IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ROBERT D. COOK, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 6309	*	**Case Number: 2004-128 & 2003-020**

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

CONSENT ORDER

On or about June 6, 2007, the Maryland State Board of Dental Examiners (the "Board") charged ROBERT D. COOK, D.D.S. ("Respondent"), license number 6309, 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; and
> >
> > (20) Willfully makes or files a false report or record in the practice of dentistry.

As a result of negotiations with the Office of the Attorney General, by Kimberly S. Cammarata, Assistant Attorney General and the Respondent, by Marc Cohen, Esquire, 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

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 January 24, 1977.

2. On or about July 8, 2002, the Board received a complaint from a dental assistant who used to work for the Respondent. The dental assistant alleged that the Respondent: recommended and provided unnecessary treatment; placed bridges on periodontally compromised teeth; and had an incredibly high failure rate on his restorative dentistry. The Board referred the complaint to its investigative unit. The Board reviewed the treatment records of fifteen (15) patients.

3. On or about November 7, 2003, the Board received a complaint from a patient hereinafter referred to as Patient A,[1] alleging that the patient had a total mouth reconstruction provided by the Respondent and that the care and treatment was rendered incompetently. The Board requested a response to the complaint from the Respondent and reviewed the Respondent's treatment records of Patient A.

4. Following a review of patient records, the Board issued these charges.

5. The review of the records revealed, *inter alia,* that the Respondent: recommended and performed extensive dental treatment without considering and or/recording the patient's periodontal condition and often without clinical justification;

[1] In order to protect patient privacy and the confidentiality of health care records, patient names are not used in this Consent Order.

administered local anesthetics in excess of recommended dosages; performed restorative procedures incompetently, frequently necessitating that they be re-done or requiring additional and more advanced procedures to be carried out; failed to record the type and amount of anesthetic used; failed to carry out comprehensive examinations; billed for services not rendered and/or up-coded or unbundled.

Patient-Specific Findings of Fact

Patient A

6. On or about 3/14/02, Patient A, a then 44-year-old female, presented to the Respondent. The patient record reflects that a full mouth series ("FMX") of radiographs and bite-wing ("BW") radiographs were taken. No examination was carried out and it was noted that the patient was referred to "Dr. Reyes."

7. On or about 3/5/03, Patient A returned to the Respondent. It is unclear from the patient record what, if any, treatment was provided. It was noted that the patient was to obtain the FMX from "Dr. Katz" and that her next visit would be for treatment planning of what appeared to be upper and lower partial dentures.

8. On or about 3/18/03, the patient record reflects that a panorex radiograph was taken. No other information was noted in the chart for that visit.

9. On or about 4/16/03, the patient was presented with two different treatment plans. The Respondent recommended extensive dental restorative treatment without recording the patient's periodontal condition or noting in either treatment plan the need for periodontal therapy. The patient elected the treatment plan wherein the Respondent recommended the following treatment:

Tooth #	Treatment
5-9	5 unit cantilever bridge
5	Pontic Splint
6	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin
7	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin
8	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin
10-15	6 unit bridge
9	Crown (porcelain fused to base metal) w/porcelain buccal margin Post
10	Crown (porcelain fused to base metal) w/porcelain buccal margin Crown Lengthening Post
11	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
12	Pontic Splint
13	Pontic Splint
14	Crown build-up Crown (porcelain fused to base metal) Splint
15	Crown build-up Crown (porcelain fused to base metal) Crown Lengthening
19-21	3 unit bridge
19	Crown (porcelain fused to base metal) Crown Lengthening Post

	Splint
20	Pontic Splint
21	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Crown Lengthening
22-30	8 unit bridge
22	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
23	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
24	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
25	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
26	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
27	Pontic Splint
30	Crown build-up Crown Lengthening Crown (porcelain fused to base metal)

10. On or about 6/10/03, the Respondent took impressions.

11. On or about 6/11/03, the patient presented to the Respondent's office for the recommended treatment. The patient was placed under intravenous sedation by Barry Berman, D.D.S. The Respondent did not have the required facility permit necessary for

administering intravenous sedation in the office. The Respondent recorded completion of tooth preparations and impressions for the following treatments:

Tooth #	Treatment
5-9	Bridge
5	Cantilever Splint
6	Removed prior crown Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
7	Removed prior crown Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin
8	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin
9	Crown (porcelain fused to base metal) w/porcelain buccal margin
10-15	6 unit bridge
10	Crown (porcelain fused to base metal) w/porcelain buccal margin Crown Lengthening Splint
11	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
12	Splint
13	Splint
14	Crown build-up Crown (porcelain fused to base metal) Splint
15	Crown build-up Crown (porcelain fused to base metal)

	Crown Lengthening
19-21	3 unit bridge
19	Remove prior crown Crown (porcelain fused to base metal) Crown Lengthening Splint
20	Splint
21	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Crown Lengthening
22-30	8 unit bridge
22	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
23	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
24	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
25	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
26	Crown build-up Crown (porcelain fused to base metal) w/porcelain buccal margin Splint
27	Splint
28	Splint
29	Splint
30	Crown build-up Crown Lengthening Crown (porcelain fused to base metal)

12. Dr. Berman left during the patient treatment and the patient experienced significant pain and distress. The Respondent completed the treatment using local anesthetics in excess of recommended dosages.

13. The patient experienced significant post-operative pain throughout her mouth. The majority of the procedures performed by the Respondent were incompetently performed and had to be re-treated or led to more advanced procedures.

14. On or about 6/12/03, the Patient returned to have her temporary crowns adjusted as they were causing her discomfort and pain.

15. On or about 6/16/03, the Patient returned to have the temporary crown on tooth # 26 re-cemented as it had fallen off. The tooth later required root canal therapy ("RCT"), which was performed by Dr. Berman on 6/23/03.

16. On or about 7/15/03, the Respondent placed the patient's upper and lower bridges. The lower bridge did not fit and new impressions had to be taken.

17. On or about 7/31/03, the Patient returned to the Respondent with pain in tooth #24.

18. On or about 8/4/03, the bridges were placed. The chart reflected that tooth #25 may need RCT. The patient was unhappy with the look and feel of the bridges.

19. On or about 8/5/03, the chart reflected that tooth #25 would need RCT and core build up and that the bridge from ##22-30, that had just been placed a day earlier, would need to be removed to carry out the treatment.

20. The bridges fell out on 8/10/03 and had to be re-cemented.

21. On or about 8/18/03, the Patient presented to the Respondent for RCT to teeth ##22, 23, 24 and 25. The Respondent was unable to adequately sedate the Patient and referred her to a "sedation dentist."

22. On or about 8/26/03, Dr. Barker performed RCT to teeth ##22, 23, 24 and 25. Dr. Barker noted during his examination of the patient that numerous deficiencies existed:

a. Open margins existed on tooth #21 (lingual surface), tooth 27 (buccal surface) and tooth # 25 (buccal surface).

b. Thick margins existed on the buccal surfaces of teeth ##7, 23 and 24.

c. The bridge from 22-30 was not properly seated and "rocks."

d. Occlusal plane – the left side was higher than the right.

e. Unable to get incisal contact.

23. On or about 9/8/03, the Respondent placed cores in teeth ##22, 23, 24, 25 and 26 and cemented the bridge from 22-30. The patient was unhappy with the look and feel of all of the bridges.

24. On or about 9/22/03, Patient A presented to Dr. Barker with complaints of pain in the upper left. Dr. Barker noted:

a. Tooth #14 – the distal margin of the crown was open, decayed and incorrectly placed.

b. Tooth #15 – poor margin

c. Debris was noted about bridge ##10-15.

d. Tooth #10 – decay

25. On or about 9/23/03, the Respondent's chart of Patient A reflects that the patient was unhappy with her bridges. Patient A did not return to the Respondent.

26. On or about 9/29/03, Patient A presented to Dr. Barker who removed the bridge from ##10-15 (which he was able to remove with his fingers) and noted decay in teeth ##14 and 15. Dr. Barker restored tooth # 15 and had to perform RCT and post and core build-up on tooth #14.

27. On or about 10/9/03, Dr. Barker removed the bridge from ##5-9 and performed RCT on teeth ##6 and 11.

28. Over the years Dr. Barker also performed additional treatment including RCT to tooth #15 on 8/25/05, re-cementing with temporary cement, the bridges and preparation for new lower bridges.

29. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient A:

a. The Respondent performed unnecessary treatment; he provided crown build-ups on teeth ##11, 22, 23, 24 and 25;

b. The Respondent provided significant restorative treatment without recording the patient's periodontal condition;

c. The Respondent placed a bridge at ##5-9 removing crowns and placing new crowns. The bridge had to be removed and tooth # 6 required RCT within 4 months;

d. The Respondent placed a bridge at ## 10-15 crowning teeth ##10, 11, 14 and 15. The bridge had to be removed and teeth ## 10 and 15 needed to be re-treated and teeth ##11 and 14 required RCT within 4 months;

e. The Respondent placed a bridge at ##19-21 and it did not fit on initial placement and open margins were noted on tooth #21;

f. The Respondent performed crown build-ups and crowns on teeth ##22, 23, 24, 25 and 26. Each tooth required RCT within 3 months;

g. The Respondent did not have a facility permit necessary for the use of intravenous sedation in his dental office;

h. The Respondent used local anesthetics in excess of the recommended therapeutic dose; and

i. The Respondent billed for splinting but provided solid casting. The Respondent billed for porcelain buccal margins, which were not provided on all the maxillary bridges and the posterior mandibular bridges.

Patient B

30. On or about 8/20/01, Patient B, a then 54-year-old female, presented to the Respondent. The patient record reflects that the patient had an examination and that a periapical ("PA") radiograph was taken.

31. On or about 8/27/01, Patient B returned to the Respondent and the record reflects that the Respondent placed a crown on tooth #31 after recording that he performed crown lengthening and a build-up. The Respondent did not perform crown lengthening.

32. On or about 9/4/01, Patient B returned to the Respondent with complaints of pain in tooth #31. The tooth required RCT and a referral was made.

33. On or about 9/23/01, the patient returned to the Respondent after having RCT on tooth # 31 and the Respondent placed a post and core and re-cemented the crown. The crown was not seated properly.

34. On or about 1/29/02, Patient B returned to the Respondent. The Respondent took a pre-operative PA and post-operative BW radiographs and recommended crown, crown lengthening, build-up and splinting of teeth ##4 and 5. There is no documentation in the record justifying the need for this treatment.

35. On or about 3/11/02, the Respondent treated teeth ##4 and 5 as planned. The Respondent did not perform crown lengthening as recorded in the Primary Treatment Plan and Patient Transactions Code; coded as 4249.

36. The Respondent billed for splinting but provided solid casting, which is included in the cost of a crown. The Respondent billed for porcelain buccal margins, which were not provided.

37. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient B:

a. The Respondent performed unnecessary treatment: he performed a crown build-up and crowned tooth #5 without clinical justification;

b. The Respondent did not record the patient's periodontal condition;

c. The Respondent performed a core build-up and crowned tooth #31 and the tooth required RCT in less than one month;

d. The Respondent placed a crown on tooth #31 which was not properly seated;

e. The Respondent noted and billed for crown lengthening which he did not perform as coded;

f. The Respondent crowned teeth with significant bone loss and/or a bony defect present; and

g. The Respondent billed for services not rendered as billed.

Patient C

38. On or about 9/7/99, Patient C, a then 67-year-old female, presented to the Respondent with complaints of sensitivity in tooth #29. The patient record reflects that the patient had an examination and that a PA radiograph was taken. The Respondent prescribed Pen VK and LorTab to the patient. The Respondent also recommended the following treatment:

Tooth #	Treatment
28-32	5 Unit Bridge
28	Crown Build Up Crown
29	RCT, Post, Crown
30	Pontic
31	Pontic
32	Crown Build Up Crown

There was no documentation in the record justifying the need for this treatment.

39. On or about 9/10/99, Patient C returned to the Respondent. The patient reported that she had a reaction to the LorTab. The record reflects that the Respondent performed RCT on tooth #29. The radiographs taken on that day of the RCT are non-diagnostic. The final fill was 3 mm shy of the apex.

40. On or about 9/14/99, the patient returned to the Respondent for follow-up treatment but the area surrounding tooth #29 was still swollen and treatment was deferred.

41. On or about 9/20/99, the Respondent performed crown preparations on teeth ##28, 29 (with a note that the post and core would be done when the RCT was completed) and 32. The record also reflected that a final impression was taken for the bridge from 28-32.

42. Three days later, on 9/23/99, the patient presented with complaints of pain in teeth ##29 and 32. She also had to have the interim crown on #32 re-cemented. The Respondent referred the patient to an endodontist for evaluation.

43. The following day the patient returned for the bridge try-in. The patient was unhappy with the fit as her upper denture was adjusted "too much." The bridge was temporarily cemented on 10/1/99.

44. On or about 10/4/99, the patient returned with complaints of pain around tooth #32 and roughness on the upper denture, which had been adjusted. The Respondent noted the bridge might need to be re-made to #32 or re-cemented.

45. The patient returned again on 10/26/99 with complaints that the bridge was pushing her natural tooth and that metal was hitting it. She advised that the bridge felt too big and that it felt like there was a hole. The Respondent polished #28.

46. The patient had some additional visits with additional complaints. Radiographs revealed that there was poor marginal fit of the abutment crowns on ##28 and 29.

47. On or about 1/6/00 the Respondent had to re-treat the RCT on #29.

48. The Respondent had to re-fill tooth # 27 on 1/10/00.

49. On or about 2/3/00, the Respondent referred the patient to an endodontist for examination of #29. The endodontist re-treated tooth #29 again.

50. Approximately two years later,[2] the patient returned to the Respondent. When the patient returned it was noted that tooth #28 required RCT and ##28, 29 and 32 needed posts, cores and crowns. On or about 6/19/02, the Respondent noted that he performed crown lengthenings, posts, and crownings of ##28, 29 and 32 and that he splinted all of the teeth in the bridge. The Respondent did not perform crown lengthening or splinting as reported and billed.

51. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient C:

a. The Respondent performed improper treatment: the RCT therapy in the abutment teeth of the right mandibular prosthesis should have not been involved and could have been avoided;

b. The Respondent did not record the patient's periodontal condition;

c. The Respondent's treatment led to recurrent decay in the teeth treated with teeth ##28, 29 and 32 needing RCT;

d. The Respondent's RCT performed on #29 was under-filled, had to be re-treated by the Respondent, and a month later re-treated by an endodontist;

e. The Respondent noted and billed for crown lengthening which he did not perform;

f. The Respondent billed for splinting of teeth which he did not perform;

g. The Respondent over adjusted the existing maxillary denture; and

h. The Respondent provided a bridge which had to be redone within two years.

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[2] The patient had medical problems, which may have prevented her from returning in a more timely manner.

Patient D

52. On or about 3/12/02, Patient D, a then 48-year-old male, presented to the Respondent. The patient record reflects that the patient had an examination and that a panorex radiograph was taken. The Respondent did not perform periodontal probings. The Respondent recommended an extensive treatment plan; he recommended a full mouth reconstruction, that all of the patient's lower teeth be extracted, and that the patient consult with another dentist for implants in the mandibular arch. He recommended the following treatment for the maxillary arch:

Tooth #	Treatment
2-5	4 Unit Bridge cantilever bridge
2	Crown lengthening, Crown Build-Up Crown, Splint
3	Pontic, Splint
4	RCT, Crown lengthening, Post, Core, Crown w/ porcelain buccal margin, Splint
5	Extract, Pontic
6-10	5 Unit cantilever bridge
6	Extract, Pontic, Splint
7	Extract, Pontic, Splint
8	Crown lengthening, Post, Core, Crown w/ porcelain buccal margin, Splint
9	Crown lengthening, Post, Core, Crown w/ porcelain buccal margin, Splint
10	Crown lengthening, Post, Core, Crown w/ porcelain buccal margin, Splint
11-15	5 Unit cantilever bridge
11	Extract, Pontic, Splint
12	Crown lengthening, Core, Crown w/ porcelain buccal margin, Splint

13	Crown lengthening, Core, Crown w/ porcelain buccal margin, Splint
14	Extract, Pontic, Splint
15	Crown lengthening, Core, Crown

53. There is no documentation in the record justifying the need for this treatment.

54. On or about 3/28/02, Patient D returned to the Respondent. The record reflects that the Respondent surgically extracted teeth ## 5, 6, 7, 11 and 14. The Respondent did not record the type or amount of anesthetic used. The Respondent did not record the surgical process or record whether sutures were placed. The record also reflects that the Respondent performed crown-lengthening and crown preparations on teeth ##8-10.

55. On or about 4/29/02, the record reflects that the Respondent performed the following services:

2	Crown lengthening, Core Crown, Splint
3	Pontic, Splint
4[3]	Crown lengthening, RCT, Core, Crown, Porcelain buccal margin, Splint
5[4]	Extract, Pontic
12	Crown lengthening, Core, Crown, Splint, Porcelain buccal margin
13	Crown lengthening, Core, Crown, Splint, Porcelain buccal margin[5]
14	Extract, Pontic, Splint[6]
15	Crown lengthening, Core, Crown

[3] Record also reflects RCT, post and porcelain. It is unclear from the entry what was done.
[4] Again, the record is unclear as to what was done.
[5] Unclear regarding the porcelain.
[6] Again, the record is unclear as to what was done.

56. There are no radiographs (no working films or final films) indicating that the RCT was provided on tooth #4. There is no size documenting the post used in providing the post and core.

57. On or about 5/9/02, the patient returned to the Respondent with pain in his lower right quadrant and received prescription therapy with an antibiotic and pain medication.

58. On or about 5/15/02, the Respondent took final impressions for all of the bridges in the upper jaw. The Respondent did not plan for the occlusion with the lower teeth. The Respondent ordered the bridges from the lab without consideration for the lower occlusion, the length of the teeth, the width of the teeth, the position of the teeth, the cant of the arch, the curve of the Spee, or the vertical dimension. Splinting was not ordered nor were porcelain buccal margins.

59. On or about 6/4/02, the Respondent seated the finished upper bridges temporarily.

60. On or about 6/5/02, the anterior bridge segment was re-cemented. The patient was to be presented with a new treatment plan for the mandibular arch. The Respondent now recommended:

18	RCT, Crown lengthening, Post, Crown
19	Pontic, Splint
20	Pontic, Splint
21	RCT, Crown lengthening, post, crown, splint
22	RCT, Crown lengthening, post, crown, splint
23	RCT, Crown lengthening, post, crown, splint

24	RCT, Crown lengthening, post, crown, splint
25	RCT, Crown lengthening, post, crown, splint
26	RCT, Crown lengthening, post, crown, splint
27	RCT, Crown lengthening, post, crown, splint
28	RCT, Crown lengthening, post, crown, splint
29	Pontic, Splint
30	Extraction, Pontic, Splint
31	Extraction, Pontic, Splint
32	RCT, Crown lengthening, post, crown, splint

61. The patient did not return for treatment.

62. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient D:

a. The Respondent used cantilevered bridges inappropriately;

b. The Respondent provided significant restorative treatment without recording or considering the patient's advanced periodontal condition;

c. The Respondent did not record the type and amount of local anesthetics used;[7] and

d. The Respondent did a full reconstruction of the upper arch without considering the lower occlusion, the length of the teeth, the width of the teeth, the position of the teeth, the cant of the arch, the curve of the Spee, or the vertical dimension;

[7] Except on 5/15/02 visit

e. The Respondent billed for crown build-ups but the records do not reflect that they were done; and

f. The Respondent billed for splinting and porcelain margin charges that were not included in the prostheses.

Patient E

63. On or about 5/1/01, Patient E, a then 37-year-old female, presented to the Respondent. The patient record reflects that the patient had a debridement. No periodontal examination or periodontal probings were recorded.

64. On or about 5/22/01, the patient returned and the record reflects that the patient had a fine scale and polish. The record reflects that the Respondent performed crown lengthening, core and crown on tooth #2 which had a pre-existing crown that had fallen off. The Respondent billed for crown lengthening but did not perform the procedure according to the CDT code 4294 as billed.

65. On or about 6/7/01, the patient returned to have her crown cemented. A subsequent radiograph taken on 9/25/01 revealed an open margin on the mesial of the crown. The Respondent recommended the following treatment:

Tooth #	Treatment
4	Crown build-up, crown, porcelain margin
13	Crown build-up, crown, porcelain margin

66. On or about 6/26/01, Patient E returned to the Respondent with pain around tooth #13. The Respondent prescribed erythromycin and recommended RCT. The RCT was carried out on 7/2/01 and a post, core and crown placed. While working on

the tooth a bur "touched" the left corner of the mouth. The crown was seated on 7/19/01. On that date the Respondent recommended crown lengthening and three surface gum line fillings on teeth ##20 and 29. There was no indication in the record that three surface fillings were necessary.

67. On or about 9/25/01, the Respondent presented another treatment plan to the patient recommending work on teeth ##3-6. The record is unclear as to what the treatment would be. Numerous phone calls were then made to the patient to go over financial plans to pay for the proposed treatment.

68. On or about 9/3/02, the patient returned to the Respondent and the record reflects that the Respondent recorded the following treatment:

3	Crown lengthening, Core Crown
4-6	Bridge
4	Core, Crown, Porcelain buccal margin, splint
5	Pontic, Splint
6	Core, Crown, Porcelain buccal margin
11-13	Bridge
11	Crown, Porcelain buccal margin
12	Pontic, Splint
13	Crown, Porcelain buccal margin

69. The bridges later had to be sectioned and re-done.

70. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient E:

a. The Respondent recommended, charged for or performed unnecessary treatment: crown lengthening, porcelain buccal margins, gum line fillings, splinting, and cores;

b. The Respondent provided significant restorative treatment without recording or considering the patient's periodontal condition;

c. The crown on tooth #2 had open margins;

d. The Respondent billed for crown lengthening but did not reference reflecting a flap or the placement of sutures; and

e. The Respondent billed for splinting which was not included in the prostheses.

Patient F

71. On or about 5/14/02, Patient F presented to the Respondent with complaints of pain in the teeth and gums. The Respondent prescribed Clindamycin and LorTab. No diagnostic testing was documented, no diagnosis was recorded, and there was no documentation of the need for antibiotic therapy.

72. The Respondent's billing record reflects that a full mouth series ("FMX") of radiographs was taken on 5/23/02. The treatment record does not reflect an entry for this date. The films are contained in the patient chart.

73. On or about 6/3/02 the Respondent presented the patient with an extensive treatment plan. The Respondent recommended significant treatment without recording or considering the patient's periodontal health. The treatment plan included an extensive case of approximately 20 crown lengthenings, 12 teeth to be filled with 40 to

50[8] surfaces, seven teeth to be crowned with each having a build-up. The Respondent again proposed porcelain buccal margins and gum line fillings.

74. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient F:

a. The Respondent recommended significant restorative treatment without clinical basis or without clinical justification and without recording or considering the patient's periodontal condition; and

b. The Respondent failed to document a full, comprehensive examination.

Patient G

75. On or about 1/31/02, Patient G, a then 48-year-old male, presented to the Respondent for an examination and prophy. The patient record reflects that the patient had an examination and prophy and that the patient would send in his prior radiographs.

76. On or about 3/12/02, the Respondent took a panorex and several PA radiographs. On or about 3/13/02 the Respondent recommended the following treatment:

Tooth #	Treatment
3	Crown Build Up, Crown, Splint
4	Crown Lengthening, Crown Build Up Crown w/ porcelain buccal margin, Splint
5	Crown Build Up, Crown w/ porcelain buccal margin
6-11	Bridge
6	Crown w/ porcelain buccal margin, Splint
7	Crown lengthening, post and core, crown w/ porcelain buccal margin

[8] Not certain of number based on worksheet differing from typed treatment plan.

8	Pontic, Splint
9	Crown Build Up, Crown w/ porcelain buccal margin, Splint
10	Crown Lengthening, Crown Build Up Crown w/ porcelain buccal margin, Splint
11	Crown Build Up, Crown w/ porcelain buccal margin
12	Crown Lengthening, Post and Core, Crown w/ porcelain buccal margin, Splint
13	Crown Build Up, Crown w/ porcelain buccal margin, Splint
14	Crown Lengthening, Post, and Core, Crown
19	Crown Lengthening, Crown Build Up, Crown, Splint
20	Crown Lengthening, Post and Core, Crown
30	Crown Lengthening, Crown Build Up, Crown

The Respondent also made recommendations for conscious sedation. There was insufficient documentation in the record justifying the need for this treatment. Comprehensive examination findings were not recorded.

77. On or about 3/20/02, Patient G returned to the Respondent and the Respondent recorded that he provided the following treatment:

Tooth #	Treatment
6-11	Bridge
6	Crown w/ porcelain buccal margin, Splint
7	Crown lengthening, crown build-up, crown w/ porcelain buccal margin
8	Pontic, Splint
9	Crown Build Up, Crown w/ porcelain buccal margin, Splint
10	Crown Lengthening, Crown Build Up Crown w/ porcelain buccal margin, Splint

11	Crown Build Up, Crown w/ porcelain buccal margin
12	Crown Lengthening, crown build-up, Crown w/ porcelain buccal margin, Splint
13	Nothing recorded in record
14	Crown Lengthening, crown build-up, Crown
19	Nothing recorded in record
20	Crown Lengthening, crown build-up, Crown
30	Nothing recorded in record

The Respondent also noted that debridement, scaling and root planing were carried out in all 4 quadrants. The Respondent rendered the treatment after administering the following medications: 1 tablet of an unidentified medication of an unidentified dosage at 6:45, 3 tablets at 8:00, 1 tablet at 9:00, and 2 tablets at 9:50. The Respondent placed a temporary bridge on ##6-11 but did not place temporary crowns on ##12 or 14.

78. The bridges and crowns were placed on 4/8/02.

79. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient G:

a. The Respondent performed unnecessary treatment in crowning tooth #3;

b. The Respondent failed to complete and/or record a comprehensive examination, including a periodontal examination;

c. The Respondent performed extensive restorative procedures despite significant bone loss and occlusal irregularities;

d. The Respondent administered conscious sedation at a rate that was not safe; administering at least 7 tablets in a 3 hour time period;

e. The Respondent did not record what medication or dosage was used for the conscious sedation;

f. The Respondent performed full mouth debridement and full mouth scaling and root planing in one visit;

g. The Respondent failed to provided temporary crowns for teeth ##12 and 14;

h. Post and cores in teeth ##12 and14 were not provided.

i. The Respondent noted and billed for crown lengthening which he did not perform as coded; and

j. The Respondent billed for porcelain buccal margins and splinting which were not ordered from the lab as part of the prostheses.

Patient H

80. On or about 3/5/02, Patient H, a then 22-year-old female, presented to the Respondent for an examination and prophy. The patient record reflects that the patient had an examination, prophy and that a panorex and two BW radiographs were taken.

81. On or about 3/11/02, the patient returned to the Respondent and the Respondent recommended the following treatment:

Tooth #	Treatment[9]
1	Occlusal lingual composite restoration (crossed out and noted as an extraction) noted as extraction on typed treatment plan

[9] Noted on Treatment Plan Worksheet

2	Occlusal lingual composite restoration
3	Crown build-up and Crown
5	Distal occlusal lingual restoration (also noted as treatment planned for crown build-up, crown w/ porcelain buccal margin)
7-12	Porcelain veneers
14	Occlusal lingual restoration
16	Occlusal lingual restoration (crossed off) noted as extraction on typed treatment plan
17	Extraction by oral surgeon (crossed off) noted as extraction on typed treatment plan
19	Crown build-up, Crown
20-29	Porcelain veneers
30	Occlusal restoration
32	Crown Build Up, Crown w/ porcelain buccal margin, Splint

The Respondent performed the occlusal lingual restoration on tooth #2 and a distal occlusal lingual restoration on tooth #5. Tooth #5 did not show radiographic evidence of decay. The Respondent also planned a core buildup and crown for this tooth unnecessarily.

82. On or about 3/18/02, Patient H returned to the Respondent and the Respondent recorded that he surgically extracted teeth ##1, 16, 17 and 32 (wisdom teeth) and placed an occlusal restoration on tooth #30. These services were not clinically indicated. The Respondent also performed a crown build-up and placed a crown on tooth #19. There was no indication that the existing amalgam restoration on tooth #19

needed to be replaced with a crown. The Respondent billed the patient for a three surface restoration on tooth #30 in addition to billing for the occlusal surface; but treated only the occlusal surface.

83. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient H:

a. The Respondent performed unnecessary treatment in removing the wisdom teeth and by replacing serviceable amalgam restorations on teeth ##19 & 30;

b. The Respondent failed to complete and/or record a comprehensive examination, including a periodontal examination; and

c. The Respondent noted and billed for multiple surfaces on tooth # 30 when restoring only the occlusal surface.

Patient I

84. On or about 3/13/02, Patient I, a then 47-year-old male, presented to the Respondent for an examination. The Respondent did not record periodontal probings. The patient record reflects that the patient would bring in prior radiographs. The patient later had a FMX of radiographs taken.

85. On or about 5/28/02, the patient had an examination and full mouth debridement.

86. On or about 6/5/02, the patient had scaling and root planing of the upper quadrants. Periodontal probings were not obtained or recorded. Tooth #3 was fractured during the procedure. The Respondent recommended the following treatment:

Tooth #	Treatment
3-6	Bridge

3	Crown lengthening (soft) Crown build-up Crown
4	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
5	Pontic Splint
6	Crown w/porcelain buccal margin
7-13[10]	7 unit bridge
7	Crown w/porcelain buccal margin Splint
8	Crown w/porcelain buccal margin Crown Lengthening (soft)
9	Crown w/porcelain buccal margin Splint
10	Pontic Splint
11	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
12	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
13	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
18-21	4 unit bridge
18	Crown lengthening (soft) Crown build-up Crown Splint
19	Pontic Splint

[10] Unclear from record if this is a cantilevered bridge with tooth # 14 as a pontic or if # 14 was not included.

20	Crown Splint
21	Crown lengthening (soft) Crown
22-27	6 unit bridge
22	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
23	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
24	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
25	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
26	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
27	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
28-31	4 unit bridge
28	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
29	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
30	Pontic Splint
31	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin

There was insufficient documentation in the record justifying the need for this treatment. Comprehensive examination findings were not recorded.

87. On or about 7/1/02, the patient returned to begin his full mouth reconstruction. The treatment notes state "see addendum." There are no treatment notes to reflect what treatment the Respondent rendered on that visit. The billing records reflect that the Respondent performed the following treatment:

Tooth #	Treatment
3	Crown lengthening (soft) Crown build-up Crown
4	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
5	Pontic Splint
6	Crown w/porcelain buccal margin
7	Crown w/porcelain buccal margin Splint
8	Crown w/porcelain buccal margin Crown Lengthening (soft)
9	Crown w/porcelain buccal margin Splint
10	Pontic Splint
11	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
12	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin Splint
13	Crown lengthening (soft) Crown build-up Crown w/porcelain buccal margin

	Splint
14	Pontic

The lab slip reveals that the Respondent ordered 2 porcelain fused to metal ("PFM") bridges from ##3-7 and ##8-14; pontics #5, #10 and cantilever pontic #14.

88. The bridge from ##8-14 did not seat properly and had to be re-cemented several times and new impressions had to be taken.

89. Respondent performed incompetent dental work and acted unprofessionally in treating Patient I:

A. The Respondent recommended and performed full mouth reconstruction without adequate diagnostic basis and without occlusal and periodontal considerations;

b. The Respondent failed to complete and/or record a comprehensive examination, including a periodontal examination; and

c. The Respondent performed unnecessary treatment in that core build-ups and crown lengthening were not necessary on teeth ##3, 4, 12, and 13; and

d. The Respondent billed for porcelain buccal margins and splinting which were included in the prostheses.

Patient J

90. On or about 3/18/02, Patient J, a then 25-year-old male, presented to the Respondent for an examination. The patient record reflects an initial exam and that a FMX of radiographs were taken and that the teeth were scaled and polished.

Periodontal probings were not recorded. In addition noting "whitening," the Respondent recommended the following treatment:

Tooth #	Treatment
12	Distal occlusal lingual restoration
13	Distal occlusal buccal restoration
18	Occlusal restoration
19	Occlusal/mesial buccal distal restoration
30	Occlusal/mesial buccal distal restoration
31	Occlusal restoration

There was insufficient documentation in the record justifying the need for this treatment. Comprehensive examination findings were not recorded.

91. On or about 3/26/02, the Respondent performed the restorations to teeth ##18, 19, 30 and 31 as recommended and noted that teeth ##12 and 13 would be restored on the next visit.

92. On or about 4/4/02 the patient returned with complaints regarding the bite. The Respondent adjusted the occlusion of ##18 and 19 but also adjusted the occlusion of natural tooth structure on teeth ##2-3, 14-15 and 30-31.

93. On or about 4/8/02, the patient complained of aching.

94. On or about 4/22/02, the Respondent again performed occlusal adjustment of teeth ##18, 19, 30 and 31.

95. On or about 5/8/02, the patient still had pain.

96. On or about 5/22/02, the patient complained of sensitivity in teeth ##18 and 19. The Respondent removed the restorations and placed Cavit on the occlusal surfaces of the teeth. The patient continued to have pain in the teeth necessitating RCT to both teeth.

97. On or about 8/26/02 the Respondent noted that he placed a post, core and crown on teeth ##18 and 19 with crown lengthening (soft) on each and that tooth #18 was splinted. The crowns were cemented on 9/18/02. There were no further entries in the patient treatment record.

98. The Respondent performed incompetent dental work and acted unprofessionally in treating Patient J:

a. The Respondent recommended and performed dental treatment without adequate diagnostic basis;

b. The Respondent removed amalgam in teeth ##19 and 30 without clinical justification;

c. The Respondent altered natural tooth occlusion by adjusting natural tooth parts;

d. The Respondent restored teeth ##18 and 19 in an incompetent manner necessitating RCT;

e. The Respondent recorded and billed for crown lengthening without clinical basis and did not perform crown lengthening as billed;

f. The Respondent failed to complete and/or record a comprehensive examination, including a periodontal examination;

g. The Respondent splinted teeth without clinical justification; and

h. The Respondent restored gum line caries but billed for three surface restorations.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent violated the Maryland Dentistry Act, H.O. §§ 4-315(a)(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) and (20)(willfully makes or files a false report or record in the practice of dentistry.)

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 September 15, 2007; and it is further

ORDERED that the **SUSPENSION** shall be **STAYED** on October 15, 2007; and it is further

ORDERED that the Respondent shall not practice endodontics as part of his practice of dentistry in the State of Maryland from the date this Order is signed or at any time in the future; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of twenty-four (24) months to commence from the date this Order is executed by the Board, subject to the following terms and conditions:

1. The Respondent shall, within ninety (90) days of the effective date of this Consent Order, consult with the Dental Well-Being Committee ("WBC") and shall enter into a Monitoring Agreement with the WBC and fully comply with all of the terms and conditions of the Monitoring Agreement; and

2. The Respondent shall complete 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"), and Periodontics, Prosthodontics, and Medical Considerations (the "PPMC"), 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;

   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;

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

3. The Respondent shall complete within sixty (60) days of the effective date of this Consent Order, the Jurisprudence, Ethics, and Risk Management Examination ("JERM") provided by the American Association of Dental Examiners, Inc., 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;

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 JERM;

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

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

5. Within six (6) months of the effective date of the Consent Order, the Respondent shall successfully complete an *extensive* Board-approved course in restorative dentistry, focusing on prosthodontics and not cosmetic dentistry;

6. Within six (6) months of the effective date of the Consent Order, the Respondent shall successfully complete an *extensive* Board-approved course in the diagnosis and treatment of periodontal disease;

7. Within nine (9) months of the effective date of the Consent Order, the Respondent shall successfully complete a Board-approved course in ethics;

8. Within one (1) year of the effective date of the Consent Order, the Respondent shall successfully complete a Board-approved course in billing and CDT coding;

9. The Respondent shall notify the Board of any changes in employment within ten (10) days of the change; and

10. The Respondent shall have a Board-approved clinical practice reviewer (the "reviewer") in general 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; and the Respondent shall permit direct observation of performance of certain procedures by a specialist, if recommended by the reviewer, or the Board;

c. The Respondent shall permit the reviewer to conduct unannounced on-site random chart review or off-site chart review based on patient selection of the reviewer, of at least six (6) patient charts, every 30 to 60 days, for a minimum of six (6) 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 2007 and thereafter;

e. The reviewer shall review all aspects of care provided by the Respondent including the Respondent's diagnosis, treatment planning, treatment, prescribing, record keeping, and billing;

f. The Respondent shall ensure that the reviewer, and the specialist(s), if any, submit written reports to the Board within thirty (30) days of each visit to Respondent's office describing the findings and making recommendations for improvement; and

g. The Respondent shall comply with all written recommendations of the reviewer, the specialist(s), if any, or the Board. Failure to comply with the written recommendations shall be deemed a violation of the Consent Order;

h. If, at the end of the twenty-four (24) month probationary period, the reviewer determines that the Respondent could benefit from additional oversight, the Board may extend the period of probation and review for up to an additional year wherein quarterly reviews could occur; 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, the JERM, fails to complete the required courses, 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, or otherwise fails to comply with the Act, may constitute a violation of this Order and may result in additional charges under the Act or 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 twenty-four (24) month 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. 2006).

9/14/07
Date of Consent Order

Barry D. Lyon, D.D.S.
Secretary
Maryland State Board of Dental Examiners

CONSENT OF ROBERT D. COOK, D.D.S.

I, **ROBERT D. COOK, D.D.S.**, License No. 6309, by affixing my signature hereto, acknowledge that:

1. I have had the opportunity to consult with counsel, Marc Cohen, 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. 2006) and Md. State Gov't. Code Ann. §§10-201 *et seq.* (2004 & Supp. 2006).

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.*

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.

9/12/07
Date

Robert D. Cook, DDS
Robert D. Cook, D.D.S.

Marc K. Cohen
Reviewed and approved by: Marc Cohen, Esquire

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 12th day of September, 2007, before me, Notary Public of the State and City/County aforesaid, personally appeared Robert D. Cook, D.D.S., and made oath in due form of law that the foregoing Consent was his voluntary act and deed.

AS WITNESSETH my hand and Notarial seal.

Notary Public

My Commission Expires: 1/1/08