JUL 2 9 2015

IN THE MATTER OF	*	BEFORE THE
RONALD G. MANZER, D.D.S.	*	MARYLAND BOARD
RESPONDENT	*	OF DENTAL EXAMINERS
LICENSE NUMBER: 5919	*	CASE NUMBER: 2013-051

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

CONSENT ORDER

The Maryland State Board of Dental Examiners ("the Board") charged Ronald G. Manzer, D.D.S. ("the Respondent"), License Number 5919, with violating provisions of the Maryland Dentistry Act ("the Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 4-101, *et seq.,* (2009 & 2014 Repl. Vol.). The Board charges the Respondent as follows:

A Case Resolution Conference ("CRC") was held in this matter before a Board committee on June 17, 2015. The Respondent represented by counsel, and the Administrative Prosecutor assigned to the case participated in the CRC. As a result of negotiations at the CRC the parties agreed to the following Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

The Board charged the Respondent with violating the following provisions of the Act and regulations:

H.O. § 4-315. Denials, reprimands, probations, suspensions, and revocations - Grounds.

(a) Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry, a limited license to practice dentistry, or a teacher's license to practice dentistry to any applicant, reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the applicant or licensee:

(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;

(18) Violates any rule or regulation adopted by the Board[.]

The underlying grounds which form the basis of the disciplinary grounds of H.O. § 4-315 (a)(18) are as follows in pertinent part at Code of Md. Regs. ("COMAR") tit. 10 § 44.30:

.02 General Provisions for Handwritten, Typed, and Electronic Health Records.

A. A dentist shall create and maintain a separate dental record for each patient.

B. Dental records shall include:

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

(2) Financial records as described in Regulation .04 of this chapter.

C. Dental records may be:

(1) Handwritten in ink;

(2) Typed; or

(3) Generated on a computer or other electronic device.

D. Dental records may not be created or maintained in pencil.

E. If treatment is rendered, dental records shall be made contemporaneously with the treatment rendered.

F. Dental records shall be created and maintained for each individual seeking or receiving dental services, regardless of whether:

(1) Any treatment is actually rendered; or

(2) Any fee is charged.

G. All entries shall be dated.

I. A dental record shall contain:

(1) The patient's name or other patient identifier;

(2) If the patient is a minor, the name and address of the patient's parents or guardian;

(3) The patient's address and telephone number;

(4) The patient's date of birth;

(5) The patient's place of employment if the patient wishes to provide the information;

(6) Emergency contact information;

(7) Medical and dental histories which shall be updated at each visit; and

(8) Insurance information.

J. To the extent practicable, each document in the dental records shall contain one or more patient identifiers.

K. Dental records shall:

(1) Be accurate;

(2) Be detailed;

(3) Be legible;

(4) Be well organized; and

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

.05 Violations.

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

The Board also charges the Respondent with violating COMAR tit. 10 § 44.32:

.02 Professional Competence.

A. A dentist shall practice dentistry as defined in Regulation .01 of this chapter.

B. A dentist shall:

(1) Limit their practice to the areas of competence by which proficiency has been gained through education, training, and experience;

(4) Use treatment only when the dentist knows that the circumstances are appropriate;

(6) Engage in ongoing consultation with other dentists or relevant professionals;

(7) Seek appropriate education, training, and experience when developing competence in a new service or technique; and

I. FINDING OF FACT

A. Background

The charges are based on the following facts which the Board has reason to believe are true:

1. The Respondent was originally licensed to practice dentistry in Maryland on July 14, 1975, and is currently licensed.

2. At all times relevant to these charges, the Respondent was licensed to practice dentistry in Maryland.

3. On or about November 12, 2012, the Board received a complaint from a patient (Patient "A"),[1] alleging that the Respondent failed to diagnose and treat a decaying tooth (the "Complaint").

4. As a result of this Complaint the Board initiated an investigation.

---

[1] The names of Patients A-H are not provided in this document in order to protect the privacy of the patients. This information, however, will be provided to the Respondent upon request.

5. On or about November 14, 2012, the Board issued a subpoena for Patient A's medical records, and requested a response to the Complaint from the Respondent.

6. On December 9, 2012, the Board received patient A's records and the Respondent's written response to the Complaint.

7. Board staff reviewed the record and noted that the record keeping was inadequate.

8. The Board subsequently requested that a Board expert review seven additional patient records to determine whether Respondent was maintaining appropriate patient records.

9. The Board expert prepared a report, in which he indicated that he found numerous examples of poor medical record keeping and incompetent and substandard treatment of Respondent's patients, herein identified as Patients A-H. The expert report is discussed in greater detail below.

B. Patient Medical Records[2]

Patient A

10. The expert report indicated that Patient A (the Complainant) presented for treatment in July 2010. The expert report opined that there are contradictory entries in the record regarding whether the date of treatment was July 5th or July 15th. The Patient presented with a broken filling on tooth #20. There is insufficient documentation regarding the procedure. There is no documentation of the medical history, necessity for treatment, anesthetic or dental materials used.

[2] The medical records for Patients A-H include numerous office visits for each patient spanning many years. This document summarizes some of the significant findings of the expert reviewer and references the dates of some office visits, but it does not discuss every single office visit for every patient.

11. There is a notation in the record indicating that bridge #11-13 needed to be replaced when the patient could afford the treatment. There were no x-rays taken of this tooth, and subsequently Patient A complained to the Board that he received inadequate treatment for this tooth.

12. On or about January 26, 2011, Patient A presented for an initial examination. The only x-rays taken were bitewings and a periapical x-ray[3] of bridge #11-13. The x-rays were incorrectly dated as January 25, 2011. The clinical notes were not signed and lacked documentation that the medical history was reviewed. There was no periodontal charting and a treatment plan was not recorded despite radiographic evidence of periodontal disease, the need for crowns and a decaying tooth (#21), which was not diagnosed in the notes. The notation was made that bridge #11-13 needed to be replaced.

13. The Patient was seen again in March 2011. The chart entry lacks clinical detail and contains only the cursory notation "Repair #12." There is no documentation of the medical history, necessity for treatment, local anesthetic or dental materials used.

14. The Patient was seen on May 13, 2011. The chart entry lacks clinical detail and contains only the cursory notation "Repair #11." There is no documentation that the medical history was reviewed and the chart entry is not signed.

15. The Patient was seen on June 22, 2011. The chart entry lacks clinical detail and contains only the cursory notation "#14-O,"[4] followed by an illegible

[3] A periapical x-ray gives the dentist an image of the entire tooth including the root. This x-ray can evaluate the root structure and bone level of a particular tooth in order to diagnose cysts and abscesses.
[4] 14-O (Occlusal) is a reference to the chewing surface of tooth #14. The surfaces of the teeth are named according to the direction in which they face. The surfaces of teeth are as follows:

abbreviation. There is no documentation in the record that the medical history was reviewed and the chart entry is not signed.

16. On August 15, 2011, Patient A presented for treatment. The chart entry lacks clinical detail and contains only the cursory notation "Repair #11.There is no documentation that the medical history was reviewed and the chart entry is not signed.

17. On January 17, 2012, Patient A was seen for a periodic examination and bitewing x-rays were taken. The radiographic decay on the distal of #21 was still undiagnosed. The notation was made that a new bridge was needed (#11-13), but the patient had elected not to proceed. There is no documentation that the medical history was reviewed and the chart entry is not signed.

18. On February 24, 2011, the patient record notes that a hole was sealed on the lingual of the bridge. No clinical details were provided. There is no documentation that the medical history was reviewed and the chart entry is not signed. The record notes that bridge #11-13 needed to be replaced, and that Patient A was given a cost estimate. The record also notes that the Respondent declined to provide a model so that Patient A could have a friend fabricate a bridge for him at a reduced cost.

Facial (F) – the surface of a tooth closest to the cheeks or lips; this surface can also be known as the Labial.

Labial (La) – the surface of an anterior tooth facing the lips.

Buccal (B) – the surface of a posterior tooth facing the cheeks.

Incisal Edge [or ridge] (I) – the biting edge of anterior teeth.

Lingual (L) – the surface of a tooth closest to the tongue.

Proximal – the surface of a tooth that touches a neighboring tooth's surface; each tooth has two proximal surfaces known as the mesial and distal surfaces.

Mesial (M) – the surface of a tooth that is closest to the midline (middle) of the face.

Distal (D) – the surface of a tooth that faces away from the midline of the face.

Occlusal (O) – the chewing surface of posterior teeth.

19. The Patient was seen on May 8, 2012, according to the chart entry. The chart entry lacks clinical detail and contains only the cursory notation "#18-D," followed by an illegible abbreviation. There is no documentation of the medical history, necessity for treatment, local anesthetic or dental materials used. There is no documentation that the medical history was reviewed and the chart entry is not signed.

20. Patient A was seen on July 25, 2012; there is an illegible cursory notation lacking clinical detail. There is no documentation that the medical history was reviewed and the chart entry is not signed.[5]

21. On August 16, 2012, Patient A's chart has multiple entries, including documentation that the patient requested an antibiotic, and narcotic medication for pain. A prescription for Tylenol was written. The chart also notes that Patient A was referred to an oral surgeon for a root canal on #11.

Patient B

22. According to the medical record Patient B presented for an initial examination on October 24, 2006. The Patient was 57 years old, but the only x-rays taken were two bitewings using pedodontic film. There was no treatment plan or periodontal charting in the record despite radiographic evidence of periodontal disease. A prescription for Amoxicillin was written, but there are no dosing instructions. The chart contains some cursory notations of treatments performed on certain teeth, but the notations are illegible. There is no documentation of the medical history, necessity for treatment, local anesthetic or dental materials used. There is no documentation that the medical history was reviewed and the chart entry is not signed.

---

[5] The expert noted that according to Dr. Manzer's written response to the Complaint a procedure was performed to repair broken porcelain on tooth #11.

23. Patient B was seen again on November 8, 2006, the chart contains the following cursory notations of treatment performed: 4-F (illegible abbreviation); 10-M(illegible abbreviation); 11-F (illegible abbreviation); 12-F deep(illegible) Pulpal RCT.[6] There is no documentation of the medical history, necessity for treatment, local anesthetic or dental materials used. There is no documentation that the medical history was reviewed and the chart entry is not signed.

24. The expert reviewer noted that from the period of October 2006, through May 2012, the Respondent diagnosed Patient B with abcessed teeth (#'s 5, 6, 19, and 12), but failed to document the symptoms, clinical findings or diagnostic testing. The Respondent did not make a referral for a root canal or endodontic[7] treatment; instead the patient was treated with fourteen courses of antibiotics without addressing the underlying pathology. The Respondent also failed to diagnose periodontal disease.[8]

25. The expert review indicated that overall with respect to Patient B the majority of the records were illegible and incomplete. The records often failed to document that the medical history was reviewed, and chart entries were not properly signed. The Respondent failed to adequately document medical history, necessity for treatment, anesthetic or dental materials used.

Patient C

26. The records reviewed for Patient C cover the period from March 31, 2001, through November 14, 2013. Patient C was seen for treatment on September 14, 2005.

---

[6] Pulpal (Root Canal Treatment) is the process of partial or complete removal of the tissue in an infected tooth; cleaning the pulp space, and filling the space with filling material.
[7] Endodontic treatment, also known as root canal treatment is a sequence of treatments for the infected pulp of a tooth, which results in elimination of infection and the protection of the decontaminated tooth from further infection.
[8] Periodontal disease is a bacterial growth in the mouth, commonly referred to as gum disease. Periodontal disease can cause tooth loss due to destruction of the tissue that surrounds the teeth.

The medical record contains the notation #3-0 Amg.[9] The record entry lacks clinical detail, and there is no documentation that the medical history was reviewed. The record also lacks documentation regarding the medical necessity for the procedure or local anesthetic used to complete the procedure.

27. Patient C was seen for treatment on July 25, 2006. The medical record contains the notations (#'s 14-O Amg, 17-O Amg, 30-O Amg). The record entry lacks clinical detail, and there is no documentation that the medical history was reviewed. The record also lacks documentation regarding the medical necessity for the procedure or local anesthetic used.

28. Patient C was seen for treatment on November 14, 2013. The medical record contains the notation #3-OL[10] Amg. The record entry lacks clinical detail, and there is no documentation that the medical history was reviewed. The record also lacks documentation regarding the medical necessity for the procedure or local anesthetic.

29. According to the expert report, the record contains numerous entries where the Respondent failed to document a review of the patient's medical history.

---

[9] Amg is a reference to an amalgam filling (silver filling), which is the most common filling material.
[10] OL refers to the Occlusal (chewing surface) and Lingual(surface closest to tongue) of tooth #3. When two or more surfaces of a tooth are involved, the names are combined. To combine the surface names, the "al" ending of the first surface is substituted with the letter "o." Abbreviations for combinations of surfaces are as follows:

Distoincisal = DI
Mesioincisal = MI
Occlusobuccal = OB
Distolingual = DL
Mesioclusal = MO
Distoclusal = DO
Mesioclusodistal = MOD
Linguoincisal = LI
Mesioclusodistobuccolingual =MODBL
Occlusolingual=OL

Patient D

30. The record reviewed for Patient D included the period of September 2008 through January 4, 2012. Patient D was seen on September 18, 2008. The chart entry contains the notation Amoxicillin 500 mg x 30. [11] The reason for the prescription was not recorded, and there were no dosing instructions. A staff member added a note to the file that the patient had a tooth ache and swelling, and required an antibiotic. This was apparently the patient's first visit, so there was no medical history in the file.

31. The patient was seen again on September 24, 2008. The chart indicated that tooth #22 had class IV perio [periodontal] with a poor prognosis. According to the expert report, an x-ray revealed that the tooth actually had a hopeless prognosis due to a periodontal abcess. The Respondent wrote a prescription for Amoxicillin, with no documented dosing instructions. There was no documentation of an oral surgery referral or a plan to extract the tooth.

32. Patient D was seen again on February 23, 2009. The expert noted that since the prior visit was for a limited problem, this visit should have been a comprehensive initial examination. However, no comprehensive x- rays were taken, and the chart does not include a documented treatment plan, dental history or periodontal charting. The only notation on this date of service is the cursory entry # 10-F Amg. The expert noted that it appeared that this restoration was performed without x-rays. There is no documentation regarding medical necessity of the procedure or anesthestic used.

33. Patient D was seen on May 2, 2009. The chart contains the entry Amoxicillin 500 x 30 for loose tooth pain, but the dosing instructions are not

[11] Amoxicillin is an antibiotic commonly used to treat bacterial infections.

documented. The expert noted that apparently this was a reference to #22, the tooth that needed to be extracted.[12] However, there was no reference to a plan for extraction. A later chart entry May 13, 2010, contains the cursory notation study model for flipper.[13] Subsequent treatment notes, reference that a flipper was made for #22, but there is no lab prescription in the file.

Patient E

34. Patient E was seen for a limited problem focused examination on July 13, 1987. She was seen for an initial examination on July 20, 1987. The record does not contain a documented treatment plan, periodontal charting or dental history. No comprehensive x-rays were taken aside from bitewings and a single periapical x-ray.

35. On September 4, 1987, a bridge was prepared for teeth #9-11 but the laboratory prescription was not retained. On September 22, 1987, the bridge was delivered. The medical record entry makes the notation that #9 was cemented with Durelon and #11 bond with composite, but there is no clinical rationale in the medical record to explain the decision to bond #11 with composite.

36. Patient E was seen on October 3, 1990. The chart entry indicates that a MOD amalgam was performed on tooth #29. The local anesthetic is not recorded. Patient E was seen again on April 1, 1992, The chart entry for this date of service lacks clinical detail and contains only the cursory notation #6-DI Amg. The medical necessity for the procedure is not documented and the local anesthetic is not recorded. Additionally, the last x-rays taken were more than 5 years old and they did not show tooth #6. Therefore, the procedure was performed without the benefit of any existing

[12] The note on September 24, 2008, indicated that #22 had a periodontal abscess, but did not include a plan for extraction.
[13] A Flipper is a temporary removable plastic tooth device.

x-rays.

37. Patient E was seen on January 13, 1994 -The patient presented for a pin amalgam on #3-BO. The medical necessity for the procedure was not documented. Additionally, the last x-ray taken that shows tooth #3 was more than 6 years old.

38. Patient E had an office visit on January 10, 2001. The chart entry for this date of service lacks clinical detail and contains only the cursory notation #8-D Amg. The record did not contain documentation regarding the medical necessity. Additionally, the last x-ray taken (July 20, 1987) that shows tooth #8-D was more than 13 years old.

39. Patient E had an office visit on March 5, 2002. The chart entry for this date of service lacks clinical detail and contains only the cursory notation #12-D Amg. There was no documentation regarding the medical necessity of the procedure. Additionally, the last x-ray that shows tooth #12-D was more than 4 years old.[14]

40. Patient E was seen on March 18, 2008. The medical record entry from this date is not legible. A periapical x-ray was taken on this date of service, but the x-ray envelope is incorrectly dated March 19, 2008. The x-ray indicates what appears to be the recent extraction socket of tooth #29. The reviewer opined that #29 appears to have been extracted at one of the recent appointments. There is no documentation of any recent x-rays. The expert opined that it appeared that the tooth was extracted based on twenty year old x-rays. There was no documentation of the extraction or the medical necessity for the procedure in the medical record.

41. Patient E was seen on March 7, 2013. The chart entry for this date of service contains a partially legible notation includes "#12 still vital Amoxicillin 500 mg."

[14] This x-ray was apparently taken on August 12, 1997.

There is no documentation of symptoms, diagnosis or diagnostic testing. The record does not include the medical necessity for the antibiotic and the quantity and dosage is not recorded. Additionally, the last x-ray that showed tooth # 12 was taken more than 25 years ago on July 20, 1987.

42. The reviewer noted overall that the medical records for Patient E were deficient, because they were often illegible and incomplete, lacked clinical detail, failed to document a review of the medical history, and often failed to document the rationale for medication, and/or the medical necessity of the treatment rendered

43. In addition, the reviewer noted that the patient record reflected a lack of treatment planning, periodontal charting, and lacked timely or comprehensive x-rays. Furthermore, treatment was performed either without the benefit of x-rays or with grossly outdated x-rays.

Patient F

44. Patient F presented for an initial examination on December 17, 2009. There is no documented treatment plan, periodontal charting or dental history. No comprehensive x-rays were taken aside from bitewing x-rays. The chart entry contains only the cursory notation #20-M Amg. There is no documentation regarding the medical necessity of the procedure or local anesthesia.

45. Patient F was seen again on December 23, 2009, The chart entry for this date of service lacks clinical detail and contains the cursory notation #18-MO and 27-M Amg. There is no documentation regarding the medical necessity.

46. Patient F was seen on January 4, 2010. The chart contains the notation 3-MO Amg, but the medical necessity is not documented. Patient F was seen again on

October 21, 2010, and the chart entry from that date contains the notation #18-L Amg and #19-B Amg. The chart entry fails to document the medical necessity for the procedure.

47. Patient F was seen on February 10, 2011. The chart entry for this date of service lacks clinical detail and contains the cursory notation #12-DO Amg pulp cap and #21-B Amg. There is no documentation regarding the medical necessity or the anesthetic used.

48. Patient F was seen on February 17, 2011. The chart entry for this date indicates that the patient was referred for a root canal on tooth #12. On that date prescriptions were written for Amoxicillin 500 mg x 30 and Tylenol #3 x 20, but dosing instructions were not documented.

49. Patient F was seen for an office visit on September 20, 2011. The chart entry for this date of service lacks clinical detail and contains the cursory notation #20-BO Amg. There is no documentation regarding the medical necessity for the procedure or the local anesthetic used.

50. Patient F was seen again on December 29, 2011, The chart entry for this date of service lacks clinical detail and contains the cursory notation #20-B. There is no documentation regarding the medical necessity for procedure.

51. Patient F was seen on February 16, 2012. The chart entry for this date of service lacks clinical detail and contains the cursory notation #14 for bridge. There is no documentation regarding the local anesthetic used, preparation of abutment #12 or final impressions.

52. The expert noted overall that the medical record reviewed for Patient F did not contain documentation that the medical history was reviewed, or documentation of the medical necessity for the treatment rendered. The chart entries lacked clinical detail, and often times contained only cursory notations referencing the tooth that was treated. The expert also noted that the record reflected the lack of treatment planning, periodontal charting and comprehensive x-rays.

Patient G

53. The medical record for Patient G covers a period of over thirty one years, during which time the patient received treatment for numerous dental problems. According to the expert report, the medical record indicates that the patient was seen on December 7, 1981, for an initial examination. The record does not contain a medical history form, dental history or periodontal charting. There were no comprehensive x-rays taken, except for bitewing x-rays, however, they are not present in the chart. The chart contains the cursory notation #29-DO Amg, without documentation regarding the medical necessity or local anesthetic used.

54. Patient G was seen again on November 13, 1982. The expert report notes that the chart notation for this date of service is almost illegible. There is a cursory notation, which reads "13 T Ex." It is assumed that this is a reference to an extraction, due to a prior chart notation of existing root tips. The record, however, does not document the details of the extraction or the local anesthetic used in the extraction.

55. Patient G was seen on June 9, 1983. The chart entry for this date of service lacks clinical detail and contains the cursory notation #18-0, 7-M, #8-D and #9-D. There is no documentation in the record regarding the medical necessity or the local

anesthetic used. The record documents that two bitewing x-rays were taken, but the films are not in the chart.

56. Patient G was seen on August 27, 1984. The chart entry for this date of service lacks clinical detail and contains the cursory notation #5-F Amg and 11-D Amg. There is no documentation in the record regarding the medical necessity or the local anesthetic used. The record documents that two bitewing x-rays were taken, but the films are not in the chart.

57. Patient G was seen on May 25, 1985. The chart entry for this date of service lacks clinical detail and contains the cursory notation #2-MO Amg. There is no documentation in the record regarding the medical necessity or the local anesthetic used. The record documents that two bitewing x-rays were taken, but the films are not in the chart.

58. Patient G was seen on July 7, 1986. The chart entry for this date of service lacks clinical detail and contains the cursory notation #9-MOL Amg There is no documentation in the record regarding the medical necessity or the local anesthetic used. The record documents that two bitewing x-rays were taken, but the films are not in the chart.

59. Patient G was seen again on May 28, 1991. The chart entry for this date of service lacks clinical detail and contains the cursory notation #19-MOFL Am and #20-D Am. There is no documentation in the record regarding the medical necessity or the local anesthetic used. The record documents that one x-ray was taken but it was not in the chart.

60. Patient G was seen on July 3, 1991. The chart entry for this date of service lacks clinical detail and contains the cursory notation #5-DF Comp, #7-DL Comp, #10ML Comp and #17-O Am. There is no documentation in the record regarding the medical necessity or the local anesthetic used.

. 61. Patient G was seen again on July 14, 1993. The chart entry from this date of service indicates that a periapical x-ray was taken of tooth #17. The x-ray indicated deep decay, however, the x-ray is not present in the chart. An indirect pulp cap with IRM was performed on the tooth with the notation that it would be re-evaluated in 6 months and may need extraction.

62. Subsequent x-rays would indicate that tooth #17 is unopposed and supraerupted.[15] This tooth had an MO amalgam placed on December 13, 1997, but was subsequently referred for extraction on July 20, 2000. The expert noted that in light of the clinical presentation of deep decay that necessitated a pulp cap on an unopposed and supraerupted tooth, it is questionable why any restorative treatment was rendered.

63. Patient G was seen for treatment on May 16, 1995. On this date x-rays were present in the chart, and indicated the need for crowns on #'s 4, 12, 18, 19, 20, and 29 due to large restorations many of which are pin retained. The expert opined that if the "teeth had been treatment planned for crowns at any reasonable juncture then the cycle of patch and fill leading in some cases to tooth loss may have been reasonably avoided."

64. Patient G was seen for service on March 2, 1997. The chart entry for this date of service lacks clinical detail and contains the cursory notation #15-0 Am. There is

[15] This occurs when a tooth continues to grow out of the gum if the opposing tooth in the opposite jaw is missing.

no documentation regarding the medical necessity or local anesthesia used. The expert noted that #19-B was restored with an amalgam despite the February 13, 1997, x-ray showing gross recurrent decay of the pin retained restoration with severe breakdown of the tooth.

65. The expert opined as previously referenced in his report, that this tooth could not be adequately restored without a crown. Finally, tooth #18 had been previously referenced as having a large mesial overhang of restorative material and needing a crown. The x-ray from February 13, 1997, indicated that the large overhanging filling had broken and IRM was placed in the mesial when a crown was the only restorative option.

66. Patient G was seen on January 8, 1998. Bitewing x-rays were taken on this date of service. The x-ray again documents the need for an extraction of tooth #17 and crowns on teeth #'s 4, 12, 18, 19, 20 and 29. By this date, however, tooth #4 has fractured and tooth #12 has developed recurrent decay.

67. Patient G was seen on January 29, 1998. The expert noted that in reference to the x-rays from the last date of service on January 8, 1998, tooth #4 had fractured and was again "patched" with a MODL amalgam with 2 pins instead of a crown. Also, the large existing pin amalgam with recurrent decay on tooth #12 was again "patched" with a MO amalgam instead of a crown, and the local anesthetic was not documented.

68. Patient G was seen again on June 7, 1999. The chart entry for this date of service indicates that a periapical x-ray was taken on tooth # 18, but it is not present in the chart. The expert noted that it was previously referenced that tooth #18 was

continually "patched" as opposed to being crowned and on March 2, 1997, IRM was placed in the broken tooth. The cursory chart notation indicated that the tooth was abscessed and might need a root canal. A prescription was written for Penicillin VK 500 mg., without documentation of the quantity or dosing instructions.

69. The expert noted that the expert review of the medical record was hindered by record keeping deficiencies and numerous missing x-rays. The expert also noted that the patient record reflects the lack of treatment planning, periodontal charting, and timely or comprehensive x-rays. There were numerous instances where treatment was performed without the benefit of x-rays or grossly outdated x-rays. There were many instances where teeth were inappropriately patched, which eventually led to decay and tooth loss.

Patient H

70. According to the Expert Report, Patient H presented for an initial examination on July 23, 1983, but there is no treatment plan, dental history or periodontal charting. No comprehensive x-rays were taken aside from bitewing x-rays. Tooth #14 had an overhanging restoration on the mesial but it was not documented for treatment. In addition, the expert noted that a number of teeth that needed crowns based on the x-rays were later repeatedly patched, and the teeth continued to deteriorate.

71. Patient H was seen again on April 7, 1984. The chart contains the cursory notation #29-MO amalgam and #30 DO amalgam without documentation of medical necessity or local anesthesia used. Teeth #'s 29 and 30 are indicated for crowns, but instead the teeth are patched.

72. Patient H was seen on June 2, 1987. The chart contains the cursory notation #10-MI composite and #13 MOD amalgam without documentation of medical necessity or local anesthesia. Also, restorative treatment was performed on tooth #10 despite the lack of x-rays for the tooth. According to the expert report, Teeth #'s 10 and 13 were indicated for crowns, but instead they were patched.

73. Patient H was seen on July 24, 1991. A root canal was performed on tooth #13. Four periapical x-rays were taken on this date of service, but they are not documented in the chart. The x-rays indicate that no rubber dam was utilized and there is no documentation of informed consent, canal irrigants, sealer, local anesthesia or temporary filling material.

74. On May 12, 1992, a root canal was started on tooth #19. No rubber dam was utilized and the local anesthesia is not documented. The chart contains an x-ray that is labeled as containing two periapical x-rays, but only one x-ray is present. Additionally, the x-rays are incorrectly dated. On May 21, 1992, the root canal was completed on tooth #19. No rubber dam was utilized, and there is no documentation of canal irrigants, sealer, local anesthesia or temporary filling material.

75. Patient H was seen on April 4, 2013. According to the expert report, bitewing x-rays taken on that date indicated a number of previously referenced treatment issues:

Teeth #'s 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 28, 29, 30, and 31 are indicated for crowns. With the exception of a failed crown on #19 these teeth were never crowned or treatment planned for crowns. Instead the treatment performed was the previously documented cycle of "patching" that continued to weaken and compromise the teeth.

76. The expert noted overall that with respect to Patient H: treatment was performed without the benefit of x-rays; restorations were placed with overhanging margins; endodontic therapy was performed without a rubber dam; post and cores placed on teeth #'s 13 and 19 were poorly performed; supraerupted and unopposed tooth #16 was restored on numerous occasions when indicated for extraction; numerous teeth indicated for crowns were continually patched.

77. The expert report noted overall that the review of the records for Patients A-H was greatly hindered by poor record keeping, as well as numerous missing x-rays from patient charts.

78. The Board expert noted that overall a review of Respondent's patient records for Patients A-H indicated a number of competency issues, included but not limited to the following:

a. Issues of documentation and record keeping;

b. failure to diagnose and treat periodontal disease and decay;

c. failure to diagnose and treat tooth decay;

d. failure to take comprehensive x-rays;

e. treatment performed without x-rays, or with outdated x-rays;

f. failure to definitively treat abcessed teeth;

g. restorations placed with overhanging margins;

h. continuous cycles of "patching" teeth with fillings when crowns were required leading to compromised teeth or tooth loss;

i. retaining and performing restorative treatment on third molars when extraction was indicated

j. Performing inadequate post and core restorations; and

k. performing endodontics without the use of a rubber dam.

79. Based on its investigation the Board determined that there was probable cause to charge the Respondent with violating H.O. § 315 (a), (6), (16), and (18); and COMAR tit.10 § 44.30.02, and § 44.32.02.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Conclusions of law the Respondent's actions as described herein violates H.O. § 315 (a), (6), (16), and (18); and COMAR tit.10 § 44.30.02, and § 44.32.02.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 10TH day of AUGUST, 2015, by a majority of the quorum of the Board considering this case hereby:

ORDERED that effective the date of this Consent Order, the Respondent shall:

1. Be suspended for one year with the suspension stayed, subject to the the following terms and conditions:

(a) The Respondent shall be placed on Probation for two (2) years subject to the following terms and conditions;

(b) Within **three (3) weeks** of the effective date of this Consent Order the Respondent shall retain, at his expense, a Board-approved Consultant (the "Consultant") to review patient records on a quarterly basis for the two years of probation to assess the appropriateness of his diagnosis and treatment plans, including endodontic treatment and prepare a quarterly report for submission to the Board;

(c) Within **twelve (12) months** from the effective date of the Consent Order the Respondent shall take and successfully complete the ADEX examination and provide documentation to the Board;

(d) Within **twelve (12) months** of the effective date of this Consent Order, the Respondent shall complete a Board-approved continuing education course in endodontics;

(e) Within **twelve (12) months** of the effective date of this Consent Order, the Respondent shall complete a Board-approved continuing education course in diagnosis and formulation of treatment plans;

(f) Within **six (6) months** of the effective date of this Consent Order, the Respondent shall complete a Board-approved continuing education course in record keeping;

(g) The courses required under this Consent Order shall not count towards the courses required to maintain the Respondent's dental license in Maryland;

(h) The Respondent shall submit the course description/syllabus to the Board for approval prior to enrolling in a course required under this Order. The Board reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject the proposed course and require submission of an alternative proposal. The Board will approve a course only if it deems the curriculum and the duration of the course to be adequate to fulfill the Respondent's requirements under this Order. The Respondent shall be responsible for all costs incurred in fulfilling the course requirements and for submitting to the Board

written documentary proof of his successful completion of the course;

(i) The course completed under this Order cannot be used to satisfy the continuing education requirements for the applicable licensure renewal period; and

(j) The Respondent is responsible for ensuring that he completes the required course in a timely manner.

2. The Respondent shall ensure that all patient charts contain timely radiographs before treatment is rendered, and properly maintain radiographs in patient charts;

3. The Respondent shall ensure that all patient records are in compliance with Code of Md. Regs. tit. 10 § 44.30;

BE IT FURTHER ORDERED that the Respondent's failure to comply with any of the conditions of this Consent Order in a timely manner as set out above, shall be considered a violation of this Consent Order; and it is further;

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board otherwise, may impose any other disciplinary sanctions that the Board may have imposed in this case, including additional probationary terms and conditions, reprimand, suspension, revocation and monetary penalty; and it is further

ORDERED that the Respondent shall comply with the Maryland Dentistry Act and all applicable laws, statutes and regulations; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in

fulfilling the terms and conditions of the Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. General Provisions §§ 4-104 *et seq.* (2014).

08/10/2015
Date

Ronald F. Moser DDS
Ronald F. Moser, D.D.S.
President, Maryland State Board of Dental Examiners

CONSENT

I, Ronald G. Manzer, D.D.S., License No. 6523, by affixing my signature hereto, acknowledge that:

1. I am represented by counsel, Anthony Dwyer, Esquire, and I have consulted with counsel in this matter. I have knowingly and voluntarily agreed to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.
2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. I, Code Ann. § 4-315 (2014 Repl. Vol.) and Md. State Gov't II, Code Ann. §§ 10-201 *et seq.* (2014 Repl. Vol.).
3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have 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 as provided by law. I am waiving those procedural and substantive protections.
4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. 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 or any adverse ruling of the Board that might have followed any such hearing.

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary actions, which may include revocation of my license to practice as dentist.

6. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

7/31/15
Date

Ronald G. Manzer, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
COUNTY OF BALTIMORE

I HEREBY CERTIFY that on this 31st day of July, 2015, before me, a Notary Public of the State and County aforesaid, personally appeared Ronald G. Manzer, D.D.S., License Number 5919, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal:

Notary Public

My Commission expires: 12/8/18