resin – O
K	Resin – MO *original plan noted only O*
T	Resin – MO *original plan noted only O*
B	Resin - DO
L	Resin - DO
S	Pulpotomy and Stainless Steel Crown ("SSC") *original plan noted only Resin - DO*
I	Sealant *not in original treatment plan*

17. The Respondent submitted a pre-treatment estimate to the patient's insurance company noting the services to be provided. The Respondent did not include teeth A, K, T, or S on the pre-treatment estimate.

[3] It is unclear from the record what treatment plan the Respondent discussed with the mother.

18. On or about 6/13/01, Patient B was treated in the operating room under anesthesia at Shady Grove Adventist Hospital. The Respondent noted in the operative report that he completed the following treatment:

Tooth #	Treatment
A	Resin – OL *original plan noted only O* *2nd plan noted MO*
J	Resin – OL *Original and 2nd plan noted only O*
K	Resin – MOB *original plan noted only O* *2nd plan noted MO*
T	Resin – OB *original plan noted only O* 2nd plan noted MO
B	Resin - DO
L	Pulpotomy and SSC *Original and 2nd plan noted only Resin - DO*
S	Resin – DO *original plan noted only Resin - DO* *2nd plan noted Pulpotomy and Stainless Steel Crown ("SSC")*
I	Sealant *not in original treatment plan*

19. The Respondent billed the patient and the patient's insurance carrier for the treatment.

20. The patient returned to the Respondent on 6/28/01 and 9/31/01. On 2/13/02, Patient B returned to the Respondent for a routine visit. The Respondent noted that he performed a simple extraction of teeth O and P with a topical. The Respondent submitted a claim for the extractions to the patient's insurance company. The Respondent billed $ 69.00 for each extraction for a total of $ 138.00. The insurance

company paid $85.60 leaving a balance for the patient of $ 52.40. The parent's complained about paying the Respondent to pull dangling baby teeth. The Respondent agreed to waive the co-pay and waived the balance of $ 52.40.

21. After being billed for removal of the dangling baby teeth and talking to other parents who used the Respondent for dental care, the patients became concerned that the Respondent may have performed unnecessary treatment on Patient B. They advised the Board of same.

22. The Board reviewed the patient records and forwarded the records to Dr. Coll. Dr. Coll opined that the Respondent performed unnecessary treatment. He found that the Respondent restored tooth K with an MOB composite restoration yet the mesial surface had no radiographic evidence of caries nor were caries noted pre-operatively. He also found that tooth B had no evidence of radiographic distal decay. He further opined that a pulpotomy was not necessary on tooth L which had only a distal lesion not close to the pulp. Dr. Coll also noted that the Respondent waived a co-payment for the two extractions of teeth # O & P without disclosing same to the insurance carrier.

2006-075

Patient C

23. On or about 6/13/05, the mother of Patient C, a then 8 year old male, complained to the Southern Maryland Dental Society that the Respondent advised her that Patient C had a considerable number of cavities and that they should be restored. She further advised that she was surprised as Patient C had had no prior findings by his previous dentist, Dr. Testen. She also noted that after speaking with other parents, she did not believe that her situation was unique.

24. On or about 9/15/05, Southern Maryland Dental Society forwarded the complaint to the Board noting that they were aware of numerous other cases concerning inappropriate treatment.

25. The patient records reveal that on or about 8/23/01, Patient C presented to the Respondent for routine check-up and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. Two BW's were taken. The Respondent noted caries and noted on the tooth charting form that the patient have the following treatment:

Tooth #	Treatment
A	Resin - MO
S	Resin - DO
L	Resin - DO

26. On or about 9/4/01, the Respondent placed the restorations on teeth S and L and noted that teeth K and T should be watched.

27. On or about 10/24/01, the Respondent placed a MOL restoration on tooth A (originally planned for MO) and a DO on tooth B (not previously planned).

28. On or about 2/27/02, the Respondent performed a routine examination and prophylaxis.

29. Patient C was then seen by Dr. Tate at the Children's National Medical Center. Dr. Tate performed the following services:

a. 08/26/02 -- Exam, BW, Prophy, Fluoride

b. 10/04/02 -- 2 surface resin on tooth K

c. 10/18/02 – 2 surface resin on tooth T

d. 03/07/03 – Exam, BW, Prophy, Fluoride

e. 10/20/03 – Exam, Prophy, Fluoride

f. 06/28/04 – Exam, Prophy, Fluoride and Sealants on teeth ## 3, 14, 19 and 30. Pulpotomy and SSC on tooth L.

g. 06/29/04 – 2 surface resin on teeth I and J.

30. Patient C was seen by Dr. Robert Testen on or about 1/27/05 for a routine examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. Two BW's were taken. Dr. Testen did not find that any treatment was necessary; he only noted that the mesial surfaces of teeth T and J should be watched.

31. Patient C returned to the Respondent on or about 7/13/05 for a routine examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. Two BW's were taken. The Respondent noted caries and noted on a proposed treatment plan that the patient have the following treatment:

Tooth #	**Treatment**
A	Resin - MO *Previously a MOL by the Respondent*
3	Resin - L
B	Resin - DO
J	Resin - MO
14	Sealant
19	Resin – B and Sealant

30	Resin – B and Sealant

32. Patient C's parents were concerned about the Respondent's treatment recommendations and took Patient C to Dr. Mark Barren for a second opinion. Dr. Barren examined Patient C and opined that the following treatment was needed:

Tooth #	Treatment
30	F
J	MO
14	Sealant

33. Dr. Barren opined that the additional treatment recommended by the Respondent was unnecessary.

34. Dr. Coll also examined the records in this case and opined that the Respondent's plan to treat teeth # 3, A, and 19 was unnecessary. Dr. Coll opined that tooth B should have been observed for pain or future radiographic signs of decay before treatment.

Case Number 2006-100

Patient D

35. On or about 10/17/05, the mother of Patient D, a then 18 year old male, complained to the Board that the Respondent advised her that Patient D, who is autistic, needed to have approximately 4 teeth restored and that it should be done in the hospital setting. The mother advised that she approved the plan but that the Respondent ended up restoring approximately 20 teeth instead of 4 and that he did so without seeking her consent.

36. The patient records reveal that on or about 2/2/05, Patient D was seen by Dr. Robert Morgenstein who examined the patient, performed a scaling and found no caries.

37. On or about 5/5/05, Patient D presented to the Respondent for an examination. The patient record reflects that the Respondent noted small incipient lesions on teeth ## 4 and 5 and that they should be monitored.

38. On or about 7/4/05, Patient D returned to the Respondent for an examination and prophylaxis. The record reflects that an examination was carried out and that the patient had a scaling and fluoride. The Respondent noted caries and provided a proposed treatment plan to the patient's mother recommending that the patient have the following treatment in the hospital:

Tooth #	Treatment
4	O
5	OL
12	O
30	B

39. The Respondent noted that the cost would be $606.00 and the patient's responsibility for payment would be $523.00. The costs were later adjusted and the patient's responsibility was noted as $594.00. The patient's mother had to make arrangements with different social service agencies for payment of the expense. The Abilities Network, Epilepsy Foundation of the Chesapeake Region was provided with the proposed treatment plan and agreed to pay $500.00 of the treatment with the parent responsible for the balance of $94.00.

40. Patient D had a pre-surgical history and physical prior to his dental surgery. On or about 9/16/05 Patient D presented to Shady Grove Adventist Hospital for his dental surgery under anesthesia. The record reflects that the Respondent took 3 BW's which were of poor diagnostic quality, performed a prophylaxis and fluoride varnish and completed the following composite restorations:

Tooth #	Treatment
1	O
2	OB
3	OL
4	O
5	OL
6	L
11	L
12	O
13	O
14	MOL
15	MO
16	O
17	O
18	OB
19	OB
20	O

21	O
28	O
29	O
30	OB
31	OB
32	OB

41. The Respondent did not during the course of the surgery discuss the need for the additional restorations, the cost of the additional restorations, the risks/benefits of the additional restorations, or obtain consent from the patient's mother to perform them.

42. The Respondent then billed the patient's mother $2711.00 for the surgical procedures; including a fee for a comprehensive evaluation, prophylaxis, fluoride and 22 additional teeth that were not treatment planned.

43. Dr. Coll opined that the Respondent performed unnecessary treatment. He found that the Respondent restored the mesial surfaces of teeth ## 14 and 15 and the yet the mesial surface of these teeth had no radiographic sign of decay.

Case 2007-106

Patient E

44. On or about 10/23/06, the mother of Patient E, a then 2 year old male, complained to the Board that the Respondent advised her that Patient E had a considerable number of cavities and that they should be restored. She further advised that she was surprised as the Respondent made the recommendations but had not taken radiographs. She reported that she requested a second opinion from Dr. Mark Barren and that Dr. Barren advised that the patient did not need the restorations.

45. The patient records reveal that on or about 10/27/05, Patient E presented to the Respondent for an emergency visit after falling onto a coffee table and striking his top front teeth. The Respondent examined the patient and made recommendations. The patient was seen for follow-up on 10/28/05, 11/1/05, 11/8/05, and 12/14/05 for that trauma as well as an additional fall.

46. On or about 8/31/06, Patient E presented to the Respondent for an initial full dental examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. No radiographs were taken. The Respondent noted caries and noted on the tooth charting form (dated 9/7/06) that the patient have the following treatment:

Tooth #	Treatment
A	O
B	Sealant
I	Sealant
J	O
K	O
L	Sealant
S	Sealant
T	O

47. The Respondent did not provide a written treatment plan but noted that he discussed the treatment with the patient's father. He also noted that he discussed performing the treatment in the office or in the hospital. The record also notes that the

patient's mother contacted the Respondent's office on 9/6/06 to request the cost of the treatment planned. The Respondent did not suggest or explain that delay of treatment was a viable option. The Respondent and his staff strongly recommended immediate treatment in the OR.

48. Patient E's parents were concerned about the Respondent's recommendations and sought a second opinion from Dr. Barren. Patient E was seen by Dr. Mark Barren on or about 10/20/06 for an examination and second opinion. Dr. Barren examined the patient and took BWs. Dr. Barren found no caries and recommended no treatment.

49. On or about 4/6/07, Patient E was seen by Dr. Gazori for a routine examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. Dr. Gazori noted an absence of caries.

50. On or about 5/11/07, Patient E was examined by Dr. Coll. Dr. Coll took photographs of the patient and his teeth, reviewed the BW's taken by Dr. Barren on 10/20/06 and examined Patient E. Dr. Coll found that teeth K and T had occlusal stains that may have been diagnosed as decay but there was not a catch detected with the dental explorer. Dr. Coll did note that teeth A and J were caries free and that at most they could have been sealed. Dr. Coll also opined that even if fillings were necessary they should not have been carried out under general anesthesia without first trying to repair the alleged caries using nitrous oxide or conscious sedation. Dr. Coll also found that teeth B and I should not have been sealed as they did not have pits and fissures.

Additional Patient Records Subpoenaed under Case No. 2003-027

Patient F

51. On or about 5/29/02, Patient F, a then 6 year old male, presented to the Respondent for an examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. No radiographs were taken. A notation was made in the chart that Patient F's mother would check to see if she had prior radiographs. The Respondent noted caries and noted on the tooth charting form that the patient have the following treatment:

Tooth #	Treatment
30	O
T	O
A	pulpotomy and SSC
B	pulpotomy and SSC
G	Extraction
J	MO

52. The chart does not include a written treatment plan or informed consent. Patient F's mother was only told that her son needed fillings.

53. On or about 7/8/02, Patient F returned to the Respondent and 2 BWs were taken. The Respondent performed the following treatment:

Tooth #	Treatment
30	O
T	O

A	no treatment
B	no treatment
G	Extraction
J	pulpotomy and stainless steel crown

54. The Respondent noted that he administered nitrous oxide but did not include details regarding the administration. Patient F's mother was not advised nitrous oxide would be administered nor was her consent obtained.

55. Patient F's mother was not informed that a stainless steel crown was necessary and the Respondent did not obtain her consent for the treatment. Patient F did not return to the Respondent.

56. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

57. Dr. Coll examined Patient F's records and opined that the extraction should not have been performed without an appropriate diagnostic radiograph taken of the tooth visualizing the end of the root. He also found that tooth J did not need a pulpotomy and an appropriate diagnostic radiograph was not taken visualizing the area between the roots.

Patient G

58. On or about 2/28/02, Patient G, a then 7 year old male, presented to the Respondent for a consultation for treatment of decay noted by another dentist. The

Respondent noted positive caries and specifically noted mottled[4] 1st molars. The Respondent recommended that treatment be carried out in the OR.

59. The patient record contains a tooth chart dated 3/4/02 which reflects the following treatment recommendations:

Tooth #	Treatment
3	OL
A	MO
B	DO
7	B
10	B
I	DO
J	O
14	OL
19	RCT
K	MOB
L	DO
T	OB
30	OB

60. A proposed treatment plan dated 3/11/02, but unsigned by the parents, noted the following proposed treatment:

Tooth #	Treatment

[4] It appears that the Respondent uses mottled in this patient and others to describe hypo-mineralized or "soft" teeth and not as defined (mottled is used to describe dental fluorosis).

3	Indirect pulp cap and OL (OL noted on tooth chart)
A	MO
B	DO
7	B
10	B
I	DO
J	MO (M stricken out on plan)
14	Indirect pulp cap (stricken out on plan)(OL on tooth chart)
19	OB and direct pulp cap (stricken out on plan) – referred for RCT
K	MOB
L	DO
T	OB
30	Indirect pulp cap and OB (OB on tooth chart)

61. The proposed cost was noted as $1215.00 with a patient cost of $447.00. It was also noted that the cost would only be $272.00 if ## 3,14,19 and 30 were the only teeth treated. It also appeared the Respondent recommended the extraction of teeth D and G and that he would accept the insurance payment as payment in full and would not balance bill the parent. The Respondent did bill the insurance company for the extractions and accepted that as payment in full, thereby waiving the co-payment portion.

62. On or about 3/20/02, Patient G returned to the Respondent and the Respondent referred the patient to an endodontist for root canal therapy on tooth # 19 and prescribed amoxicillin.

63. On or about 3/22/02, Patient G presented to Health South Surgery Center for dental treatment under anesthesia. The Respondent performed the treatment as noted on the proposed treatment plan. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

64. Dr. Coll examined Patient G's records and opined that the Respondent restored interproximal areas on teeth L and K yet no interproximal decay was evident on the radiographs. Dr. Coll also observed that a subsequent radiograph taken revealed that although noted and billed, the Respondent did not perform a mesial restoration on tooth K.

65. On or about 3/26/03, the Respondent noted that he would complete a repair of the mesial occlusal composite of tooth K. Again, the mesial surface was not restored nor was decay evident.

Patient H

66. On or about 4/5/02, Patient H, a then 10 year old male, presented to the Respondent for an examination and prophylaxis.[5] The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. Two BW's[6] and a panorex (PAN) were taken. The Respondent noted caries and noted on the tooth charting form that the patient have the following treatment:

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[5] The patient's chart contained treatment notes pre-dating this visit covering 1995-1998. These appear to be from another dental provider.

[6] The BW was not diagnostic for diagnosing decay on tooth J.

Tooth #	Treatment
19	B
30	B
3	M
14	M
A	MOD *(noted as a defective pre-existing MO)*
J	DO *(noted as an existing MO)*
K	MO
T	DO

67. The chart does not include a written treatment plan or informed consent.

68. On or about 5/29/02, Patient G returned to the Respondent and the Respondent performed the following treatment:

Tooth #	Treatment
3	M
30	B
A	MOD
T	MOD (treatment planned for DO)

69. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

70. On or about 6/4/02, Patient G returned to the Respondent and the Respondent performed the following treatment:

Tooth #	Treatment
J	DO

14	M
19	B
K	MO

71. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

72. The Respondent noted that he had to re-do teeth # 3, A, T and 30 on 11/5/02.

73. Dr. Coll examined Patient G's records and opined that teeth J and T did not require distal restorations as there was no evidence of distal decay radiographically.

Patient I

74. On or about 3/7/02, Patient I, a then 4 year old female, presented to the Respondent for her first dental examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a tooth brush prophylaxis on the mother's lap while crying. No radiographs were taken. The Respondent noted caries and noted on the tooth charting form and on a proposed treatment plan that the patient have the following treatment in the operating room:

Tooth #	**Treatment**
A	pulpotomy and SSC
J	OL
K	OB
T	OB
B	DO
I	DO

L	DO
S	DO

75. The Respondent also proposed performing a prophylaxis and fluoride while in the OR. The patient's mother signed the treatment plan.

76. On or about 5/31/02, Patient I presented to Shady Grove Hospital for dental restorations under anesthesia. The Respondent performed the following treatment:

Tooth #	**Treatment**
A	pulpotomy and SSC
J	OL
K	O *(planned for OB)*
T	pulpotomy and SSC *(planned for OB)*
B	Sealant (planned for a DO)
I	DO
L	DO
S	Sealant *(planned for DO)*

77. No radiographs were taken.

78. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

79. Dr. Coll examined Patient I's records and opined that the treatment provided by the Respondent should not have been performed without diagnostic radiographs and likely treated without clinical justification.

Patient J

80. On or about 1/15/01, Patient J, a then 4 year old male, presented to the Respondent for an examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. The record reflected that they were unable to get BW's. The Respondent noted caries and noted on the tooth charting form, dated 1/17/01, (no treatment plan was contained in the file) that the patient have the following treatment:

Tooth #	Treatment
E (supernumerary)	Extract
D	F5
G	F5
R	F5
S	SSC
A	OL

81. The record reflects that the Respondent discussed using nitrous oxide in the operatory or performing the procedures in the OR.

82. On or about 1/14/01, the Respondent wrote the patient's insurance carrier and noted that the patient had "severe dental caries," that he needed 8 restorations and an extraction of an extra tooth. The Respondent also noted that the caries were severe, needed immediate treatment and that failure to treat could cause a life threatening dental abscess.

83. The record indicates that a proposed treatment plan was submitted to MetLife on or about 1/23/01 for an estimate of benefits. The following treatment was submitted for predetermination:

Tooth #	Treatment
E (supernumerary)	Extract
D	Resin based composite crown *(noted as F5 on tooth chart)*
G	Resin based composite crown *(noted as F5 on tooth chart)*
R	F5
S	SSC
A	OL
8	Extract impacted tooth *(not noted originally on tooth chart)*
B	1 surface resin *(not noted originally on tooth chart)*
I	1 surface resin *(not noted originally on tooth chart)*
J	1 surface resin *(not noted originally on tooth chart)*
K	1 surface resin *(not noted originally on tooth chart)*
L	1 surface resin *(not noted originally on tooth chart)*
T	1 surface resin *(not noted originally on tooth chart)*

84. On or about 2/22/01, Patient J presented to Shady Grove Hospital for dental restorations under general anesthesia. The Respondent performed the following treatment:

Tooth #	Treatment
E	Extract

D	F5 *Noted as Resin based composite crown on pre-treatment estimate(noted as F5 on tooth chart)*
G	F5 *Noted as Resin based composite crown on pre-treatment estimate(noted as F5 on tooth chart)*
R	F5
S	Pulpotomy and SSC *(originally noted as a SSC)*
A	SSC *(originally noted as OL)*
8	Extract impacted tooth *(not noted originally on tooth chart)*
B	SSC *Noted as a 1 surface resin on pre-treatment estimate (not noted originally on tooth chart)*
I	DO *Noted as 1 surface resin on pre-treatment estimate (not noted originally on tooth chart)*
J	MO *Noted as 1 surface resin on pre-treatment estimate (not noted originally on tooth chart)*
K	MO *Noted as 1 surface resin on pre-treatment estimate (not noted originally on tooth chart)*
L	SSC *Noted as 1 surface resin on pre-treatment estimate (not noted originally on tooth chart)*
T	MOB *Noted as 1 surface resin on pre-treatment estimate (not noted originally on tooth chart)*
F	Extraction *(not previously planned)*
8 mesiodens	Extraction

85. The Respondent also noted that a prophylaxis was performed and fluoride was given. No radiographs were taken.

86. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

87. The Respondent billed the patient and the insurance company for the extraction of tooth # 8 as a completely bony impacted tooth, code 7240. Dr. Coll opined the tooth was not completely bony. At best it was partially bony, code 7230 or more likely impacted, soft tissue, code 7220.

88. Dr. Coll examined Patient J's records and opined that the extensive treatment provided by the Respondent should not have been performed without diagnostic radiographs.

Patient K

89. On or about 4/29/02, Patient K, a then 4 year old male, presented to the Respondent for an examination and prophylaxis. The patient record reflects that an examination was carried out and that the patient had a prophylaxis and fluoride. The treatment note did not indicate that radiographs were taken but BWs were noted in the tooth chart and billing records. The Respondent noted caries, specifically noted mottled "e's" and it was recorded that nitrous oxide vs. OR was discussed with Patient K's father. It was recorded that the dad would call back. The following restorations needed were noted on the tooth charting form:

Tooth #	Treatment
A	SSC
C	F5
H	F5
K	O
L	O
S	O
T	O

90. No treatment plan and no informed consent form were contained in the chart.

91. On or about 5/14/02, the Respondent wrote the patient's insurance carrier and reported that the patient had "severe dental caries," that he needed 10 restorations, and that the child was "extremely apprehensive and uncooperative and unable to be treated in the dental chair." The Respondent also asserted that the caries were severe, needed immediate treatment and that failure to treat could cause a life threatening dental abscess. The patient did not have severe caries and the treatment notes reflected that the patient was apprehensive but quiet, that he held his dad's hand and that nitrous oxide was a viable alternative to treatment in the OR.

92. On or about 5/17/02, Patient K presented to Montgomery Surgery Center for dental restorations under anesthesia. The Respondent performed the following treatment:

Tooth #	Treatment
A	SSC
B	Sealant *(not planned)*
C	F5
H	F5
I	O *(not planned)*
J	O *(not planned)*
K	OB *(O was planned)*
L	O
S	O
T	OB *(O was planned)*

93. The Respondent billed the patient and the patient's insurance carrier for the treatment and also billed for indirect pulp caps to teeth A and H.

94. Dr. Coll examined Patient K's records and opined that the Respondent's letter to the insurance carrier was misleading. He also opined that tooth A was not in need of a stainless steel crown.

Patient L

95. On or about 5/13/02, Patient L a then 3 year old male, presented to the Respondent for an examination. The patient record reflects that an examination was carried out. No radiographs were taken The Respondent noted caries and noted on the tooth charting form and proposed treatment plan that the patient have the following treatment in the OR:

Tooth #	Treatment
A	MOL
B	DO
C	I
D	Composite resin crown
E	Composite resin crown
F	Composite resin crown
G	Composite resin crown
I	DO
J	MOL
K	MOB
L	DO
M	F5
R	F5
S	DO
T	MOB

96. On or about 5/30/02, Patient L presented to Shady Grove Hospital for dental restorations under anesthesia. The Respondent performed the following treatment:

Tooth #	Treatment
A	OL *(planned as MOL)*
B	DO
C	Indirect pulp cap and I *(planned as I)*

D	Composite resin crown
E	Composite resin crown
F	Composite resin crown
G	Composite resin crown
I	DO
J	OL *(planned as MOL)*
K	OB *(planned as MOB)*
L	DO
M	F5
R	F5
S	DO
T	OB *(planned as MOB)*

97. The Respondent also noted that a prophylaxis was performed and fluoride was given. No radiographs were taken.

98. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

99. Dr. Coll examined Patient K's records and opined that the extensive treatment provided by the Respondent should not have been performed without diagnostic radiographs.

Patient M

100. On or about 4/2/02, Patient M a then 6 year old male, presented to the Respondent for an emergency examination. The patient record reflects that an examination was carried out and a periapical radiograph ("PA") was taken. The

Respondent noted swelling, an abscess around teeth S,T, and K and caries. It was noted on the tooth charting form and proposed treatment plan that the patient have the following treatment:

Tooth #	Treatment
A	O
B	DO
J	Pulpotomy and SSC
K	Extract
L	DO
O	Extract
S	Extract
T	Extract

101. The treatment was scheduled to be done in segments and it was noted that nitrous oxide use or treatment in the OR was discussed. The patient's mother elected to try the treatment with nitrous oxide.

102. On or about 4/4/02 the record reflects that the Respondent extracted teeth S and T after administering nitrous oxide and lidocaine and Carbocaine. The Respondent did not record the amount of nitrous oxide given. The Respondent noted that he administered 1 carpule of lidocaine and 1 ½ carpules of Carbocaine to a 6 year old patient. The Respondent did not record the patient's weight. The maximum recommended dosage of lidocaine or Carbocaine is 2 mg per pound. Patient M

weighed only 47 pounds[7]. The Respondent administered excessive dosages of anesthetic. The Respondent noted that the patient should have the remaining planned treatment done in the OR.

103. On or about 5/10/02, Patient M presented to Shady Grove Hospital for dental restorations under anesthesia. The Respondent performed the following treatment:

Tooth #	Treatment
A	OL *(originally planned as O)*
B	SSC *(originally planned as DO)*
J	Pulpotomy and SSC
K	Extract
L	SSC *(originally planned as DO)*
N	Not originally planned *(O was planned as an extraction)*

104. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

105. Dr. Coll examined Patient M's records and opined that the extensive treatment provided by the Respondent should not have been performed without diagnostic radiographs.

Patient N

106. On or about 5/1/02, Patient N a then 3 year old female, presented to the Respondent for an examination and treatment of previously diagnosed caries. The

[7] Per Shady Grove Hospital records.

patient record reflects that an examination was carried out and a right sided BW[8] taken. The Respondent noted caries and that tooth K was badly broken down. The record reflects that treatment using nitrous oxide was discussed as was having the treatment in the OR. The Respondent noted on the tooth charting form and proposed treatment plan that the patient have the following treatment:

Tooth #	Treatment
A	O
B	sealant
I	sealant
J	Pulpotomy and SSC
K	Pulpotomy and SSC
L	sealant
S	sealant
T	O

107. On or about 6/7/02, Patient N presented to the Montgomery Surgery Center for dental restorations under anesthesia. The Respondent performed the treatment as planned. The Respondent also noted that a prophylaxis was performed and fluoride was given.

108. The Respondent billed the patient and the patient's insurance carrier for the treatment rendered.

[8] The record also contains a BW taken by Dr. Offit of the left side.

109. Dr. Coll examined Patient N's records and opined that tooth J did not require a pulpotomy as the occlusal caries were not in or near the pulpal chamber.

Patient O

110. On or about 4/16/02, Patient O, a then 4 year old male, presented to the Respondent for an examination and restoration of caries diagnosed by another provider. The patient record reflects that an examination was carried out and that caries were noted. Radiographs were taken of the patient. The Respondent recommended that treatment be carried out in the OR under anesthesia. The following restorations needed were noted on the tooth charting form and in a proposed treatment plan:

Tooth #	Treatment
A	MO
B	DO
D	Composite crown
E	Composite crown
F	Composite crown
G	Composite crown
I	DO
J	MO
K	MO
L	DO
N	Composite crown
O	Composite crown
P	Composite crown

Q	Composite crown
S	DO
T	MO

111. No treatment plan and no informed consent form were contained in the chart.

112. On or about 5/8/02,[9] the Respondent wrote the patient's insurance carrier and noted that the patient had "severe dental caries," that he needed 8 restorations and 8 crowns, and that the child was "extremely apprehensive and uncooperative and unable to be treated in the dental chair." The Respondent also noted that the caries were severe, needed immediate treatment and that failure to treat could cause a life threatening dental abscess. The patient did not have severe, life threatening caries as referenced in the letter to the insurance carrier.

Patient P

113. On or about 4/23/02, Patient P a then 9 year old female, presented to the Respondent for an examination. The patient record reflects that an examination was carried out, 2 BWs were taken and that the patient had a prophylaxis and fluoride. The Respondent noted caries and the record reflects that treatment of tooth 30 was discussed and that RCT vs. extraction were given as options. The patient's father elected to have the tooth extracted. The record also reflects that use of nitrous oxide vs. OR was discussed and that the patient's father elected to have the treatment performed in the OR under general anesthesia. The Respondent noted on the tooth

[9] Letter appears to be incorrectly dated 5/8/01.

charting form and proposed treatment plan that the patient have the following treatment in the OR:

Tooth #	Treatment
3	MOL
A	MODL
B	pulpotomy and SSC
I	Pulpotomy and SSC
J	Extraction, space maintainer
14	MOL
19	MO
K	MOD
L	pulpotomy and SSC
S	Extraction, space maintainer
T	MOD
30	Extraction

114. On or about 6/28/02, Patient P presented to the Montgomery Surgery Center for dental restorations under anesthesia. The Respondent performed the following treatment:

Tooth #	Treatment
3	MOL
A	Pulpotomy and SSC *(planned as MODL)*
B	SSC *(planned as pulpotomy and SSC)*

I	Pulpotomy and SSC
J	Extraction, space maintainer
14	MOL
19	MO
K	Pulpotomy and SSC *(planned as MOD)*
L	pulpotomy and SSC
S	Extraction, space maintainer
T	SSC *(planned as MOD)*
30	Extraction

115. The Respondent also noted that a prophylaxis was performed and fluoride was given.

116. Dr. Coll examined Patient O's records and opined that tooth # 14 did not have evidence of radiographic mesial decay; that a SSC was not appropriate treatment for tooth T as there was not evidence of distal or mesial decay or large occlusal caries; and that tooth A did not require a pulpotomy as the decay did not appear near or approaching the pulp.

117. The Respondent practiced dentistry in a professionally incompetent manner and behaved dishonorably and/or unprofessionally in treating his patients. The Respondent, *inter alia,*

a. Recommended and performed dental treatment without clinical justification and/or without diagnostic radiographs;

b. Failed to consider and or inform of treatment alternatives;

c. Performed treatment beyond that which he obtained consent for;

d. Billed for unnecessary dental services and/or up-coded the services;

e. Waived co-payments;

f. Misrepresented the severity of treatment needed and/or the need for general anesthesia to parents and insurers; and

g. Administered local anesthesia to a child in an excessive dose.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent, practiced dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of H.O. § 4-315(a)(6), behaved dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of (a)(16), and abrogated or forgave the copayment provisions of any insurance policy, insurance contract, health prepayment contract, health care plan, or nonprofit health service plan contract by accepting the payment received from a third party as full payment, without disclosing to the third party that the patient's portion would not be collected, in violation of (a)(23).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is by a majority of the quorum of the Board considering this case hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland is **SUSPENDED** for a period of **ONE (1) YEAR**; and it is further

ORDERED that the **SUSPENSION** shall become effective on May 2, 2008, and it is further

ORDERED that during the active period of **SUSPENSION**, the Respondent agrees not to be present in the dental office and that his employee dentist, Saman Madani, DMD, will assume all clinical, management and supervisory duties during that period; and it is further

ORDERED that the **SUSPENSION** shall be **STAYED** on August 31, 2008; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of three (3) years to commence from the date this Order is executed by the Board, subject to the following terms and conditions:

1. The Respondent shall complete and pass with at least a 75 %, within ninety (90) days of the effective date of this Consent Order, the Dental Simulated Clinical Exercise ("DSCE") provided by the American Association of Dental Examiners, Inc. which includes units on: Diagnosis, Oral Medicine and Radiology (the DOR), Comprehensive Treatment Planning (the CTP), Periodontics, Prosthodontics, and Medical Considerations (the PPMC), and the Jurisprudence, Ethics, and Risk Management Examination ("JERM") with the following provisions:

   a. The Respondent shall authorize release of the results to the Board, or release to the Board his results upon their receipt; and

   b. If required by the Board, the Respondent shall appear before the Board Case Resolution Conference panel to determine if any other remedial courses are necessary in addition to those specified below, based on the results of the DSCE and the JERM.

2. The Respondent shall comply with all course work recommendations made by the Board based on the results of the DSCE and JERM;

3. Within (1) year of the effective date of this Consent Order, the Respondent shall successfully complete a Board-approved individual tutorial (or an intensive ethics program with a one-on-one component) which focuses on professional ethics in the dental field. The Respondent shall:

a. authorize the Board to provide the tutor with the entire investigative file, this Consent Order, any other material contained in the Board's disciplinary file;

b. authorize the tutor to send periodic reports to the Board regarding the progress of the tutorial;

c. ensure that the tutor submits to the Board an assessment at the completion of the educational tutorial which includes the tutor's impressions and professional opinions, a report of attendance, participation and completion of assignments, including a copy of any essay or other written assignment, if any, which the Respondent is required to write;

4. Within six (6) months of the effective date of this Consent Order, the Respondent shall successfully complete an extensive Board-approved course in the diagnosis and treatment planning of pediatric patients;

5. Within six (6) months of the effective date of the Consent Order, the Respondent shall successfully complete a Board-approved course in billing and coding with a focus on the avoidance of improper billing, rather than on how to maximize receipts;

6. The Respondent shall complete a detailed and restorative specific, written treatment plan and informed consent document for any treatment other than routine examinations and radiographs. The treatment plan and informed consent documents are required to be prepared at the time the treatment is recommended and updated as necessary and are required to be signed by the patient or the patient's guardian. The

informed consent should reflect the diagnosis, all reasonable treatment options available, including no treatment, and a description of the risks and benefits of each option. The Respondent shall provide a copy of the documents to the patient or the patient's guardian;

7. The Respondent shall only perform operative dentistry with appropriate pre-operative radiographs and in a facility which has proper intra-oral dental radiographic equipment;

8. The Respondent shall have a Board-approved clinical practice reviewer (the "reviewer") in who specializes in pediatric dentistry, to monitor the Respondent's practice of dentistry as follows:

a. The Respondent shall permit the reviewer to directly observe the Respondent's treatment of patients, during at least one ½ day unannounced visit per month for the first three (3) months of the probationary period and every other month thereafter for the first year of the probationary period and on additional unannounced visits thereafter as recommended by the reviewer, or the Board, but not less than quarterly, for the duration of the probationary period;

b. The Respondent shall permit the reviewer to make announced visits for direct observation of the Respondent's treatment of patients, at the discretion of the reviewer, or the Board;

c. The Respondent shall permit the reviewer to conduct unannounced on-site random chart review of at least eight (8) patient charts, every 30 to 45 days, for a minimum of eight (8) visits within the first year of probation, and at least quarterly for the remaining probationary period, to review all aspects of Respondent's practice;

d. The Respondent shall provide to the reviewer the complete record for each patient whose care is being reviewed. The reviewer shall focus on the care and treatment rendered by the Respondent from 2008 and thereafter;

e. The Respondent shall ensure that the reviewer, and the specialist(s), if any, submit written reports to the Board and the Respondent within fifteen (15) days of each visit to Respondent's office describing the findings and making recommendations for improvement;

f. The Respondent shall comply with all written recommendations of the reviewer, if any, or the Board. Failure to comply with the written recommendations shall be deemed a violation of the Consent Order; and

9. For the first six (6) months after the Respondent resumes practicing dentistry, except in the case of an emergency, the Respondent shall have the practice reviewer review all of the Respondent's treatment plans, informed consent documents, and records related thereto to determine if clinical indications exist for the planned treatment and if treatment in the office or operating room is indicated. If, in the opinion of the reviewer, a determination cannot be made without examination of the patient, the reviewer can require the examination of the patient by the reviewer or another Board-approved dentist at the Respondent's expense prior to the Respondent performing the planned treatment;

10. For the first year after the Respondent resumes the practice of dentistry, prior to the scheduling of any treatment in the operating room, the Respondent shall have the practice reviewer review the dental records to evaluate whether appropriate clinical indications exist for the treatment in the operating room. If, in the opinion of the reviewer, a determination cannot be made without examination of the patient, the reviewer can require the examination of the patient by the reviewer or another Board-approved dentist at the Respondent's expense prior to the Respondent performing the planned treatment in the operating room;

11. For all operating room procedures performed by the Respondent within the first six (6) months after the Respondent resumes the practice of dentistry, up to a

total of fifteen (15) patients, the practice reviewer, or another Board-approved designee, shall be present in the operating room to proctor the procedure; 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 reviewer, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order; and it is further

ORDERED that any finding by the Board indicating that the Respondent fails to take the DSCE or JERM, fails the DSCE or JERM, fails to complete the required courses and tutorial, fails to obtain adequate informed consent, fails to provide adequate informed consent, fails to have the practice reviews, fails to cooperate with the practice reviewer, fails to follow the written recommendations of the practice reviewer or the Board, or that the Respondent's dental care or record keeping fails to meet appropriate standards, may constitute a violation of this Order and may, in the Board's discretion, be grounds for lifting the stay of the suspension or for immediately suspending the Respondent's license. In the event that the Respondent's license is suspended under this provision, he shall be afforded a Show Cause Hearing before the Board to show cause as to why his license should not be suspended; and it is further

ORDERED that the Respondent shall comply with and practice within all statutes and regulations governing the practice of dentistry in the State of Maryland; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that the Respondent may petition the Board, in writing, for termination of his probationary status without further conditions or restrictions only if the Respondent has satisfactorily complied with all conditions of this Consent Order, including the expiration of the three (3) year probationary period and the Respondent has no pending complaints before the Board; and it is further

ORDERED that any violation of any of the terms of this Consent Order shall constitute unprofessional conduct in addition to any other applicable grounds under the Act; and it is further

ORDERED that this Order is a public document pursuant to Md. State Gov't Code Ann. §§ 10-611, *et seq.* (2004 & Supp. 2007).

4/10/08
Date of Consent Order

W. King-Smith, D.D.S.
Maryland State Board of Dental Examiners

CONSENT OF OPHIR I. ALALOUF, D.D.S.

I, **OPHIR I. ALALOUF, D.D.S.**, License No. 12149, by affixing my signature hereto, acknowledge that:

1. I have had the opportunity to consult with and be advised by counsel, Kevin A. Dunne, Esquire before signing this document.

2. I am aware that I am entitled to a formal evidentiary hearing before the Board, pursuant to Md. Health Occ. Code Ann. § 4-318 (2005 & Supp. 2007) and Md. State Gov't. Code Ann. §§10-201 *et seq.* (2004 & Supp. 2007).

3. I acknowledge the validity of this Consent Order as if entered into after 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 law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and consent to the foregoing Findings of Fact, Conclusions of Law and Order, and agree to abide by the terms and conditions set-forth herein. I waive any right to contest the Findings of Fact and Conclusions of Law, and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order as set forth in § 4-318 of the Act and Md. State Gov't. Code Ann. §§ 10-201 *et seq.* (2004 & Supp. 2007).

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, and, following proper procedures, I may be subject to disciplinary action, which may include revocation of my license to practice dentistry in the State of Maryland.

6. I sign this Consent Order without reservation as my voluntary act and deed. I acknowledge that I fully understand and comprehend the language, meaning, and terms of this Consent Order.

4/2/08
Date

Ophir I. Alalouf, D.D.S.

Reviewed and approved by: Kevin A. Dunne, Esquire

City/County of Baltimore
State of Maryland
Sworn to and subscribed before me this 2ND day of April, 20 08
Witness my hand and official seal.
Notary Public

My Comm. Exps. 9-1, 2010