State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. BDS 461-16
AGENCY DKT. NO. N/A

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF ANDREW MARON, D.D.S., LICENSE NO. 22DI01835900, TO PRACTICE DENTISTRY IN THE STATE OF NEW JERSEY.

Joan D. Gelber, Deputy Attorney General, for complainant Attorney General of New Jersey (Gurbir S. Grewal, Attorney General of New Jersey, attorney)

Susan Berger, Esq., and **Sarah Cox Garcia**, Esq., for respondent Andrew Maron, D.D.S. (The Ringler Law Firm, attorneys)

Record Closed: June 22, 2018 Decided: May 6, 2019

BEFORE **SUSAN M. SCAROLA**, ALJ (Ret., on recall):

STATEMENT OF THE CASE

The Attorney General of New Jersey, acting as the statutory complainant, filed a Complaint charging that Andrew Maron, D.D.S., a licensee of the New Jersey Board of Dentistry ("Board"), violated various professional responsibilities and standards and

engaged in various acts of misconduct, negligence, gross negligence, and/or repeated acts of negligence in connection with the care of patients, including failure to personally perform pre-op consultation, examination, X-rays, diagnosis, and plan; pressuring patients to take large loans to finance treatment; failure to obtain informed consent; failure to obtain professionally adequate consent; failure to comply with Board regulations and standards of practice for parenteral sedation and/or general anesthesia; failure to provide safe environment for surgical procedure; failure to perform surgical procedures competently; and failure to personally follow up after extraction or implants.

Dr. Maron denies the allegations and contends that he should be permitted to retain his dental license and return to practice.

PROCEDURAL HISTORY

On September 2, 2015, the Attorney General of New Jersey, acting as the statutory complainant, filed a Complaint charging that respondent, Andrew Maron, D.D.S., a licensee of the Board, violated various professional responsibilities and standards and engaged in various acts of fraudulent billing, professional misconduct, negligence, gross negligence, and/or repeated acts of negligence, in connection with the care of patients. An answer to the Complaint was filed on October 5, 2015. The parties entered into a series of interim Consent Orders prohibiting respondent's practice of dentistry in New Jersey until this matter was concluded.

The matter was transmitted to the Office of Administrative Law, where it was filed on January 8, 2016. N.J.S.A. 52:14B-1 to -15; N.J.S.A. 52:14F-1 to -13.

A Supplemental Complaint was filed on December 19, 2016, which was consolidated for hearing with the original Complaint. On February 1, 2017, an answer was filed to the Supplemental Complaint.

The hearing was held on November 27, 29 and 30, and December 11 and 17, 2017, and January 9, 2018. Each party presented expert testimony, as well as other witnesses, and numerous documentary materials. Following the close of testimony, the

record remained open for the filing of closing statements and briefs. The record closed on June 23, 2018.[1]

FACTUAL DISCUSSION

TESTIMONY

For the Petitioner

BOARD'S EXPERT WITNESS

Dr. Michael Kleiman, D.M.D., a board-certified oral and maxillary surgeon, was accepted as an expert in oral and maxillofacial surgery, including implants. He reviewed the patient cases provided to him, as well as Dr. Maron's testimony to the Board, and rendered a report on July 19, 2015, on the standard of care expected of a dentist practicing oral and maxillofacial surgery, including implants and extractions.

Dr. Kleiman explained how a dentist should evaluate and treat patients. This includes:

1. Reviewing the diagnostic history, records, and imaging; examining the patient; and consulting with other doctors or dentists;

2. Speaking with patients, educating them, consulting with them, and then presenting treatment alternatives;

3. Once consent has been given by a patient, preparing a treatment plan that meets acceptable standards and following up. With implants, the treatment plan is mandatory; and

4. Billing appropriately.

[1] Extensions of time were granted for the filing of this Initial Decision.

Dr. Kleiman noted that Dr. Maron saw patients at several offices, some that he owned and some where he worked as an independent contractor. The standards for dentistry are included in the American Association of Oral and Maxillofacial Surgeons (AAOMS) Code of Professional Conduct. Those standards are the same for a dentist working as an itinerant surgeon as they are for a dentist working out of one location, although the standards can be more difficult to meet for the dentist who is itinerant.

Oral surgery is unique, as it involves anesthesia in the office, which is given by the same person performing the surgery. This process should result in providing care to the patient in an affordable way. The risk is obvious, as patients are "put under" without an anesthesiologist.

New Jersey requires training and education, and has stringent office inspections for usage and equipment. Anesthesia is a continuum from light, to deep, to general. In order to provide general anesthesia, a permit/license is required. For light (parenteral) anesthesia, a different permit is required.

Patients' reactions to anesthesia can vary enormously. The surgeon must wait for the anesthesia to take effect. Drugs should be titrated: the dentist starts with a small amount and looks for a response. Light sedation usually is slower to take effect and the patient is less responsive. With deeper anesthesia, the patient loses protective signs like coughing. Dentists look for signs the anesthesia is taking effect, such as Verrill's sign (eyelids drooping).

In a complex extraction, a patient may have to have local anesthesia as well as general. Sometimes during a procedure, the patient goes into a deeper state; such changes are not uncommon. For example, if four wisdom teeth were being removed, the patient would be sedated first. After waiting, the dentist would do local anesthesia and local injections in the order of his work.

Prior to the commencement of the procedure, the anesthesia sheet should record the ASA[2] status (overall assessment) of the patient. The anesthesia sheet should also include all the drugs administered to the patient, as well as the patient's vital signs (blood pressure, pulse rate, oxygen saturation, and carbon dioxide). These readings provide a fast way to see if something is going wrong during the procedure. The pulse oximeter measures oxygen saturation in the blood; if it drops, something is wrong. Because it can take a half minute before low levels of oxygen can be seen, the carbon-dioxide monitor is a faster guide. As a sedative, Versed is better than Valium. It can take five minutes to become effective and can build on itself.

From Dr. Maron's responses to questions presented by the Board and reviewed by Dr. Kleiman, he felt that Dr. Maron gave too much Versed, which resulted in deep sedation. Dr. Maron did not believe that he had to have a general-anesthesia permit to do this. The dose that Dr. Maron mentioned that he used was 15 mg of Versed, which is high and would deeply sedate most people.

Dr. Kleiman noted that access to a vein must be maintained during a procedure. The most common way to do this is to run fluids and drips in to keep the catheter from clotting. This serves two purposes: the line is maintained to administer medications and, in the event of an emergency, to be able to give drugs. Dr. Maron said he did not run fluids; rather, he "pushed 10–15 mg of Versed" to get the sedative effect. Dr. Kleiman could not tell from Dr. Maron's records whether he left the needle or the catheter in the patient during surgery. But other aspects of Dr. Maron's testimony to the Board made Dr. Kleiman conclude that Dr. Maron used a high level of drugs.

Dr. Kleiman also noted that some of the records he reviewed showed no consultations with the patient by Dr. Maron. This is not acceptable. A surgeon must consult with the patient and cannot delegate this responsibility to a person with lesser qualifications. Dr. Maron had a legal responsibility to consult with the patient and to not let others do it for him.

[2] American Society of Anesthesiologists.

As for implants, an implant must be in the proper position and at the proper angle and there must be enough bone to support it. The bone needs to be tall and wide. Often there is not enough bone, and some implants could be short. The most common way to address this is to build bone with lifting the sinus lining and placing a bone graft. The body replaces the bone after the graft. If enough bone is present—five millimeters of bone is good—the implant should be strong and stable. If less than five millimeters, then the implant is not stable. If a bone graft is done to support the implant, the surgeon waits nine to twelve months for the graft to integrate with existing bone, and then the implant is placed.

The minimum standard of care for the placing of implants is a Panorex X-ray, as a two-dimensional X-ray does not tell how wide the bone is or how healthy the sinus is. The CT scan, now the cone-beam CT, provides an exact measurement, so the height, width, and health of the sinus can be seen, but this advance is not yet the required standard of care. The best available tool that Dr. Maron could have used would have been the cone beam. But if that were not available, the minimum standard was a Panorex X-ray of good quality.

Dr. Kleiman then reviewed the records and information obtained from Dr. Maron's records and testified as to the issues with each patient's care:

Count 2, Patient J.B.

J.B. was a fifty-nine-year-old female whose implant went into her sinus. She had first gone to one dentist who was too expensive. She then saw Dr. Feldman on October 28, 2010, who referred her to Dr. Maron. She then saw Dr. Maron for two implants and a sinus bone graft during her lunch break on June 23, 2011. The work was financed through CareCredit.

J.B. later complained that she was concerned about the bone graft and called the office. She was told it was "OK," that she did not need the graft. Dr. Maron told her the membrane was absent. According to Dr. Maron's records, J.B. did not return until July 30, 2011, and the area was healing well.

After the procedure, J.B. saw Dr. Feldman, who referred her to Dr. Corry, who performed surgery into the sinus to retrieve the implant and remove reactive tissue. He performed a biopsy, then a bone graft, and closed the hole. Dr. Corry did not note any bone-graft material in the sinus and the implant was not in the bone. No bone or bone-graft material was noted in the report. The graft material would have had to disappear and 100 percent totally fail. There may be no way to know if bone-graft material had been placed there, although one would expect to find it. There was no evidence of a sinus lift or remnants of bone material.

Dr. Kleiman noted that Dr. Maron's patient records were inadequate. The X-rays of J.B. were not adequate for Dr. Maron's intention to do a sinus lift and bone grafting. J.B. required a Panorex X-ray (or cone-beam CT scan if available). The X-ray dated October 9, 2009, showed a low sinus floor. The implant should not have been placed without the bone graft. Dr. Maron should have performed a sinus lift before the implant and should have done more studies.

The records revealed no notes of a consultation, no note of a diagram, and no record about any conversation with the patient about the sinus lift. The surgical note is brief, with no description other than implant and bone graft. Dental implants and grafts come with stickers, and they should be affixed to the patient's chart in case a specific lot of material is found to have problems. In this case, there was no sticker and no documentation for a bone graft other than the statement.

There should also be a consent form for the procedure. There was one from December 18, 2010, for a possible tooth extraction of tooth #4. The legal requirement is to do the consent process (treatment, risk, benefit, education); the forms prove the procedure was done. Here, they were not present. Further, the patient was not billed for a bone graft, which is another suggestion that the procedure was not done.

Dr. Kleiman's assessment of Dr. Maron's care of J.B. was that it was not good. It was poor, and well below the standard of care expected. The consultation was inadequate; the surgery had a poor result. With only two millimeters of bone, no implant

should have been done; it was a bad plan. The poor result and outcome were predictable.

Count 3, Patient M.K.

M.K., a twenty-nine-year-old woman, was seen in Dr. Maron's Shrewsbury office for an extraction of tooth #31 and two implants—one to replace #31 and one on the left. M.K. had first gone to another one of his offices. After she left, Dr. Maron telephoned her and said he could treat her in his new Woodland Park office for $3,000 for the extraction and the two implants. That was acceptable to M.K. and she had the procedure. After the operation, M.K. had a rocky recovery. She made lots of visits to multiple offices depending on where Dr. Maron was on a particular day. About three weeks later, the implants failed.

Then M.K. went to Dr. Haghighi in Red Bank, where she was told that the implants were not there.[3] There were no records or notes of her treatment. The issue for Dr. Kleiman was the lack of knowledge by M.K. that Dr. Maron had removed the implants, and that there were no medical records at all. The procedure had been done in Woodland Park and there were no records from that office. The records from the Monmouth office dated December 23 and 28, 2012, showed that the implants had been removed.

Only one X-ray was available from December 28, 2012, and Dr. Kleiman could not tell if the implant was in good bone. The area looked dark, the implant was not placed well, and the angulation was not correct. If the tooth had been infected and there was not enough bone, the implant could have shifted; it was not likely, but possible.

Dr. Kleiman's assessment was that Dr. Maron fell below standards of practice (lack of documentation and lack of system to document conversations); inadequate X-rays; no documentation of consulting or planning with the patient; implants failed

[3] Dr. Haghighi provided a photocopy of his X-rays, and had diagnosed chronic infection with no implants present. He treated the infection.

almost immediately due to plan not carried out; and treatment below standards. This was a high-maintenance patient who required extra skill. Consultation, diagnosis, and treatment were all well below accepted standards of care.

Count 4, Patient M.T. (submitted by niece, P.T.)

M.T. was a ninety-three-year-old woman whose niece complained to the Board. Several areas of concern were noted by Dr. Kleiman. M.T. had four implants in her lower jaw and extensive restorative treatment in her upper jaw. After the procedure, she had difficulties and sought care at Monmouth Medical Center. The physicians there had some trouble with the lower denture and took a CT scan.

M.T. had begun this treatment in early 2010 under the impression that Dr. Maron accepted Medicaid. She had a range of treatment options available to her: implants in her canine teeth, as a male/female snap would provide good stability and generally did well; or more implants for stability; or a bridge could be made and cemented in.

M.T. had the implants in the lower jaw and a removable device placed. Dr. Maron said Dr. Mitgang planned on using skinny implants, but the implants seen in the CT scan were full diameter. The CT scan also showed that two of the implants were poorly positioned and punctured the bone near the tongue.

Dr. Maron said that Dr. Mitgang said to put in mini implants, but the implants in M.T. were too large and not placed right. Dr. Maron did not know why the patient could not get the device out of her mouth, but felt that was not his problem, it was Dr. Mitgang's.

The X-rays from Dr. Maron's office were inadequate. If no CT scan were available, then a Panorex should have been taken. The nerve in the lower jaw needed to be located and assessed, and the dimensions of the jaw needed to be determined. Bone was necessary for implants. The X-rays produced from Dr. Maron's office were of no value. Three were for bridge work on the upper teeth.

These implants failed totally—there was no osteointegration, and inflammation and bone loss around each one. The CT scan was significant. It is necessary to take time for good treatment.

The finances were troubling. Double billing was acknowledged, plus two crowns were billed for that were not seen in the CT scan. Here M.T. took two loans, totaling $31,000, with CareCredit, which paid the office before the implants failed.[4] CareCredit is not a bad thing—it is a healthcare line of credit with 0 percent interest if paid within one year, and it is easy to qualify for. The problem is not CareCredit: the problem is that people make decisions too quickly and patients need a consultation first. CareCredit can amplify the problem because people do something they might not do if they had time to think it through.

Dr. Kleiman concluded that the work for M.T. fell well below standards of care. M.T. was in distress, she suffered. The restorative dentist and surgeon must have a discussion as to treatment. Here, the prosthetics were wrong, as M.T.'s teeth could not support a bridge or dental work (at age ninety-three, her teeth had no strength); doing four implants with four snaps was inappropriate, as snaps can be difficult to undo; M.T.'s age, dexterity, and strength should have been taken into account; and there were significant billing errors. While Dr. Mitgang was a big part of the problem with the denture he made, Dr. Maron was responsible for the surgical part, and it was poorly executed.

Dr. Kleiman acknowledged that some old people want teeth, and that being old does not disqualify people from having beautiful teeth. However, other factors must be considered, including the person's ability to take care of the work that is done and the age of the person. Many procedures are not covered by Medicare or Medicaid, and even if a dental office accepts these plans, that does not mean the procedure will be covered by the plan, or that the patient could afford to pay.

[4] It appears that a civil case was pursued and that $30,000 was refunded to M.T.

Count 5, Patient F.D.[5]

F.D. was an eighty-four-year-old woman who underwent multiple extractions and placement of four implants in preparation for a fixed denture. Following the surgery, she had to go to the hospital for bleeding. Several issues were raised with her care. F.D. thought she was having one tooth removed, not four. The consent forms include one dated April 19, 2010, signed by F.D. and Sandra Moon, a non-dentist. The forms were incomplete. Dr. Maron did not appear to be involved with this consent form. A second consent form was dated May 7, 2010, which was signed by F.D. and Dr. Maron, but which did not specify the treatment. Moreover, the cost of the treatment was not feasible for F.D.

The treatment plan was not clear and was changed during the procedure. Four implants were placed on the date of surgery, but the only pre-operative X-ray available was dated April 22, 2008. A post-operative Panorex was dated June 7, 2010. More images should have been taken. The implants were placed in the teeth sockets and it did not appear that any reference points for restorative work had been considered.

Further, the records did not include updated medical information or a recent medical history showing that the patient had been on Coumadin, an anti-coagulant, on the date of the surgery. The file contained medical records from 2004 and 2006. No chart or other information showed F.D.'s medical status at the time of the surgery. F.D. had a complicated medical history, including a mini-stroke and taking anti-coagulants (blood thinners). Nothing in the medical record showed this. F.D. said she had significant post-operative bleeding, causing her to seek emergency medical treatment. Dr. Maron said that she was not taking medications, but he had no records or medical history to support his conclusion.

Another aspect of this case was the financial situation that F.D. was placed in. In this case, the cost of care was over $13,000 to a patient on Medicaid. Nothing indicated that other and/or cheaper treatment options or alternatives had been discussed by F.D.

[5] The Board relied on Dr. Kleiman's report.

and Dr. Maron, or that he had presented such options to her. The costs related to treatment should be considered, particularly where the patient may not have the financial ability to comfortably repay any loan taken for the cost. The record shows that treatment was well below the standard of care, and also that the consultative and informed-consent process was well below the standard of care.

Count 6, Patient N.C.[6]

N.C., a twenty-six-year-old woman, complained of a difficult surgical experience, during which she said she was not properly anesthetized. This was a case involving a difficult surgical extraction. In addition, she complained that Dr. Maron's eight-year-old son was present during the surgery, causing distraction and handling instruments. And further, she complained that she had to see another surgeon that day because of continued bleeding and the feeling that air was passing between the extraction site and her sinus cavity.

N.C. said she had already signed the consent form before Dr. Maron arrived. Dr. Maron said that when he arrived, N.C. was already in the chair with a topical anesthesia applied. Dr. Kleiman said the consent form was inadequate, referring to a "#4 Ext," which would not be understandable to a layman. The consent form was not signed by Dr. Maron, nor had he reviewed it with N.C.

Dr. Maron told the Board that he agreed that his son was present in the operatory that day due to failure of day-care arrangements, and that the child ran into the operatory to pick up a fallen suction cup. Dr. Kleiman noted that Dr. Maron was the person responsible for the safety of his patient and the environment of the operatory.

As far as the post-operative complications that arose, Dr. Kleiman noted that this was not an ideal result, but was not necessarily a sign of negligence. However, the overall treatment of N.C. fell well below the standard of care.

[6] The Board relied on Dr. Kleiman's report and Dr. Maron's reply.

Count 7, Patient J.K.[7]

J.K. was a patient of Perfect Smile, a practice of Dr. Maron's. The problem presented by J.K. started with financing. He had paid almost $10,000 and was being dunned by GE Capital for the balance. Interest of $5,000 had been added to his balance of $9,000. J.K. had gone over three years in treatment, accumulating debt, without reaching a comfortable state of completion of his dental work.

On May 14, 2012, Dr. Maron performed surgical extractions of ten teeth and placed four dental implants in the upper jaw and two in the lower. The records did not indicate any diagnostic process or informed consent. The X-rays and Panorex should have indicated to Dr. Maron that there was not sufficient room in the maxilla to place implants into the proposed sites without doing, or at least considering, a sinus-floor-augmentation bone graft. The consent form is non-specific and does not mention a sinus-lift bone graft. The post-operative Panorex shows the implant in #4, even though short, extending significantly into the sinus. Failure could have been predicted. J.K. was then referred to Dr. Taylor for follow-up.

J.K. returned on June 13, 2013, and another X-ray and Panorex were taken that showed that the implant on #4 had displaced into the maxillary sinus and was lying in a horizontal position. The patient was not advised.

The first reference in the records to a displaced implant was on June 12, 2014, one year later, when J.K. reported that his otolaryngologist (ear, nose, and throat doctor) had told him the implant was in his sinus. On June 19, 2014, Dr. Maron noted that the implant would need to be removed. There was no further information. Here, there was too little bone to hold the implant.

Dr. Kleiman found that the case should have been better planned, as it presented another implant displaced into the sinus. A Panorex should have been done for J.K.

[7] The Board relied on Dr. Kleiman's report and Dr. Maron's reply.

and Dr. Maron should have felt it when drilling. The patient was having problems: the implant extended into the sinus, and thirteen months later it was floating into the sinus.

Dr. Kleiman's conclusions were that treatment was well below standard of care; the treatment itself was not good; the problem was not picked up in a timely manner; and the financial aspects were unacceptable, as J.K. paid or was paying for the service and did not get what he paid for.

Count 8, Patient M.H.[8]

M.H. had been under treatment for many years by dentists at Perfect Smile. She had never achieved a satisfactory result and refused to pay her balance of $750.

Dr. Kleiman noted that the consent forms were either not in the file or were incomplete. The record had no consent forms for many of the procedures done for M.H.

Implants had been placed in the upper jaw and the X-rays showed that two extended into the maxillary sinus. No notes in the file indicated that Dr. Maron had recognized this issue or had dealt with it.

Dr. Kleiman concluded that treatment was well below the standard of care. Treatment planning was not done. Further, the situation should have been recognized during surgery and it was not. Dr. Kleiman acknowledged that sometimes an implant extending into the sinus may not cause problems. Here, the problem was not so much with the surgery as with the dentists performing the work. But as the owner of Perfect Smile and Gentle Dental, Dr. Maron was responsible.

Count 9, Patient R.P.[9]

R.P. went to Amalgamated Dental Center in Union, where Dr. Maron worked on a per-diem basis. Here, the issue was animosity between Dr. Weber and Dr. Maron,

[8] The Board relied on Dr. Kleiman's report.
[9] The Board relied on Dr. Kleiman's report.

which led to communication failures. Dr. Maron and Dr. Weber never discussed a treatment plan for R.P. R.P. reported that after she had been given anesthesia, Dr. Maron convinced her to have dental implants, which she did not want and could not afford. The office arranged immediate financing, and Dr. Maron extracted one tooth and placed two implants.

One of the implants fell out and R.P. swallowed it; the other failed, and Dr. Maron later removed it in his Red Bank office. The consent form was not filled out and was inadequate, as it referred to a different surgeon. Dr. Maron said he drew pictures for R.P., but no pre-operative X-rays were produced. An X-ray was later produced, but there was no way to know if it was R.P.'s.

In her first letter to the Board, R.P. blamed Dr. Maron. Dr. Maron first told the Board that he did not write the letter to the Board in response to the Complaint, and that someone else must have. Later in his testimony, Dr. Maron said he did send the letter, and offered to re-do or replace the implant for R.P. Then, in a second letter to the Board, R.P. blamed Dr. Weber, not Dr. Maron.

Dr. Kleiman noted that as the surgeon, Dr. Maron was responsible for proper diagnosis, informed consent, good surgery, and appropriate follow-up care. Treatment here was well below the standard of care required.

Count 10, Patient A.P.

A.P., a sixty-eight-year-old woman, raised the issues of level of care, level of anesthesia, and accuracy of medical records provided by Dr. Maron. The medical records produced were not contemporaneous records and were not made on the same date of the treatment. Implants are documented by the presence of the bone graft and stickers that designate the implant; here, the stickers were absent. No sticker means "no sticker to be put on or no one put it on."

Dr. Maron said that he first met A.P. on September 27, 2013, and placed eight implants in a jaw where the patient had a pre-existing history of temporomandibular joint

problems. No pre-treatment model was available, no surgical guide was present, and no CT scan was performed. A post-operative Panorex showed that the right posterior implant extended significantly into the sinus, with the possibility of future problems. In a case where a bridge is contemplated, implant placement is critical. The implant must be below the spot where the tooth is going to be put. A.P.'s case was a major case on the upper end of complexity, if done properly. It was critical for the implants to be in the proper position.

The level of anesthesia for this patient was also concerning, since Dr. Maron gave her 15 mg of Versed in two divided 7.5 mg doses. This should be considered as "deep sedation" and required monitoring of the patient during the procedure. However, the actual anesthesia record was not present, nor was the date of treatment necessarily accurate, as the date of service recorded is September 27, 2014, not 2013. The X-rays sent to the Board were dated September 23, 2014.

Count 11, Patient T.B.

Patient T.B. was being treated by Dr. Michael Taylor, a dentist employed by Dr. Maron in Red Bank. Dr. Maron never saw or met this patient, but the issue here is consent. T.B. previously had crowns on teeth ## 8 and 9, and open margins with decay under #9. Tooth #8 was cosmetic. Dr. Taylor tried to save the initial crown. The X-rays provided were inadequate and not marked properly for identification. The consent form appeared to have been altered: the first copy provided had a check mark next to the word "other" and no other checks; the second one provided included checks for "fillings," "crowns," and "X-rays/exam." The patient denied altering the form and said he had signed only one copy, so the second copy must have been altered. Dr. Maron was responsible for his employee, Dr. Taylor, who was working in Dr. Maron's office, even if Dr. Maron had not treated the patient.

Count 12, Patient A.A.[10]

A.A. was a fifty-three-year-old woman who was treated by Dr. Mitgang and Dr. Maron at Dr. Maron's office, Perfect Smile. She was disabled and receiving Medicaid; her treatment was financed through CareCredit. She complained that she was receiving calls from collection agencies because she was unable to pay. She felt she had received dental work she did not need or want. The patient's record was not clear as to which medications she was taking, and the form she completed might have been ambiguous as to whether she was taking the listed medications or allergic to them. This should have been clarified by Dr. Maron, but the records did not indicate that it had been done. The X-rays appear inadequate, as they are not marked "left" or "right." Dr. Maron told the Board that A.A. had root-canal therapy on tooth #15 on June 30, 2008, but the Panorex dated March 10, 2010, did not reflect this. The imaging studies were below the standard of care and could not be reconciled.

Further, the records provided were devoid of any diagnosis, treatment planning, or informed consent. This is below the standard of care required.

Count 13, Patient E.D.[11]

Patient E.D. complained to the Board that on November 19, 2011, Dr. Maron had extracted all of her upper teeth and had placed a temporary upper denture. In May 2012, E.D. saw Dr. Maron and the dentists at his office for a course of treatment consisting of four implants in the upper jaw and an implant-retained overdenture. E.D. was uncomfortable and had many visits to the office, but her complaints were not resolved. She asked for her records in July 2013, but they were not received. She went to another dentist on August 17, 2013, who noted a large lesion on the right side of her tongue. It turned out the lesion was cancer, for which E.D. was treated with a partial removal of her tongue and lymph nodes.

[10] The Board relied on Dr. Kleiman's report.
[11] The Board relied on Dr. Kleiman's report.

No one in Dr. Maron's office mentioned or noted the lesion, and Dr. Maron had not treated E.D. in the interim. Nevertheless, Dr. Kleiman opined that the lesion should have been noted sooner, and that this failure to diagnose must be considered well below the accepted standard of care.

Count 14, Patient C.S.[12]

C.S. complained of tooth #2 breaking during a root canal for tooth #3 that was performed by Dr. Benhamu, an employee of Dr. Maron. She was then referred to Dr. Maron for an extraction. The dentist's explanation of the cause of some observed bruising was credible and the cause of the problem did not appear to be negligence. However, Dr. Kleiman noted that the medical record was wholly inadequate. No medical history was noted. The surgical note was too brief and illegible. Although the patient had been treated by Dr. Maron with intravenous sedation, no anesthesia record was present. The surgical consent was not adequate, as it was not dated, Dr. Maron's name did not appear, and there was no witness. No specific procedure was noted, and the consent did not include intravenous sedation, or include the date, or list the tooth to be extracted.

The billing was also problematic, as the charge was $1,350 for a high-noble crown, and the laboratory invoice showed a non-precious metal for the crown. This billing was a misrepresentation of the service that was provided.

Count 15, Patient Y.Z.[13]

Y.Z. was treated by Dr. Taylor, an employee of Dr. Maron's, for a crown on tooth #27. The issue here was the type of metal used in the crown: precious or non-precious. The insurance company was billed for high-noble metal, while the laboratory invoice showed a non-precious metal. This was the second such billing error seen by Dr. Kleiman where he was able to compare charts and lab invoices, although Board

[12] The Board relied on Dr. Kleiman's report.
[13] The Board relied on Dr. Kleiman's report.

rules require that lab prescriptions be part of a patient's chart. Generally, the cost of precious metals is significantly higher than the cost of non-precious metals.

Dr. Maron said it was the same code for either metal type, and that there was no intent to defraud since the payment for the procedure was the same.

Count 16, Patient S.A., Jr.[14]

S.A., Jr., is a seventeen-year-old who had four wisdom teeth removed by Dr. Maron on September 23, 2013, at American Dental Center, an office not owned by Dr. Maron. The only Panorex X-ray in the file was from November 18, 2009, four years prior. Bite-wing and periapical X-rays were dated November 18, 2009, and August 29, 2013. No up-to-date Panorex X-rays were available, although the file showed billing to Horizon on September 29, 2013, for a Panorex. The file contained no documentation that appropriate X-rays had been taken at the time of surgery.

In general, the dentist needs to see if the teeth are impacted, or if there are any extra teeth or fewer teeth. The dentist also needs to see the position of the teeth and their relation to other teeth, or if a cyst or tumor is present. Often there are hints that a tooth is more problematic for nerve damage, which would be shown in a cone-beam CT scan. For S.A., his second molars were not present yet. Dr. Kleiman saw no discussion about this in S.A.'s chart. Removal might affect his second molars coming in. A Panorex X-ray was required.

Dr. Kleiman concluded that the standard of care was not met: a current X-ray was required, and it was not in the file; there was no documentation in the file of a consultation, which was necessary because there are risks involved in removing three molars, such as nerve damage; no anesthesia record was present; and no signed consent was in the file. These three issues are significant: the lack of documentation; no evidence of consultation; and no evidence of proper imaging studies.

[14] The Board relied on Dr. Kleiman's report.

Dr. Kleiman was also concerned about the amount of anesthesia. S.A. was given 15 mg of Versed, which causes deep sedation. The record further showed that Dr. Maron billed for general anesthesia, yet his license to administer general anesthesia had been inactive since October 31, 2009. Dr. Kleiman's conclusion was that Dr. Maron's treatment fell below accepted standards of care, as he should not have been putting patients to sleep without an active license to preform general anesthesia.

However, Dr. Kleiman agreed that if the Panorex that he had not been provided with had been taken on August 29, 2013, that would have been sufficient. It also appeared that S.A.'s mother had signed a consent form that was adequate.

Count 17, Patient S.B.[15]

S.B. was a twenty-five-year-old pregnant patient whom Dr. Maron did not recall treating in 2013. A mostly illegible note in the file indicated that Dr. Maron planned to extract four teeth (## 1, 16, 17, and 32). S.B.'s obstetrician sent a note, which said that the patient could have X-rays with double shielding, Novocain without epinephrine, Tylenol with codeine, and Amoxicillin. A consent form in the file was not signed by Dr. Maron or witnessed by any other person. Further, nothing in the record indicated why all four molars would be removed, as there was no indication that S.B. had any complaints about her left side. No X-rays had been produced.

After the procedure, Dr. Maron prescribed Vicodin 7.5/300 and Amoxicillin 500. Nothing is noted in the file about dosing. Further, rather than prescribe the Tylenol that the obstetrician had said was acceptable, Dr. Maron prescribed Vicodin. He also used Septocaine as the anesthetic, which contained epinephrine, which the obstetrician had indicated was not acceptable. Nothing in the patient's file indicated that Dr. Maron had attempted to discuss treatment with the obstetrician, nor was there any documentation as to why he diverged from the obstetrician's preferences, although as far as Dr. Kleiman knew, the patient suffered no ill effects from Dr. Maron's treatment.

[15] The Board relied on Dr. Kleiman's report.

Count 20, Patient G.P. (Count 1 in Supplemental Complaint)[16]

G.P., a sixty-two-year-old woman, was a patient of Dr. Frederick, who recommended an extraction of (probably) fractured tooth #14 and replacement with an implant. They discussed doing the procedure in one visit. On the date of surgery, August 17, 2015, G.P. met Dr. Maron for the first time. She had no discussion with him regarding treatment. He removed the tooth and placed the implant and bone graft in a short amount of time. He left the room and she never saw him again.[17]

A note in her chart on August 21, 2015, from Dr. Maron stated that the "area was healing well." G.P. saw Dr. Frederick in September and November, at which time X-rays were taken and no problems were noted. On December 15, 2015, G.P. saw Dr. Frederick for what she thought was going to be the uncovering of the implant for restoration work, but Dr. Frederick told her the implant was too high in the sinus and could not be used as the foundation for a successful restoration.

G.P. went to another dentist, who also informed her that the implant could not be used, and an otolaryngologist, who noted that there was a "foreign body left maxillary sinus." Dr. Frederick suggested that the implant migrated, but that is wrong; the implant was too high from the time it was placed. Dr. Kleiman reviewed the immediate post-operative Panorex and subsequent X-rays and said that the implant was placed in a position that was too high and extended into the sinus at the time of surgery. This should have been apparent from the beginning. The crown-to-root ratio was inadequate.

The implant should not have been placed. G.P. needed a bone graft to increase the height of the bone. Bone grafts to increase width are good and usually successful, but efforts to build height have not been as successful. There is also a different kind of implant that can handle a high crown-to-root ratio.

[16] The Board relied on Dr. Kleiman's report.
[17] Dr. Maron's license to practice dentistry was suspended on September 15, 2015.

The treatment of G.P. was well below the standard of care: the treatment was based on the general dentist's analysis and consultation; there was no available pre-operative imaging; and the diagnostic phase was below standard of care, as Dr. Maron did not personally have a consultation with G.P. and execute an informed consent. He placed an immediate dental implant at the time of extraction in a manner that would predictably result in an implant not suitable for restoration and use. Record keeping and documentation were inadequate, and possibly inaccurate. It reflects an inadequate amount of time spent with and attention to the patient.

Count 21, Patient Mi.K. (Count 2 in Supplemental Complaint)[18]

Mi.K., a sixty-year-old man, was a patient of Dr. Frederick at Monmouth Dental Group, where Maron was the oral and maxillofacial surgeon.[19] Here, the issue involved the placement of implants in the lower jaw, and subsequent numbness. Mi.K. had been told by a previous dentist that he could not get implants in his lower jaw because of the risk of nerve damage.

Dr. Maron placed an implant at #29 on November 4, 2013, and an implant at #21 on November 12, 2013.[20] On December 17, 2013, the file note by someone other than Dr. Maron indicated that Mi.K. was still numb on the lower lip and chin, and had been numb since the surgery. On April 17, 2014, a note in the file from another dentist asks for Dr. Maron to back out the lower implants to alleviate Mi.K.'s paresthesia. On April 28, 2014, Dr. Maron noted that he backed out ## 20 and 28.

Nerve damage is a known risk of implants. It is important that the nerve be located and not contacted with any instrument or by the implant. A minimum Panorex is required, but a CT scan is more accurate to be sure that contact is not made with the nerve. An implant should be planned in a way so that its placement does not violate the nerve. An error in planning or in surgical technique can result in loss of function. If just

[18] The Board relied on Dr. Kleiman's report.
[19] Civil litigation commenced by Mi.K. is pending.
[20] Dr. Kleiman indicated there was some confusion over tooth numbering in the office record, which is not uncommon when teeth are missing. References to ## 20 and 21 and to ## 28 and 29 refer to the same teeth.

a slight injury, the nerve may return, or if caused by localized swelling, function may return.

If an implant has been placed in a way that damages a nerve, it should be addressed as soon as possible. If an implant is placed and the patient is numb the next day, the cause is obvious, and implants should be removed the next day. Here, numbness was complained of and was evident soon after the procedure. The paresthesia should have been apparent at the first operative visit and addressed.

Treatment was well below the accepted standard of care. The placement of implants caused injury to the nerve for the lips, jaw, and chin. Better planning and execution could have avoided the damage, and, once recognized, the problem was not treated right away. It was five months later and was too late. By that time, the implants cannot be removed. If the implant works, it fuses to the bone, making for a difficult procedure.

There was no documentation of any consultation between Dr. Maron and Mi.K. There were no consent forms for either November 4 or November 12, 2013. There was no record of any diagnostic process carried out by Dr. Maron, nor were there any images available to review. There were no X-rays on this patient at all.

Dr. Kleiman's FINAL CONCLUSIONS

In evaluating Dr. Maron, it was necessary to go back to the beginning and determine what needed to be accomplished with dental treatment. Patients should know their treatment options and the dentist should help them to come to a decision. Patients are entitled to quality care and follow up. With Dr. Maron, there was a repeated lack of doing this. Treatment plans were made by someone who was not a surgeon; the surgeon had no conversation with the patient about the treatment plan. Documentation and record keeping were sparse or lacking. Anesthesia was given that was not properly documented. The culture of care demonstrated here did not allow enough time for Dr. Maron to accomplish the purposes of the treatment. Dr. Maron was

responsible for his work. He operated under his license and bore responsibility for all those who acted for him or on his behalf.

Separate from care, Dr. Kleiman opined that regarding false or disparate dates for M.K. and A.P., the person who wrote the note was responsible. Further, if a staff member put in an incorrect date or made a billing error, that person and the supervising dentist, here Dr. Maron, were each responsible for any mistakes or errors.

PATIENT WITNESSES FOR THE BOARD

Count 16, Patient S.A., Jr.

S.A., Jr., now twenty-one years of age, testified that he went to American Dental Center and was told that his third molars were crowding his mouth and that he had to get them removed. His mother accompanied him and inquired if a different specialist were necessary or whether it could be done in-house. They were advised that the procedure could be done at that facility, and scheduled an appointment on September 26, 2013. His mother signed the consent form. An X-ray was taken.

S.A., Jr., remembered that the dentist (Dr. Maron) came in and introduced himself. He received two needles in his jaw, and an IV in his arm, and then fell asleep. He did not awaken until after he was home. His mother told him that he could not walk after the procedure and that two assistants had to help him to the car. His two siblings had to help him into the house, where he finally awoke an hour later. He was confused as to how he got home, and felt pain and discomfort on the bottom right side. The next day he took out the gauze and saw a piece of tooth in his gum. He took a tweezer and removed it. He went back to American Dental and they told him it was healing properly.

Count 3, Patient M.K. (now M.S.)

On December 4, 2012, M.K. went to The Apprehensive Patient and saw the oral surgeon on duty. She needed to remove two bottom teeth plus have implants, but was concerned about the cost. After she left, Dr. Maron called her on her cell phone and

told her he was opening Dowling Dental (practice) in Woodland Park and that he could do both implants for her for $3,000.

In order to get the procedure, she needed to get approved for credit from Springstone Financial. She gave her information to Delores (an office worker) and was then approved. When she asked for a copy of the contract to show this was done, Laura (an office worker) showed her the paperwork. M.K. said she would not sign it because the interest rate was fourteen percent, but that she would sign it after Laura talked to Springstone on Monday. She then found out that the application indicated that she earned $70,000 per year, which was not true; she was making $25,000.

On December 8, 2012, M.K.'s (then) fiancé accompanied her to Dr. Maron's office in Woodland Park. M.K. told Dr. Maron she did not want to miss a lot of work. He said it was a simple procedure and everything should be fine. He drew a picture for her. M.K. was put under, as she did not want to be in pain for too long. When she woke up, she remembered being in the waiting room, and her fiancé looked upset.

M.K. felt discomfort. A couple of days later, her face and throat swelled up; it was painful to touch and there were large lumps where he did the work. She called Dr. Maron, but she could not get him.

She went to Monmouth Dental, then Dr. Maron called her back. He told her she was a hypochondriac, and he would see her at Perfect Smile in Red Bank. She went to Perfect Smile and Dr. Maron said all was normal. He prescribed steroids, an antibiotic, and painkillers. The next day the pain became really bad and she went to see Dr. Maron in Woodland Park. He told her it was a dry socket. And then every time she saw him, he was doing more things in her mouth.

She saw Dr. Taylor at Perfect Smile and he said there was no infection. Then she saw Dr. Maron, who said she did have an infection. Dr. Maron was always in a rush. He was always late and wanted to get her out as fast as he could.

On December 19, 2012, she had gray spots on her right gums; she felt it was an infection, and Dr. Maron said it was blood. He kept calling her a hypochondriac.

On December 28, 2012, M.K. saw Dr. Maron for the last time at Monmouth Dental Group. She was still in pain and had large lumps. He said it was food lodged in her gum. He took a Panorex X-ray and she took a picture of that X-ray on her cell phone. He numbed her and took out his pliers. He never said what he was doing. There was blood all over her face. He told her he was leaving the country and she did not hear from him again.

Then M.K. went to another dentist, Dr. Kayvon Haghighi, who took an X-ray and said there were no implants in her mouth. She felt she was "robbed" and had been taken advantage of. She tried going to small-claims court, but Dr. Maron never showed up. She paid over $4,000 and got back $1,500, but no implants were put in. There were no records from the Dowling Dental office. She had an unsigned copy of the credit application.

S.S., now M.K.'s husband (previously her fiancé)

On December 8, 2012, S.S. accompanied his then fiancée, M.K., to Dr. Maron's office at Dowling Dental to have two implants put in. Dr. Maron said she would not be charged for the anesthesia. He said the anesthesia took some time, but then she went under.

S.S. was in the waiting area. The procedure was done, and Dr. Maron said everything looked good. Someone told him to bring his vehicle to the front of the office and they would bring M.K. out. He drove to the front, but no one brought M.K. out. S.S. went in and found M.K. sitting by herself, half conscious. He brought her out to the car by himself, and when he looked back, he saw Dr. Maron closing the doors of the office.

Count 2, Patient J.B.

On December 18, 2010, J.B. saw Dr. Feldman and discussed removing a bridge and fitting a flipper. She then saw Dr. Maron the same day. He extracted a tooth and she asked no questions about an implant. She felt something was still in her mouth, so she went back. She saw Dr. Maron at the next consultation and he said skin was hanging.

On June 23, 2011, J.B. went to Dr. Maron to discuss implants. She had previously discussed implants with Dr. Feldman and Dr. Gold in Westfield. Dr. Gold had said to use cadaver bone, and then later the implants would be placed. They discussed the procedures and the pricing, but J.B. felt it was too much money.

J.B. then consulted with Dr. Maron about implants. She was employed at the time and had only about forty-five minutes to an hour to spare for the consultation. Dr. Maron said he could do the two implants right then and there and named a price. Because the price was good, J.B. decided to let Dr. Maron do it. She immediately completed an application for CareCredit to borrow the $2,700 needed for the procedure, and Dr. Maron started working on her mouth. She did not know if he took X-rays or had used the X-rays sent by Dr. Feldman.

While he was doing the implants, he had a couple of assistants. Dr. Maron said to one of them that he would take the cadaver bone, and the assistant said, “It’s not here.” Dr. Maron said, “Forget it.” Dr. Maron called the back office for the cadaver bone. After he spoke with “Joanne,” he said, “[the bone was] not necessary.” Afterwards he told J.B. she did not need bone.

J.B. was not sure whether she went back to the office two weeks later. But she did return on July 30, 2011. At that point she had no discomfort, so she did not complain. Later after the procedure, she was not feeling great. As time went by, J.B. experienced problems. She had a “bad taste in [her] mouth” and her “spit was yellow.” She knew something was wrong.

J.B. did not contact Dr. Maron about pain until September. She had no idea it was the implant. On October 3, 2011, she told Dr. Feldman she was in pain. She still did not think there was a problem with the implant, because she was having problems and not feeling great in the sinus area on the right side of the nose, not by the implants.

J.B. went back to Dr. Feldman and X-rays were taken. Dr. Feldman said, "You have a problem," and referred her to Dr. Corry, an oral surgeon. Dr. Feldman told her to go that night, as her face was swollen and dripping. J.B. promptly called Dr. Maron's office. His office said he would not be back until October 8, so she went to see Dr. Corry on October 4, the next day.

Dr. Corry took a Panorex and said the implant was upside down in her sinus and he would have to do things to get it right. Dr. Corry then took care of the problem and a three-part treatment plan was developed: take out the implant and sew up the gum; then a couple of months later, place the bone in; and then later place the implants. Her teeth finally seem good. J.B. would not return to Dr. Maron after that.

The problem had to do with the cadaver bone and the failure of the implant. Moreover, she was still paying CareCredit for the failed work completed by Dr. Maron.

Count 21, Patient Mi.K.

Mi.K. had previously had implants and a bridge placed in his mouth by a dentist in New York. A piece of the top implant had come loose, affecting the bridge. His upper teeth were coming loose, and he was looking to get his top teeth done. On October 31, 2013, he saw Dr. Frederick at Monmouth Dental Group, who said he needed more implants. Then Mi.K. spoke with Dr. Maron, who said his upper jaw would support the needed implants. As for bottom ones, Mi.K. had spoken with a doctor in New York who said his nerve endings were shallow and he could not put in any more implants. Mi.K. told that to Dr. Maron, who responded that he could do it without any damage.

They discussed the work to be done, and Mi.K. signed the consent form on the basis that Dr. Maron said there was no risk. On November 11, 2013, Dr. Maron put in lower implants using Novocain. After three days, Mi.K. still had numbness in his lower lip and chin. He went back and saw both Dr. Frederick and Dr. Maron. He told them he was still numb, and Dr. Maron said it could take up to seven months to get feeling back. The receptionist and the dental assistants also said it could take seven months.

The second implant on the lower jaw might have been performed on November 12, 2013, and Dr. Maron did it. Mi.K. told Dr. Maron that his bottom lip and chin were still numb, and was again told it could take up to seven months. He saw Dr. Maron twelve times, and each time told him how he felt. Dr. Maron kept saying seven months.

This numbness has continued and has affected his life: he cannot pronounce some words; he drools a lot; he has to speak slowly; and he has no feeling in his chin. This has affected his social life. He was a salesman for twenty-eight years and loved having the "gift of gab." Now he has withdrawn from social activities.

One of the top implants came loose, and Dr. Maron took it out and tried it again, and it did not take. On the lowers, Dr. Maron removed the implants by doing a quarter turn, and the numbness remained.

Mi.K. and his wife spent $10,300 for the whole procedure. He paid some in cash and put some on his American Express card. He had great insurance coverage, and that company paid $10,000, for a total of over $20,000. So now three teeth are out of his mouth (## 20, 28, and 4); they were never replaced; and he never received financial credit for this outcome.

Mi.K. reported that the numbness in his jaw and chin is still there. He later saw another doctor in Metuchen, who told him that both nerves were severed. He has no feeling in his gums, and civil litigation is pending.

Count 11, Patient T.B.

T.B. went to Perfect Smile in Red Bank in March 2011 and wanted crowns on teeth ## 8 and 9. He had a problem with them before and needed to have these teeth done. He was treated by Dr. Michael Taylor, an employee of Dr. Maron, and received crowns for ## 8 and 9. He was asked to sign a consent form. In his complaint to the Board, he noted that the consent form that he signed said "other" and was for any work that needed to be done. It was signed and initialed. (The consent form found at Exhibit a285 is the same as a312, except that he did not make the additional marks that appeared on the form.)

Dr. Taylor performed the work in March; a month later the cap on #8 fell off and T.B. nearly swallowed it. T.B. gave Dr. Taylor the tooth and he reattached it, but then it fell out again. When T.B. looked at his original tooth, it looked too small to hold the crown. The tooth had been filed down by Dr. Taylor to hold the new crown. The tooth fell off again, but no one explained to T.B. why this kept happening, and nothing was mentioned to him.

Ultimately T.B. had to have a post put in and a new tooth refitted for the post. He was not billed for that, but he was billed for the repeated cementing of the cap. He felt he should not have to pay again since the job had not been done properly.

T.B. went back three times, and thought it was wrong that he had to keep going back to get the tooth reattached, and when Dr. Taylor said a post would have to go in. He told the Board that a dentist had told him afterwards that he had to get a new tooth with a new post because the old tooth was filed down too much for the crown to fit.

Blue Cross/Blue Shield and MetLife were billed for the work. T.B. remembered calling the office and asking why the insurance company was billed for the second and third time if the procedure had been done properly.

T.B. still receives calls from collection companies about this matter, and the office never erased the fees.

T.B. never met Dr. Maron and was not treated by him. His medical history was taken on March 9, 2011, but he was not treated until March 13, 2011, after he reviewed the financials with his wife. He had to go over CareCredit. He was seen by Dr. Taylor and told he needed to get the work done. And with CareCredit, he called Kelly and set up an appointment. He saw the dentist, filled out the consent form, and then was treated on March 11, 2011. In 2012 he received a telephone call from Perfect Smile and was told he owed them money and they were sending him to collections, but CareCredit had paid for the services.

T.B. previously had crowns on teeth ## 8 and 9, and open margins with decay under #9. Dr. Taylor had tried to save the initial crown. The whole thing was an insurance mess because of lack of communication.

Count 20, Patient G.P.

On August 7, 2015, G.P. went to Dr. Frederick with a toothache. Dr. Frederick recommended an endodontist to see if the tooth needed to be extracted. On August 14, 2015, she went to Dr. Gutentag in Red Bank and he recommended extraction. She returned to Monmouth Dental Group and again spoke with Dr. Frederick, who said he would schedule the extraction with Dr. Maron.

Dr. Frederick gave her treatment options: he told her that the best option was implant and bone graft, and that she was a good candidate and he would schedule the procedure. Dr. Frederick told her everything is done at the same time.

On August 17, 2015, G.P. went for an extraction, bone graft, and implant. She signed the consent. Dr. Maron came into the room and prepared the anesthesia. She opened her mouth, he put the anesthesia in, and he left. He came back and looked at her mouth. He said “OK,” then extracted the tooth, placed a bone graft, and put in the implant. When he was done, he left the room.

Dr. Maron did not examine G.P. before the anesthesia, which was just a needle. She received no other form of anesthesia, such as intravenous. He discussed nothing with her involving the extraction, graft, or implant.

She did not see him again, not even for a follow-up examination.[21] He did take an X-ray after the procedure was done, but she was not shown the X-ray and it was not discussed with her. She went back for follow-up to check the healing with Dr. Frederick. Each time she followed up, an X-ray was taken. Dr. Frederick said that everything looked good and that it was healing well. Although the file indicated that Dr. Maron saw her on August 27, 2015, that notation was incorrect, as she saw Dr. Frederick that day. G.P. saw Dr. Maron only on August 17, 2015.

On December 15, 2015, G.P. returned to get the skin uncovered and the crown filled. Dr. Frederick came in and said he could not do anything with the implant because it was near the sinus cavity. She was upset. No other surgeon there could see her. Then Dr. Frederick started mentioning other options. She was disappointed and upset and left.

The next day, G.P. called another dentist and wanted to know if he agreed with what Dr. Frederick had said and what could be done. She went to Champagne Smiles and saw Dr. Jean Bichara, who said the implant was in her sinus cavity. He sent her for further X-rays, and after looking at them, Dr. Bichara said the implant was in the wrong place and could not be corrected, as it would be quite a procedure to have it out.

G.P. had pain in her jaw. She saw Dr. Kumar, an ENT doctor, and told him what happened. He told her to have the implant removed because it might cause complications. She paid $2,000 the day of the implant, and it was not refunded to her.

[21] Dr. Maron was out of practice by September 15, 2015.

Count 4, P.T., for Patient M.T. (now deceased)

P.T. testified on behalf of patient M.T., who was her aunt (her father's sister) and had died on February 2, 2017.[22] The complaint had been filed on October 28, 2010.

P.T. was under the impression that her aunt had been referred to Dr. Maron's group by the Brandywine facility where she resided. M.T. needed a dentist who took Medicaid and who was located where the facility or dental office could drive her. She was approximately ninety-two and a half at the time.

P.T. stated that one day M.T. called her and said she had received a bill for $20,000. P.T. was surprised and said, "Don't tell me someone did implants."

CareCredit was then relatively new. P.T. believed she called the office first and wanted a copy of her aunt's ledger. Dr. Maron got on the phone briefly and then turned the call over to a staff member.

M.T. had dental difficulties starting in April, with pain in her lower jaw. She went to Monmouth Medical Center, where she saw Dr. Sheridan. The four implants in the lower jaw were failing. She also had an overdenture that was supposed to be removable, but although M.T. was very dexterous, neither she nor Dr. Sheridan could remove it. M.T.'s oral hygiene was compromised. Dr. Sheridan and others were not able to fix the failing situation in M.T.'s mouth.

At one time, Dr. Maron told P.T. that M.T. was "not nimble," but P.T. thought the denture was cemented when Dr. Sheridan could not get it out. They went to Dr. Maron's office. He briefly came out into the waiting room, and her aunt responded to him. He said she had missed her appointment. They were dismissed, and P.T. never spoke with him again.

[22] P.T. was permitted to testify by telephone.

P.T. received a copy of a letter that showed that M.T. had been charged for crowns on teeth ## 2, 3, and 14, but no crowns were there. She was also charged twice for overdentures. P.T. found that M.T. had taken out loans for $20,000 and for $11,000, for a total of $31,000. Dr. Maron's office credited CareCredit, but they did not work with him. CareCredit was calling M.T. constantly, causing her to become upset and confused. The only credit P.T. recalled M.T. receiving was for the $4,500 overdenture. Her cousin handled the litigation filed, and Dr. Maron's office paid the settlement.

P.T. thought that M.T. had not gone back to Dr. Maron's office for treatment again.

For the Respondent

Valerie Schwab, Dr. Maron's sister, testified that she has been the office manager at Perfect Smile for four years. She oversees the practice, booking appointments and ordering supplies. Professional billers do the billing and she does not supervise them, although on occasion she assists with billing. She does not do the coding; others do it. She did not remember if Dr. Maron ever checked the codes. She had no role in filling out applications for insurance compensation. She does not do payroll.

She frequently passed the surgical suite, where she would see Dr. Maron and two assistants. She noted a pulse oximeter on the patient's finger and a blood-pressure cuff on the patient.

With regard to the "altered" consent form for T.B., when the complaint came in, the records and X-rays were requested. T.B. was not Dr. Maron's patient. What they had, they sent to the Board. Then a subpoena came to Dr. Taylor, who took the chart, looked through it, wrote a few things, made copies, and sent it to Board.

Schwab is not the owner of Perfect Smile, nor does she own other dental offices. She is not a dentist. She was a dental assistant (but not in New Jersey), and never

owned a dental practice. She did not write a printout from the internet about the practice.

Perfect Smile had been owned by Dr. Maron. He had an office at 540 44th Avenue in Brooklyn, but he sold it months ago. He had also sold his office at 1976 Second Ave in Manhattan more than two years previously.

Schwab denied any financial interest in Perfect Smile or the other dental offices. She is paid with a salary. Although a sign in the parking lot of Perfect Smile designated her as vice president, the man who made the sign told her to put her name on the sign with that title, and Dr. Maron knew nothing about it. When he was working there, the sign was not there. She denied that the sign had been up for eight or nine years. She did not remember if Dr. Maron had ever told her to take it down.

Dr. Andrew Maron testified that he attended the New York University College of Dentistry from 1984 to 1988 and did his oral-surgery residency at Hahnemann Hospital from 1988 to 1992. He is not board certified in oral surgery, and presently has no hospital privileges. When he said he had an academic appointment at Brick Hospital from 1996 to 2015, it was a misunderstanding, as that was not a teaching hospital. He had not meant to mislead anyone; he did not know it had to be a teaching hospital to say he had an "academic appointment." He was a member of the AAOMS at one time, but it was too expensive so he gave up the membership years ago, although he did not know if he had done it before 2014.

Dr. Maron said that his curriculum vitae was not correct and needed to be updated. Although it said he was a current private practice owner/oral surgeon of eight group practices, he no longer owned any of those practices.

In 1992, he went into private practice with Dr. Thomas at 30 East 40th St., New York City, and practiced general oral surgery. In 1993, Dr. Thomas relocated to India, and Dr. Maron left the practice and started to do services for large dental practices. Offices would set up oral surgery and keep surgery in their own practice, and Dr. Maron would perform oral surgery there. In 1996, he and Dr. Paul Galante bought a practice,

Shore Points Oral Surgery, in Manasquan, New Jersey, where they performed only oral surgery. They also kept doing their own per diem at other dentists' offices.

He did not recall any complaints ever received from the Board. He found that the practice gave him more time with patients. In 1998, Dr. Galante decided to buy Monmouth Dental Group in Eatontown, which was a large group of dentists who kept oral surgery in-house.

In 2000, Dr. Maron was working at American Dental in Secaucus, and he and Dr. Galante then bought that practice. In 2006, Dr. Mark Weber asked if Dr. Maron would come in and do oral surgery at Perfect Smile; Dr. Maron and his partner Dr. Richard Palmer bought Perfect Smile in 2007.

He was also the sole owner or partner in CompCare 2000/Monmouth Dental Group in Eatontown, CompCare 2000/The Apprehensive Patient in Secaucus, Gentle Dental of Red Bank (Perfect Smile), and Dowling Oral & Maxillofacial in Woodland Park. He worked at The Apprehensive Patient in Eatontown, Shrewsbury, Union, and Clifton; Poller Dental Group in Clifton; American Dental Center in West Long Branch; Amalgamated Dental Center in Union; and Bordia Dental Associates in Freehold. CompCare 2000 went out of business in 2016; Gentle Dental was sold to Dr. Frederick; and his interest in The Apprehensive Patient in Eatontown and Union never matured.

At one point, he owned Brooklyn Fourth Avenue Dental with a partner, Christopher Park; Shore Points Oral Surgery; Monmouth Dental Group; and American Dental, and was a per-diem dentist in the Bronx until 2004 or 2005. In 2005, Dr. Galante and Dr. Maron had separated their interests: Dr. Galante kept Shore Points and Dr. Maron kept Monmouth Dental Group and American Dental.

Dr. Maron has now divested himself of all the practices he owned, and the rest were sold or dissolved. Perfect Smile is now owned by Dr. Frederick. Dr. Maron stopped practicing dentistry in New Jersey in 2014 and participated in the Board's hearing in September or October of that year. He worked for about a year afterward, then entered into a consent order for the suspension.

He has a 100 percent ownership interest in one office in Brooklyn, at Georgetown Dental Spa, and gets a monthly stipend of $1,500. The rest goes to running the practice.

Dr. Maron has no hospital affiliation. He did have a general-anesthesia permit once he started working in New Jersey (1993 to 2015). His last license permitted him to administer general anesthesia, and was valid from October 18, 2013, to October 31, 2015. That license had been issued in error when the department changed computer programs, but he did not use the license between 2013 and 2015, as he chose not to continue to give general anesthesia in office because it could create problems and could lead to serious concerns. He chose to use a more peri-conscious sedation effect: the patient is maintained semi-consciously and is comfortable. His feelings on administering general anesthesia started to change in 2009. With antegrade anesthesia, patients had a sketchy memory of events or none at all. Versed gave this effect: patients did not remember what happened during surgery.

Dr. Maron described his sedation process as:

- Reviewing the medical history with the patient;
- Having a conversation with the patient—going over their body systems (gastric, cardiac, etc.), medications, and drug allergies;
- Creating an ASA (anesthesia classification) for each patient as to how much anesthesia they could handle;
- Discussing with patients the local anesthesia, such as Novocain or intravenous; and
- Reducing anxiety.

He would use the pulse oximeter and take blood-pressure readings, and then place an indwelling butterfly. Some MD's place fluids and have IV drips, but the majority do not. The catheter stayed there the whole time to administer medications and in case of emergency.

Dr. Maron would give 5 mg of Versed, 3 ccs in the syringe, and then look for clinical signs of sedation. The most common are the vernal signs (pupils dart back and forth, eyelids are at half-mast, and speech is slurred). He would then administer three more ccs, and then in a minute or two he would see the sedative state in the patient.

The catheter would remain in place, and he would give more sedation during the procedure. Although most procedures took twenty-five to thirty minutes, some were longer. When the procedure ended, he would take a final blood-pressure reading, then the patient would go to recovery and discharge. All along, one assistant would support and control the patient's head and another one would assist in the surgery.

He had thirty years of clinical experience, and he could titrate medications to get the desired effect. He would convert pounds to kilograms to determine the sedation: it was based on sex, age, weight, and other medications the patient might be taking. For example, tolerance may have been built up if the patient had been taking benzodiazepines, and the patient could need a lot more medication to get the anesthetic effect. He would customize for each patient and look for those signs to bring the patient into sedation. He always had an indwelling catheter, and would titrate more medication during a procedure.

Dr. Maron understood the concerns of the State Board and admitted that his records were bad. Dr. Maron admitted he was a horrible note taker and did not include all this sedation information in his patient records. He only put down essentials. He did not put down everything he should have, and he was remiss in doing this. He agreed it limited the ability of his colleagues to see what he had done, and he could see why his colleagues were alarmed. He now understands that record keeping is as important as any procedure he performs. His records reflected nothing he had done, and his conversations with patients were not documented. He drew pictures for his patients.

He has had the opportunity to work for two years in a practice in New York with Dr. Bodie. Everything is computer based, with a template that included patient medications, patient monitoring, and the creation of a comprehensive record. They have internal mechanisms to keep good records. He has also taken continuing-education courses in ethics and avoiding malpractice.

Dr. Maron had concerns about the way he ran his practice between 2010 and 2015:

- It was not conducive to who he was as a doctor;
- He would not repeat how he ran his career for twenty to twenty-five years;
- He understood the need to be with the patient from beginning to end;
- He did not create an environment where he could be on top of everything;
- He relied on other dentists, some good, some not—this was a mistake;
- He did not always do what was best for patients;
- He relied on his previous attorney, and was not prepared for the Board hearing, and had no command of the circumstances placing fault with him;
- He always minimized the effect of good record keeping, especially with patients with difficulties.

Dr. Maron understands why his colleagues at the Board were alarmed by his responses to questions about his patients. For example, he explained Versed to the Board the same way he explained it to his patients, with words such as “put to sleep.” He used “IV push,” but he meant the drug would be given by a syringe. Because of lack of documentation about blood pressure and pulse readings and the total amount of the sedative used, it sounded like the sedative was put in all at once with one injection, rather than over time. He gave the sedative amount as a total, not the smaller amounts injected over time that added up to that total.

Dr. Maron is confident in his work and has self-esteem, but he was intimidated and afraid before the Board, and believed he did not come off well. He has performed

800 to 1,000 implants per year for twenty years. He went to multiple office locations, and he performed 7,500–10,000 extractions per year for thirty years. He saw about 75 to 100 patients per week, working six to seven days per week.

As far as implants are concerned, the failure rate is about three percent. Implants work because they are bio-compatible, and the body does not reject them because as the bone repairs itself, it locks the implant into the bone. Implants are placed by the orthopedic surgeon and then the regular dentist provides any further care. Sometimes implants can become problematic, but they are safe to place in the body.

Billing

Dr. Maron had nothing to do with fees, as patients were billed in the name of the office. He received fifty percent of the compensation after the insurance company paid the office. Dr. Maron was aware that the Board rule prohibits fee-splitting (N.J.A.C. 13:30-8.13). When questioned as to whether he had read the Board rules and was aware that they provided that the patient's records must include documentation of the patient's current medical history, Dr. Maron did not agree. He did not have the records of the patients and did not know if some or all of them were current. All of his records did not include documented diagnoses or dental treatment plans, although some offices did include treatment plans. Dr. Maron agreed he was a horrible record keeper. He did not keep patient options, treatment plans, etc., which were all missing from his records.

Application for UnitedHealthcare

Dr. Maron did work as an independent contractor at Amalgamated in Union and Amazing Smiles and American Dental. An application for provider privileges would facilitate those offices letting him work. Dr. Maron said he was a provider with UnitedHealthcare. The application was filled out, but Dr. Maron did not know why, as it was filed without his knowledge and it was not his signature. He was already participating with that insurance company. Some insurance companies mandate that a dentist must be a provider so the patients can be seen, but some companies do not

mandate participating in the plan. It is not always desirable to be a provider because then the dentist is locked into their fee structure.

Dr. Maron reviewed the patients who were the subjects of the complaints:

Count 2, Patient J.B.

Dr. Maron met J.B. in December 2010 at The Apprehensive Patient in Union, New Jersey, where he was a per-diem oral surgeon. J.B. came in for an extraction under local anesthetic, and he removed tooth #4, as it was non-salvageable. J.B. reviewed her medical history and her body systems (gastric, cardiac, etc.), and said she was taking no medications and had no allergies.

The extraction went well, as there was always a chance a tooth could break. She signed the consent form and he went over treatment options—from doing nothing, to a bridge, to an implant. He did nothing that day but remove the tooth. She thought there was a piece left behind, but it was just a protruding piece of tissue, nothing remarkable.

Dr. Maron next met her in June. She wanted to discuss implants and was missing teeth ## 3 and 4. He went through her history. She was knowledgeable about implants, having previously seen Dr. Gold, who said tooth #3 had bone loss and bone atrophy. The sinus in that area begins to enlarge, and tooth #3 did not have an adequate amount of bone. J.B. said Dr. Gold was too expensive and she wanted a fee she could handle.

Dr. Maron went over this with her. He had recently trained with an oral surgeon in Miami to do a one-stage procedure where the bone is grafted at the time of the implant. It was less expensive, it saved time, and it took less than a year for the entire process.

Dr. Maron said that Dr. Kleiman described the sinus eloquently. The surgeon goes through the bone, teases up membrane, puts the implant through, packs the bone

around it, and lets it heal. Then it would be a one-step sinus-lift implant. Dr. Maron was going to attempt this procedure. He took a Panorex, but he was not the custodian of these records. Dr. Maron told J.B. that if he could not get stabilization, he would abort the procedure. The upper jaw is porous, like a sponge. He would go and raise membrane and see if he could do it in one step. She consented, and he proceeded to do the surgery.

The first part of the implant went in without any problem. Then he performed the sinus-lift procedure. The entire procedure took thirty minutes.

After the procedure was done, he wanted to see if the implant was stable and vertical, so he took a Panorex. The first post-op Panorex showed that the implant was still vertical. J.B. had no complaints and was discharged. He did not want her to blow her nose, as the bone graft can be blown into the cheek. She was told to resist creating internal pressure.

Although J.B. said no bone was placed, he did place bone, but not the type he prefers. It was synthetic, not cadaver bone. The records of the surgery did not show a bone-graft sticker. Dr. Maron said the fault was his, as his record keeping was below par. His mistake was delegating and not following up. The stickers are important, because they can have a bad batch, and companies want documentation in case of problems or intervention. If the implant failed, he would replace it free of charge, and the companies wanted that failed implant back to see what had happened.

He told J.B. to come back in a week, but the chart said two weeks. Dr. Maron was not sure whose error this was.

J.B. returned on July 31, 2011. Everything looked good, and the second post-operative X-ray showed the implant in the same position. Dr. Maron did not remember complaints of pain or discomfort. An implant should not cause pain or problems.

He did not charge for each Panorex because the fee was comprehensive.

On October 4, 2011, Dr. Maron first became aware of J.B.'s problems when the office manager called to say the implant was in her sinus. This was alarming, but was not an emergency. He told her he could see her on October 8 and would take care of it by retrieving the implant and suturing the hole. Instead, J.B. went to another oral surgeon, and he did what Dr. Maron could have done.

Dr. Maron was sorry the procedure did not work out. He did not want to disadvantage her. He did not know why the implant failed. It could not be done in one step and was not as stable as he had hoped. It was probably lack of adequate stabilization that he had thought he had.

Dr. Maron responded to the concern expressed by both Dr. Kleiman and Dr. Feldman that no bone was found in the sinus, but the sinus is a strong filter. Cilia push debris into the nose or down the throat, and it could have drained. J.B. had complained of post-nasal drip and a bad taste in her mouth, and this may have been that. The material could have been cleared through the sinus.

Count 3, Patient M.K.

M.K. was originally treated at The Apprehensive Patient, owned by Dr. Poller. Tooth #31 on the lower right had an infection, and she was also missing her lower-left and lower-right first molars. They discussed a treatment plan. He would remove #31 and place bone-graft material in preparation for implants located at ## 19 and 30, and then #31. They discussed risks and costs; she was not a candidate for bridgework.

M.K. said the fees were too expensive and she left. She then went to another practice in Monmouth where Dr. Maron also practiced. He called her to tell her he had just opened Dowling Dental in Woodland Park, New Jersey, and told her he would do the surgery at a reduced rate. He would do the implants for $3,000, and the general dentist would do the restorative work.

Dr. Maron and M.K. discussed payment. The office used Springstone Company, which provided credit at a lower interest rate. For a certain period of time the patient

would not be charged interest, then interest commences. This made treatment affordable for M.K.

M.K. spoke with someone in the dental office and gave her financial information (salary, Social Security number), which was called into Springstone. She was approved for credit for the fee. Springstone took ten percent of the fee, $3,000, from the payment and gave the dentist $2,700. The salary amount put down would have little impact on the granting of credit, and it may have been a misunderstanding of what she said her salary was.

M.K.'s boyfriend drove her up to Dowling Dental, which was a boutique office with three chairs. Dr. Maron took her medical history, started an IV, and gave her Versed. The pre-operative Panorex had been taken at The Apprehensive Patient in Shrewsbury. He viewed the Panorex original and duplicate before the procedure and was quite familiar with M.K.'s mouth. He had all of M.K.'s records with him in Red Bank, but they had had a flood and all these records were destroyed beyond recognition.

Dr. Maron gave her Versed and everything went well. A post-op X-ray was taken, and they discussed implant placement. Implants should be parallel to adjacent teeth and the abutments are angled. They correct for angle abutments; one was parallel, but one was off by ten degrees.

The office was small, and it was only six feet to the waiting room. Everyone could see M.K. after the procedure. She was brought from the rear to sit on a couch. A receptionist was looking after her, and her boyfriend was asked to get their vehicle. M.K. was deemed ready for discharge. Dr. Maron and the boyfriend walked M.K. to the vehicle. The office manager and Dr. Maron called her later to check on her. She had secondary amnesia and no issues. She was groggy but expressed no concerns. Dr. Maron saw her two days later and she complained of pain. She lived in South Jersey, and he was affiliated with four practices in Central Jersey.

The first time she had an issue, she went to the emergency room. Dr. Maron saw her and told her she had just had surgery. She was calling all the time. He was

trying to assuage her issues. He removed the infected tooth and placed two implants. She was told it was not usual for pain to last for seven to ten days. M.K. was very nervous, and had Dr. Maron's personal cell-phone number. She was also seen by both Dr. Taylor and Dr. Maron at Perfect Smile a couple of times.

Dr. Maron told her to come back in another week and they would go through her treatment options. He wanted to see if they could get her over the acute phase. If there were no resolution, the remaining option was to remove the implants.

By December 28, M.K. had no resolution of her complaints. She was uncomfortable. Dr. Maron said he would numb her and make the incision and inspect. He then took X-rays and a Panorex. Dr. Maron said she signed a consent for the procedure. He looked at the implants and saw lots of granulation and tissue around them. He told her he was going to take out the tooth and the bone graft because he needed to give her psychological relief. He would put in bone and quiet things down in her mouth. And once she healed from those procedures, he would replace the implants. He advised M.K. that he was going away to see his children in Israel, and that he could be reached in Israel.

M.K. said there was blood all over, and Dr. Maron agreed that there must have been some blood, as this was surgery. She never returned. She went to another surgeon, who told her no implants, and M.K. said she was surprised, but Dr. Maron would have replaced them for free. He gives a ten-year guarantee on implants, and the practices did the restorative care.

M.K. wanted $3,000 back, but Dr. Maron had only received $2,700, as he had taken out the tooth and done the bone grafting. The office returned $1,500 to her.

Count 4, M.T.

M.T. was a patient at Perfect Smile. Perfect Smile accepted Medicare (for medically related expenses for those over age sixty-five) and Medicaid (income-tested coverage for basic dental requirements, labs not covered). When someone wanted a

service not covered by Medicare or Medicaid, the procedure was to submit the service to the insurer to see if it would be covered. If the service were declined, the patient could pay for it privately. The doctor must evaluate what the patient is saying. Once the treatment plan is presented, the patient can apply for financing if he or she wants to go forward. Dr. Maron had no discussions with M.T. regarding payment.

Dr. Mitgang worked at a Perfect Smile and formulated a treatment plan with M.T. for a fixed bridge maintained by implants. Dr. Maron was called in to place implants. M.T. was elderly but was in possession of her faculties. M.T. had previously had work done outside Medicare or Medicaid; she had used credit for crowns.

Dr. Maron placed four implants in M.T.'s lower jaw, although Kleiman thought two would have been sufficient. Dr. Mitgang suggested mini implants, where there is less bone width, not vertical. M.T. had good bone, so Dr. Maron elected to go with regular implants. Dr. Maron chose four rather than two, as they were a "go-direct" implant. Lower dentures are difficult to retain; seventy-five percent of older people give up. M.T. had an atrophic ridge, her bone has melted away, and she could not retain an alveolar plate. The lower denture had twelve teeth and Dr. Maron felt that only two implants could not have held the denture. Four would form a more stable base.

Dr. Maron was able to put the four implants in that day, and they were screwed in tight. Dr. Mitgang could have a denture ready that day. M.T. went back to Dr. Mitgang, and Dr. Maron did not continue treatment. Dr. Maron left the practice that day, and M.T. was with Dr. Mitgang, and that was all that he did.

M.T. came back sometime later and said the dentures did not fit. Dr. Maron held himself responsible because things went wrong, but it was not his fault. Dr. Mitgang put in a hard-cure acrylic. It gets hard in the denture, and it hard-cured in M.T.'s mouth. It lodged into undercuts in the implants and could not be removed.

Implants need stress relief because there is tremendous torque on them when glued in. It sets up problems: food accumulates; hygiene is bad; and the tissue affects the bone and then the implants.

When M.T. returned, Dr. Mitgang cut out half the denture and left half in. That was the last straw on the implants and they failed. A colleague called Dr. Maron and told him how M.T. had presented. Dr. Maron tried to get her back as a patient, but he had no contact with her. At that point, M.T.'s niece said, "enough." Dr. Maron never had a chance to do anything about this horrible situation. Dr. Maron never met the niece and never talked to her on the phone.

After this happened, Dr. Maron reviewed the records. He saw that one crown was double billed, and $4,500 was refunded to M.T., and then $31,500 also refunded. Dr. Mitgang made crowns on those teeth because M.T. wanted to save the teeth. She had been billed for other crowns, but they were never done.

This matter went horribly wrong, and it was Dr. Maron's responsibility because Dr. Mitgang was employed by him.

Count 5, Patient F.D.

F.D. was a patient at Perfect Smile, and she filed a complaint about taking a line of credit for dental work. In 2009 she wanted implants, and she applied for credit after being advised that Medicare and Medicaid did not pay.

On April 15, 2010, Dr. Maron met F.D. at the request of the general dentist. They went over her medical history. F.D. said she was on Plavix and aspirin. He reviewed the December 7, 2009, Panorex. Even though he went over this information, her medical form should have been updated in writing and he should have obtained a written medical history. She needed four teeth removed and was considering a flexy partial denture where the clasp flexes and it is light and cosmetic. They discussed dentures and implants.

Dr. Maron removed four teeth ## 23–26. It was much easier to remove those four teeth because of the effect on bone. She said she came in to get one tooth removed. She returned on May 7, 2010, and had no complaint about bleeding. He

placed two implants, and F.D. made no reference to bleeding. He found out later that she was not clotting and that she had gone to the hospital, but had received no treatment.

Dr. Maron sent a letter to F.D.'s cardiologist after she said she was on Coumadin. The cardiologist did not mention Coumadin and did not recommend stopping any blood clot. Sometimes it is more appropriate to leave the patient on blood thinners and treat the bleeding locally.

F.D.'s work was completed. Her complaint was written by her caretaker, and she remained a patient until she died. And she made no complaints.

Count 6, Patient N.C.

Dr. Maron treated N.C. at American Dental Center on August 1, 2014, to remove tooth #4. He introduced himself, discussed the procedure, and reviewed N.C.'s medical history and a Panorex. They discussed risks such as numbness, etc., and she opted for a local anesthetic. He did not go over some aspects of care, as they were not relevant to her case. This was a difficult extraction; the inner tissue had been removed. These teeth are difficult to remove, and the extraction requires pressure. He removed a piece of buckle bone, so he could remove the root. Dr. Maron used forceps, and the tooth fractured. He had told N.S. the procedure would be difficult. He gave her no pain medication before, but Vicodin later. The procedure was covered by Medicaid.

Dr. Maron's son had been present in the office that day because Dr. Maron had no childcare for him. The office has 800 square feet, the child was sitting at a desk, and the operatory was open. The child did not interfere with the procedure. But Dr. Maron's assistant dropped the suction and the child ran in to pick it up. The assistant admonished him.

Dr. Maron said he did not write a prescription in another dentist's name; it is not in his handwriting, nor is it his signature. The dosage is not right, nor is the date. N.C. had also seen another dentist that day who could have written the prescription.

Count 7, Patient J.K.

On May 14, 2012, J.K. was referred to Dr. Maron by Dr. Taylor to extract ten upper teeth. The plan was to put in four implants, plus two on the bottom to hold the dentures. The plan was discussed with Dr. Taylor, as patients hate the acrylic palate; it can cause a lisp and affect the tongue and cause gagging on the soft palate. Having the implants is more comfortable for patients.

An X-ray was taken post-op and the implants looked fine. Dr. Taylor put in immediate dentures, which had been constructed in advance, so the patient can have the teeth out and implants placed with temporary dentures until the rest of the work can be done.

There was a problem with the #3 implant. The X-ray showed that tooth #3 had displaced into the sinus. Dr. Maron retrieved the implant from the sinus and closed it back up.

As far as the prescriptions, the prescription pad said Dr. Taylor, and showed his handwriting. Dr. Taylor would have been the last person the patient would have seen; it was not Dr. Maron's signature or handwriting. J.K. was Dr. Taylor's patient.

Count 8, Patient M.H.

M.H. was treated in 2007. She had implants holding an upper denture and wanted something that was fixed. They discussed two more implants on teeth ## 4 and 13 and on the lower jaw, leading to fixed bridgework on top and bottom to create as natural a product as can be provided.

On ## 4 and 13, parts of the implants extended into the sinuses. Dr. Maron said if the implants were engaged in bone, bone could grow around them. An increase in radiodensity can be seen around implants. If the implant in the sinus were stable, this would not be a problem.

The fee of $750 that she complained about was returned to her.

Count 9, Patient R.P.

R.P. had no posterior teeth on the lower left side of her mouth. Dr. Maron and she discussed options of doing a partial denture, or doing nothing. He drew a picture for her and suggested removing #21 and putting implants in ## 21 and 19, so that he then could make a three-unit bridge. R.P. agreed and got financing for the expense.

Subsequently, one implant failed quickly, and the other failed and was restored, but it ultimately failed too. Dr. Maron did not find out about this until later. He did not want to work with a doctor at the office R.P. had visited. At some point, R.P. came to the Red Bank office, although the other dentist had told her not to. When she came in, he took out the implant. Implants can fail for many reasons and not integrate into bone. There is a ninety-five percent success rate, but some just fail.

After the implant failed, Dr. Maron told her he would do it for free or refund her money. She was refunded the total of $8,000 (representing his portion and that of the other office).

Count 10, Patient A.P.

On September 27, 2013, Dr. Maron saw A.P. at American Dental Center to place implants in her upper jaw, as she wanted fixed bridgework. They discussed the risks, such as with the sinus or with implant failure, during the examination. If critical implants failed, the time for treatment might be extended. They agreed on the treatment plan, which was to place four implants in each upper side, so she could have a fixed bridge on either side. This procedure would be one to one and a half hours long, and the office had made arrangements for the cost.

Dr. Maron noted nothing unusual about A.P.'s medical history. She was taking Klonopin, but she had not taken it the day of the procedure. She had been taking a

benzodiazepine for a long time, which can affect sedation. A.P. was attached to a pulse oximeter and a blood-pressure machine.

Dr. Maron agreed that his record keeping was below standard. The records said he gave "Versed 7 push, 7 push." He said he gave 5 mg and saw some effects (the vernal signs), and then gave her 2.5 mg more. She weighed about 70 kg. He checked the sedative process throughout and she was never incoherent. He thought two assistants were present and that he was never alone with the patient.

When he had the desired level of sedation, he delivered another 7.5 mg to keep her under using an indwelling catheter, but he had not explained this well to the Board and gave a poor presentation at the Board hearing. He had spoken about "sleeping" and "pushing drugs," and not about "titrating" them.

A.P. was scheduled for follow-up, but she was hospitalized for a long time thereafter, which was totally unrelated to the dental work. He subsequently saw her, and the implants were fine for restoration. She was a nice woman and never complained about the work. He called the practice, but she never came back to them. They owed her $6,000–7,000, which was never claimed.

Count 11, Patient T.B.

T.B. was a patient of Perfect Smile in Red Bank. Dr. Maron never saw T.B. He only saw his records after the Board action and was trying to understand why there were discrepancies on the Board form. He could not figure out how this had happened. Maybe T.B. came in one day, and then on another? The only thing Dr. Maron could conclude is that the chart was altered when it was sent in. He accepts responsibility that someone altered the consent form. But he said that he never saw T.B.'s chart, and that Dr. Taylor may have altered the form after the Board's two requests for the information.

Count 12, Patient A.A.

A.A. came in for veneer work, which takes time. Medicaid and Medicare do not pay for this treatment. When patients asked for veneers, the office policy was for them to sign an acknowledgement that Medicaid and Medicare would not pay. Dr. Maron did not discuss the financing with the patient. He did not discuss his work plan with A.A., as she was Dr. Mitgang's patient.

Dr. Maron met A.A. on February 5, 2010, for a tooth extraction. He told her that the extraction was covered by Medicaid or Medicare, but neither the implant nor the crown would be. He examined her and reviewed her medical history. She consented to the tooth removal and he took a post-operative X-ray. She received an implant with no problem, and she had no problem with the veneers. In a letter, A.A. said she was happy with the treatment.

Count 13, Patient E.D.

Dr. Maron described this as a "sad case." On November 18, 2011, he saw E.D., a woman in her late forties or fifties, who said she wanted implants. The plan was to remove the maxillary teeth and place a denture. He removed the teeth and placed the implants. When he examined her mouth that day, he saw nothing unusual. Dr. Maron thought Dr. Taylor saw her that day, too.

Impressions were taken so a temporary denture could be made. He did not give her prescriptions, but Dr. Taylor may have. E.D. returned for numerous visits, and would have seen Dr. Taylor over months and years. In reviewing the chart, Dr. Maron noted that E.D. was not comfortable with Dr. Taylor's denture. No other doctors noted a complaint about pain in the tongue.

On June 14, 2013, the office asked her to schedule an appointment, and she never complained about a lesion on her tongue. Two independent doctors also made no comments about E.D. having pain in her tongue. They referred her to him, but she never returned. She was seeing another dentist, and it turned out that she had tongue

cancer. She had a lesion on her tongue that was resectioned, and she is now disease free.

Count 14, Patient C.S.

C.S. was eighty-six years old, and was seen by Dr. Maron on October 23, 2008, for extraction of tooth #14. She was bruised after the extraction, caused by capillary fragility and loss of connective tissues. The bleeding may have pooled into the cheeks or neck area, but it should have gone away on its own. The procedure took thirty minutes. Dr. Maron gave her sedation—intravenous Versed 15 mg through a catheter, given over increments. Two assistants were in the room. He had no conversation with the patient and noted nothing unusual about her medical history. After the extraction, he never saw her again.

Dr. Maron was aware that Dr. Benhamu had ordered a high-noble metal for the crown. There are three types of metal used in crowns: non-precious, semi-precious, and high noble. Dr. Maron did not know if Dr. Benhamu had sent in a prescription for a high-noble metal or if the prescription were for a non-precious metal. It could have been a mistake in communication or a breakdown from the doctor's office, but the price difference is not large; it is about $100.

Count 15, Patient Y.Z.

Y.Z. was originally a patient of Dr. Taylor at Perfect Smile. Dr. Taylor had dental concerns about two crowns, #27 canine and #28 first molar. Y.Z. had been referred to Dr. Maron, who had seen him in 2014. Teeth ## 4 and 5 were non-restorable (#5 was broken to the gum line and #4 had a fracture) and needed to be removed and replaced with implants.

On February 21, 2014, Dr. Maron and Dr. Taylor discussed removal and implants, and both agreed that these teeth should be removed and replaced with implants. Y.Z. and Dr. Maron discussed the options: doing nothing, or placing a removable bridge, a fixed bridge, or an implant. This information is not in Dr. Maron's

records. He agreed that he was a horrible record keeper. He said he discussed options with his patients, but that he did not write this down. He would write down the treatment plan, but not the discussion.

In Y.Z.'s case, the best option was implants. The option of a fixed bridge was not good because the span was too big, and he would have had to grind down the other teeth to support the bridge. When the patient is younger, implants are a more definitive replacement.

They discussed insurance and Dr. Maron said implants were not covered, but bridges were, but they could cost more over a lifetime. Dr. Maron said he went over this with all of his patients. No note in the file describes a conversation with the patient.

Y.Z. wanted implants, but the cost was the issue. Y.Z. paid the deposit on February 28, 2014, the day of surgery. On that day, Dr. Maron reviewed Y.Z.'s medical history, and used a local anesthetic to remove two teeth. Y.Z. had lots of space between his good teeth. Dr. Maron removed two teeth which were spread far apart, but this treatment plan is not in the record; the notes reflected only the bridge.

Y.Z. is still a patient of the office, and his teeth and his bridge with implants are doing well. He paid a reduced amount of money for the work that was done.

Dr. Maron was not aware of problems with the crowns Dr. Taylor had made for Y.Z. Dr. Maron later learned that Dr. Taylor had prepared the crowns for teeth ## 27 and 28. They were billed to the insurance carrier as precious metal, but the laboratory made them from non-precious metal. Higher gold should be more compatible with surrounding tissue.

Dr. Maron agreed that it was his job to note what he did, but it was not his office. He had no knowledge of what was billed. The carrier was billed for general anesthesia, although the operative report said local, but Dr. Maron said it was not his signature. He was responsible for bills in his name, and here they billed for deep sedation. He does not disclaim responsibility.

Y.Z. had insurance, which paid the same for the crowns. There was a mistake here in the billing. When Dr. Maron became aware of it, he looked into it and found that the insurance compensation was the same. In the future, he said he would check each code to be sure it was right.

Y.Z. asked for copies of the records, which were not provided to him. Dr. Maron said he was not aware that records were not produced for Y.Z.

Count 16, Patient S.A., Jr.

S.A., Jr., was a minor who was having four wisdom teeth removed in September 2013. Dr. Maron went to the office to do the work and met with S.A.'s mother, J.S. He went through the issues with J.S., and she signed the consent form.

He took a pre-operative Panorex, and the insurance company approved the removal. He discussed the sedation effects with his patients, so they would know what to expect to feel. That day he used Versed. He liked this drug because it created amnesia from the injection to waking up. He used a pulse oximeter and a heart-rate monitor, and blood pressure was taken manually. He placed the catheter in the vein, and then gave 3 cc (15 mg) as a test dose to see effects. He was looking for vernal signs, like drooping of the lids and nystagmus, and a certain degree of depressed consciousness (relaxed state), to see if he needed to give more.

The case took forty-five minutes to an hour, during which he gave 15 cc of Versed. There were usually two assistants in room; one stabilized the patient's head and one assisted him.

The procedure was stopped when S.A. became playful and flirtatious with the assistant. He was not "out cold," he was always arousable. Patients do not remember the procedure; the sedation has an anterograde anesthetic effect. Plus, Versed is a drug that has an antagonist that can immediately reverse the effect.

Dr. Maron said he gave the drug incrementally, but he was a poor note maker. The dosage also depended on weight, age, etc. The procedure with S.A. went well; he was in recovery until he could walk, and he was alert. It is normal to have pain and swelling after tooth removal. Instructions were given to the mother about swelling and using cold compresses on and off.

Count 17, Patient S.B.

On September 13, 2013, S.B. went to American Dental Group complaining about wisdom teeth on one side of her mouth, but the other side was also bad. All the teeth had decay, and removal of all four wisdom teeth was the treatment plan. She had previously seen another dentist. S.B. was pregnant and Dr. Giovine was her obstetrician. The patient discussed the removal with Dr. Giovine, who advised not to use epinephrine on the patient.

Dr. Maron used a local anesthetic that did contain Novocain. His mistake was not to note what he was doing, and not to call Dr. Giovine before. If injected into an artery, it can cause palpitations, but the anesthetic should go to the nerve. Epinephrine provides a more profound anesthetic effect and precludes the body from releasing its own adrenaline. He aspirates it to make sure the injection did not go into an artery. S.B. had no adverse effect.

A letter had been sent from S.B.'s obstetrician that said she may have Novocain with epinephrine, and Dr. Maron gave her a local with epinephrine. Dr. Maron agreed that there was no discussion of pregnancy gingivitis, nor did the record reflect any clinical findings or a treatment plan. He did not write down what he discussed with the patient. She was complaining of pain, but he put no documentation to that effect in the record, nor did he confer with Dr. Giovine, the obstetrician.

Count 20, Patient G.P.

G.P. had been a patient of Dr. Frederick at Monmouth Dental Group. She saw Dr. Frederick, who said tooth #4 was questionable. He sent her to Dr. Gutentag for a

root-canal group. He also thought that the tooth was not salvageable, and that removal was needed.

G.P. returned to Dr. Frederick, and they discussed an implant after removal. Dr. Maron reviewed G.P.'s records. G.P. signed the consent, and a pre-operative X-ray was taken, which confirmed why the implant was necessary.

Dr. Maron introduced himself and went through the treatment options. He took a pre-operative Panorex. The procedure took longer than a minute. He used lidocaine with epinephrine and waited. Once she was numb, he removed the upper-left first molar. The procedure took four to five minutes.

He then performed a sinus elevation, placed putty bone, then placed the implant and sewed it up. This procedure took about twenty minutes. The Panorex looked fine. The implant was high up in the sinus, which was the proper location. This implant was placed in the palate root because it had the most intense bone. It was a sinus lift and a portion was in the sinus; that was how he wanted it. It could look as if it were in the sinus, but the implant was where he intended it to be.

Dr. Maron saw G.P. on August 21, 2015, and the healing looked good. That was the last time he saw her because of the cease-and-desist order that was entered. All he would have had left to do was to uncover the implant, build a crown abutment, and place the implant.

Dr. Maron became aware that there was controversy about this implant. Other practitioners took over his work, and one was uncomfortable about where the implant was placed. When atrophic bone is in that area, a sinus lift must be done. The crown-to-root ratio is one to three. The root should be two-thirds imbedded in the bone. Dr. Maron said that it is acceptable to get to fifty-fifty. He had seen this before and the implant was well-integrated. He believed the implant was still there. And there was no extra charge for a custom abutment.

Dr. Maron intended the implant to be partly in the sinus, and he did a sinus lift, but the chart did not indicate that he told G.P. it would be in the sinus. G.P. knew they were adding bone.

Count 21, Patient Mi.K.

Mi.K., a retired man, saw Dr. Frederick first. Mi.K. had no natural teeth. All his teeth were implant-supported bridges, and he was a teeth grinder. The problem was that one implant or abutment was loose. Dr. Maron's concern was that Mi.K. had no teeth in back and his restoration was not stable. His bridge was cantilevered—this creates a rocking motion and causes the bridge to fail.

Mi.K. received two or three posterior implants to give better support, and had a severely atrophic bridge. Any damage to the nerve would not have caused facial problems, because it is a sensory nerve. That nerve was questionable in Mi.K.'s case. Mi.K. knew it was a difficult case: he had previously gone to Tooth Savers in New York City and was aware of possible nerve damage.

The plan for Mi.K. was to do upper implants. Dr. Maron usually did all implants at one time, even twelve or thirteen. But Mi.K. was to be done in two stages, with the bottom first. Dr. Maron divided the work because of the risk to the nerve. That was what was done; implants were placed on the top, and one on the bottom. When he came back for the second bottom implant, Mi.K. did not say he was numb on one side. Dr. Maron saw Mi.K. once after that, because he was getting the other work done by Dr. Frederick.

Later, Mi.K. complained of numbness. Dr. Maron saw the note of Dr. Frederick indicating that the numbness could abate. If Dr. Maron had known about this, he would have removed the implants to relieve the pressure on the nerve. There was no complaint of numbness after the first bottom implant or after the second. When Dr. Maron became aware of the numbness, he removed the implants. There is no documentation in the record to show that he discussed paresthesia with the patient or Dr. Frederick.

Dr. Maron agreed he was ultimately responsible. If he could go back and do it again, his note keeping would be more precise, and he would do a CT scan. This is now a pending malpractice case.

Dr. Maron claimed that he discussed paresthesia with the patient, but he has no documents in the records to prove it.

Dr. Maron used a pulse oximeter and took Mi.K.'s blood pressure, but did not monitor the pressure with an EKG. He was not then aware that this had to be done. The offices had the equipment and the medications. Dr. Maron used surgical stents occasionally but not routinely. (For the Dowling office, Dr. Maron did not remember if he had a branch permit, but believed he usually did.)

When he testified previously, he said he reviewed all systems with the patient and, in his mind, he created the ASA classification, but he never documented it in the file. The ASA gives an idea of morbidity of patients, and risk factors. The purpose of documenting the ASA is to show the doctor's determination. Dr. Maron totally agreed with the allegation that he did not do this, and he should have.

He calculated the sedation dose depending on the patient's weight, but no chart showed the weight of the patient. He did not routinely put in sutures in extractions, as the suture does not join skin and can create inflammation. On routine extractions, pressure is enough. And he did not routinely do follow-ups with patients who had extractions. He usually said, "follow up as needed." In more involved procedures, patients were instructed to follow up, and the front-desk personnel would call patients to check on them. The majority of the time, follow-ups were done by Dr. Maron, but some were done by the general dentist.

Other issues addressed by Dr. Maron:

Dental Records

Dr. Maron does not have some of the Panorexes he took. He always took them pre- and post-operatively to see what his work looked like. If he was not the custodian, then he does not know where the records are. Also, there was a flood at Perfect Smile and records were destroyed. He agreed it is better to have everything on a computer.

Insurance Forms

Dr. Maron did not fill out the forms for his insurance coverage and the signature on the forms is not his. He did fill out other forms where he did indicate that he was under investigation.

Statement of Dr. Maron

Dr. Maron stated that he has learned from this experience that he was hard-working, but also that he did not understand that being an oral surgeon is not just taking out teeth. Things must be made comprehensibly adequate. Although he was a good oral surgeon, he was not good at record keeping. The way he was practicing was not conducive to his personality. He was trying to be a businessman, owner, and surgeon at the same time. He was running around doing more than he could adequately do.

If he can keep his license, he could practice with one person who does administrative work. He would be diligent with record keeping. He wishes he could go back and correct his actions. The only thing he can do is try to move forward. He can be rehabilitated and can work to be productive. He would get professional assistance. He realizes he was under a tremendous amount of stress. His ex-wife had taken their children to Israel, which was traumatic, and he was overwhelmed. He went to a therapist, and is participating in an assistance program for healthcare professionals.

He has taken courses in ethics, avoiding malpractice, record keeping, and computers. He is willing to have oversight and to accept constructive criticism. His hardship over the past three years has been instructive.

EXPERT WITNESS FOR DR. MARON:

Dr. Hamlet Garabedian is an oral and maxillofacial surgeon, practicing since 2005. He is board certified, and has testified as an expert for both petitioners and respondents. Dr. Garabedian was accepted as an expert in oral surgery.

Dr. Garabedian had conversations with Dr. Maron and relied on the complaints made, as well as his review of Dr. Kleiman's report. Dr. Maron had many practices; he was both an employee and an owner. Dr. Garabedian was aware of the kind of practices they were. Dr. Garabedian reviewed the sedation records. He agreed that Dr. Maron's record keeping was fairly poor, and that the records did not show what he was doing. According to Dr. Maron, he would indicate the total sedation dosage. If given as a one-bolus dose, it would be general, and if titrated, it would be lower sedation. Dr. Maron said he titrated.

Dr. Garabedian read Dr. Maron's testimony before the Board. Dr. Maron came across as ill-prepared; his answers made no sense and were not logical. Dr. Maron clearly had not reviewed his records.

Dr. Maron's main problem in this type of practice was to provide quality of care. He had a high volume, both business and medical. He was stretched way too thin running businesses and treating patients. So many issues presented themselves at one given time. Dr. Maron needs close monitoring and refresher courses. He should not be given the same practice situation.

Dr. Garabedian reviewed the patients:

Count 2, Patient J.B.

J.B.'s case involved a sinus lift and an implant. Approximately 3–5 mm of bone is needed to stabilize an implant. A sinus lift can be done in almost every case if no other medical conditions or problems are present. Clinical judgment is needed; the dentist must have knowledge of anatomy, knowledge of the health of the patient, and prior experience. An implant can succeed if only a portion is in the sinus. If an implant is loose or moving, it is a problem, but a partial placement might work.

In December 2010, J.B. went to Dr. Maron at his office in Union for an extraction and was given a consent form, which did not identify the tooth. The chart did not note dosage or number of pills given. J.B. returned and said she felt bone. He pulled back bone and told her it was skin. It is not unheard of to remove bone, but not skin. Dr. Maron told her it was skin, but pulled out more of the tooth; this should have been explained to the patient.

J.B. returned to Dr. Maron on June 23, 2011, and said she was on her lunch hour and wanted a consultation about an implant. She had previously consulted another oral surgeon, who said she would need cadaver bone. J.B. said she would let Dr. Maron know her decision, but he said, "Why wait? I'll do it right now." The procedure took more than an hour. She was given a CareCredit form, she signed a paper, and Dr. Maron started drilling. She said he took no films at all, and this would have been improper.

She said Dr. Maron called out, "Where is bone?" and then said, "Forget it, I don't need it." There is nothing in the record about the bone. Dr. Maron said he asked for specific bone and used material that was not what he asked for, but this was not stated in the patient's chart.

Dr. Garabedian agreed there was no informed consent and no sticker for a bone graft.

J.B. reported pain, throbbing, bad taste, and swelling, and went to another doctor, who referred her to Dr. Corry. He found that the implant of tooth #3 was inverted, and the implant of tooth #4 was inverted and into the sinus. J.B. had acute sinusitis, and no trace bone grafting material was present. Dr. Garabedian agreed this was not correct.

J.B. had to undergo additional expense for an implant and sinus lift, which all would have been unnecessary if the original treatment had been correct. But Dr. Garabedian spoke with Dr. Maron and believed that what Dr. Maron did was correct. J.B.'s problem could have been corrected with surgical removal of the implant.

Count 3, Patient M.K.

M.K. complained of pain and swelling after an extraction, which is common. The maximum degrees of implant should be less than 10–15 degrees of deviation. Some with more degrees can work if abutments were added. Depending on anatomy, the angulation of close teeth can cause issues. Sometimes it is impossible, as the angulation may be too far tilted, but proper abutments may work.

A patient can have prolonged discomfort, but it is not common. A systematic approach is necessary if consistent complaints of pain are present. Once all possibilities are exhausted, removal of the implant is appropriate. Here, it was appropriate to remove M.K.'s implant.

M.K. presented a detailed and long complaint. She first declined treatment because of money; Dr. Maron then contacted her and offered a discount of $3,000 for two implants and free anesthesia, and a credit-company loan. Dr. Garabedian acknowledged he had seen this. M.K. learned that the loan application said her income was $75,000 per year, which was not true. Dr. Garabedian agreed this was not a good thing to do.

M.K. said that she was supposed to get the implants on December 8, 2012. The records included no diagnosis or treatment plan or Panorex or sketch. On the day of her procedure, Dr. Maron put her to sleep. When she woke, she was in the waiting room by herself. Her fiancé found her there, and neither she nor her fiancé saw anyone around. Dr. Garabedian agreed this was not proper post-sedation treatment, if M.K. were recalling the events of the day accurately.

Dr. Garabedian had only the picture of the X-ray that M.K. took with her cell phone available, and did not dispute Dr. Kleiman on the poor angulation based on the X-ray. However, Dr. Garabedian said both implants looked restorable to him, based on the picture from M.K.

M.K. said her face and throat swelled up and she had trouble reaching Dr. Maron, because he was itinerant. Dr. Garabedian saw that, but noted that, unfortunately, the Board allows itinerant practices. Itinerant practice limits good care. Any difficulties were initiated by Dr. Maron's choice in practicing in that manner.

It would not have been appropriate for Dr. Maron to call M.K. a hypochondriac. It also was not conducive to good post-operative care for Dr. Maron to send her to different offices which did not have her records.

On December 20, 2012, M.K. reported a grayish spot on her gums. Dr. Maron told her it was a blood vessel. On December 23, 2012, Dr. Maron told her to go to another office. On December 24, 2012, the gums were painful and bled when touched, which meant they needed to be inspected. Dr. Maron was busy and could not see her, so she went to Dr. Taylor, who said the lumps she complained of were normal.

On December 28, 2012, M.K. saw Dr. Maron and he took an X-ray. He numbed her and told her he was going to pop the lumps on her gums. He used pliers (forceps) and removed the implants. Dr. Garabedian found no consent form in the records. Dr. Maron told her the lumps were from food. It would have been improper if Dr. Maron had failed to disclose an infection. The information should not be misstated to the patient.

There were no stickers to document the bone graft. Both implants were removed. Dr. Maron's notes were equivocal about the bone graft. Dr. Maron did not at first say what he did, then later he did. He said he removed implants put in the bone, but no stickers were found.

In Dr. Maron's testimony, the procedure was in 2012, but his notes were from 2013. No records were produced from Dowling Dental or Perfect Smile. The chart should have been documented.

Count 4, Patient M.T.

M.T. was a ninety-three-year-old woman who received multiple implants in her lower jaw. Her issue was instability of a denture. Implants can stabilize a denture. In her case, two implants would be the minimum, but the more implants, the more stable the denture would be. If one failed, the other three could be used, and the denture would still be stable or capable of restoration.

Although it was not in the records, Dr. Mitgang had placed a denture that had hard-cured over the implant and could not be removed. Everything was affected by this, including the tissue. Dr. Mitgang sectioned the denture in half, which is as bad as it gets. M.T. ended up in Monmouth Medical Center, and that was when Dr. Maron became aware of the problem.

The quality of the X-rays for M.T. is poor. There was some bone loss after the implants. These X-rays were prepared, presumably by Dr. Mitgang's office, after the problems on August 6, 2010. One implant was slightly angulated, there was some bone loss, and there were abutments, but they were of workable quality and could be restored.

Age does play a role. A lot of patients in Dr. Garabedian's practice were in their eighties and nineties and wanted to get implants. Just because a patient was on Medicaid or Medicare was not a reason not to offer them implants, although the cost is

not covered by either plan. Some people on Medicaid do get implants. Although age is not a precluding factor, the doctor must assess the patient's ability to tolerate the procedure.

Dr. Garabedian noticed that most of Dr. Maron's patients who complained were elderly and living in care facilities. Dr. Maron served a population in underserved areas in terms of pricing and fees; his prices were at a substantial discount and lower cost. Many of these patients took out substantial loans to pay for the treatment.

After the implants were placed in M.T.'s mouth, no follow-up was done to be sure the work had gone well. Dr. Maron did not do any follow-up unless a dentist called and asked for it. Dr. Maron was relying on other dentists for follow-up, which was not proper. Follow up is necessary.

Dr. Maron's office double-billed for the overdenture and paid prior to delivery. It may be a second denture, but it is impossible to tell because the records are so bad. The office admitted the double charge and credited M.T. $4,500. Dr. Garabedian agreed, and noted that a doctor is responsible for his office's billing.

M.T. needed much repair work at the clinic. Dr. Garabedian agreed with Dr. Kleiman that mini-implants were more appropriate for M.T. for place and angulation, but those that had been placed were standard size. Dr. Garabedian was not in full agreement with Dr. Kleiman that Dr. Maron should have known they were inappropriate.

In reviewing M.T.'s CT scan of August 23, 2010, the implants looked acceptable. Dr. Garabedian did not agree with Dr. Kleiman that the implants were faulty. He has seen worse implants that were successfully restored.

Dr. Garabedian said he could neither agree nor disagree, based on the information before him, that the CT scan showed that two of the implants were perforating bone on the lingual side. He needed to see the actual CD of the scan.

Dr. Garabedian did see that the maximum dentation was not enough to support the bridgework. Here, Dr. Maron was blaming Dr. Mitgang, but it is proper for the restorative dentist to consult with the oral surgeon. The records contained no notes that Dr. Maron had consulted with Dr. Mitgang, or that any treatment planning had occurred before the procedure.

Count 5, Patient F.D.

F.D. is an eighty-four-year-old woman who underwent four extractions and immediate implants on April 15, 2010. Dr. Maron's chart and record keeping were not good. There was a note about Plavix and aspirin. The patient had not complained of a bleeding problem prior to surgery. If a patient had a problem with bleeding, this could cause excessive bleeding after extractions. If a patient is on Coumadin, the latest thinking is not to stop the Coumadin or anti-coagulant. Anti-coagulency can be measured, and the international normalized ratio should be checked within one day of surgery. The thinking is that bleeding is easier to deal with than a thrombotic event.

The patient said that Dr. Maron extracted multiple teeth and put three needles in her gums. They knew she was on Coumadin. A female staff member helped her sign a paper, and then she was put to sleep. When she awoke she was bleeding, and then realized four teeth had been removed instead of one.

Dr. Garabedian had a consent form for an extraction on April 19, 2010, signed by Sandra Moon, and with no tooth number indicated. This is improper. No office visit was charted for April 19, 2010, for the patient. No current medical history of the patient had been taken since 2006. The medical history up to 2006 indicated a mini-stroke in 2004, and kidney and glaucoma issues in 2006. Nothing was recorded by Dr. Maron as to her medications. No pre-operative consultation with the doctor prescribing Coumadin was noted in the record. It is a good idea to have a medical consultation with the treating physician, and there was no documentation that it had been done here. And there was nothing in the chart to indicate that Dr. Maron had had a consultation with a restorative dentist.

F.D. reported that she had asked Dr. Maron why four teeth were removed, and he was rude to her, and said they were loose, and walked out. This would be improper. F.D. said she was pressured to accept implants. Dr. Garabedian said that it is important that the patient and the doctor agree about the treatment.

Count 6, Patient N.C.

This was a complex and difficult extraction of tooth #4 because of a prior root canal. N.C. said that on August 1, 2014, she had had to explain that she had an appointment, and was told to sign a consent form for oral surgery and anesthesia before she met the doctor. Often the patient is given a form to read, but as far as Dr. Garabedian can tell, this did not happen. No treatment plan was present.

A man came in to the treatment room accompanied by a boy, introduced himself, and told the boy what he was doing. The records provided no evidence of a discussion with N.C. N.C. said the dentist came back with pliers and injected her some more; the boy picked up something the doctor had dropped; and the doctor removed the tooth. Dr. Garabedian agreed that this was all unprofessional, if it occurred.

N.C. was handed a prescription by an assistant, and Dr. Maron's name was not listed as the prescriber. The prescription given to the patient for twenty tablets (5/300 strength) had only the name and date and looked like carbon paper. The treatment chart had no indication that this patient had been seen by any other doctor.

N.C. reported that after she left the office, when she breathed through her nose, air came up through the space where her tooth had been. Dr. Garabedian thought this observation could be subjective.

Dr. Kleiman says this appeared to be a difficult extraction, as more needed to be done to get the tooth out. Dr. Kleiman had found no fault with the treatment itself, and Dr. Garabedian agreed.

Count 7, Patient J.K.

J.K. is a sixty-four-year-old man who had several implants placed, but one implant displaced into the maxillary sinus. This is not uncommon. Dr. Garabedian would remove such an implant, and, eventually, J.K.'s implant was removed by Dr. Maron.

J.K. had several chronic conditions, including illnesses, smoking, diabetes, and back problems. On May 14, 2012, he had ten teeth extracted, and implants placed on teeth ## 4, 12 and 22. The treatment was financed with a CareCredit loan. The record contained no documentation of consultation with J.K.'s physician, even given his medical history. No consent form was in the file; neither a CT scan nor a surgical guide was done.

The patient's chart from May 16, 2013, noted that J.K. had pain at #22, and the tooth should be removed by Dr. Maron. Although the patient said he tried to speak with Dr. Maron, there is no record that Dr. Maron spoke with him. Tooth #4 was in a horizontal position and in the sinus. Dr. Maron did not arrange for treatment, even after the patient complained of pain. Dr. Maron said Dr. Taylor saw him; Dr. Maron did not see J.K. for a follow-up. J.K. did not learn until June 2014 that one implant had fallen out and that one was in his sinus. This was also improper.

Count 8, Patient M.H.

M.H. was a seventy-four-year-old female who saw Dr. Maron over a five-year period, ending up with Dr. DiCesare. The X-ray may seem to show a portion of the implant in the sinus, but it may be fully encased in bone. A portion of an implant could be in the sinus without a problem. M.H.'s problem could have been handled by Dr. Maron.

M.H. reported that on December 11, 2009, Dr. Maron extracted teeth ## 28 and 29 and placed implants. No consent form was in the records, nor was there any

consent for the procedure in January 2008 on teeth ## 4, 5, and 13. No treatment plan was in the file.

On June 14, 2010, tooth #31 was extracted. In August 2010 teeth ## 22, 23, 24, 25, 26, and 27 were extracted. Teeth ## 22 and 27 received implants. Dr. Maron's employee said there was also an implant in #5, but there was nothing in the record about that treatment. In February 2011, tooth #18 was extracted and an implant placed. On March 3, 2014, the patient complained of pain at tooth #19. It looked like tooth #18 was re-extracted and replaced. The notes from March 3 are Dr. Taylor's notes; the notes from March 14 are Dr. Maron's notes. There is confusion regarding these two notes. It was possible that a tooth was misnumbered, which can happen from time to time. It was a careless mistake.

Each implant had a different size, and no explanation was provided. The patient was uncomfortable. A Panorex from July 25, 2011, was viewed and it revealed that teeth ## 5 and 13 extended into the maxillary sinus, but there was no acknowledgement of this in Dr. Maron's notes.

Dr. Garabedian agreed that the patient should not have to pay the balance without the work being completed. Here, the patient went to Dr. DiCesare, who found problems. Dr. Garabedian agreed that the patient was being asked to pay for a situation that was never corrected.

Count 9, Patient R.P.

Dr. Garabedian reviewed the records of R.P., who was fifty-eight years old. At the time of treatment Dr. Maron was a per-diem dentist at Amalgamated Dental Center. He and Dr. Weber, who also worked at Amalgamated Dental, had personal issues between them. Here, the problem involved treatment and planning for implants on teeth ## 19 and 21.

Some implants do fail; there is a 5–10% long-term failure rate. It is less common within the first six months. If the implant has clearly failed, it must be removed. Most practices would refund full or partial cost, or redo it.

R.P. said she had an appointment to have one tooth extracted. She said that Dr. Maron gave her injections to numb her mouth, and that she was pressed to get implants. Dr. Garabedian agreed this would be improper. R.P. said that Dr. Maron said "everyone" was getting implants, that he discouraged her from a flexi-partial denture, and that he said he had to know before he pulled the tooth. He took no X-rays; there was no consent or treatment plan; and there was no consultation or surgical guide. He wore her down, and she could not afford the cost. The business manager came in and qualified her for a loan, all within twenty minutes. Dr. Garabedian agreed that this was rather quick.

The records of May 7, 2010, showed a reference only to tooth #21, but there were two implant stickers.

R.P. was prescribed Vicodin, a Schedule II controlled dangerous substance (CDS), and amoxicillin. Garabedian agreed there was no documentation of quantity or any record of the prescription.

A month later, an implant fell out and R.P. swallowed it. R.P. said the other implant was always bothersome, and in December 2010, Dr. Taylor told her the implant had to be removed.

She said Dr. Maron was a fast-talking dentist, and Dr. Garabedian agreed.

Dr. Maron made no attempt to transfer this patient to another oral surgeon after he had terminated practice with Dr. Weber. While it should be assumed that Dr. Weber would get another oral surgeon, the records showed no indication of a follow-up.

Count 10, Patient A.P.

A.P. was a sixty-eight-year-old female whose case involved questionable treatment and anesthesia.

A.P. was missing upper teeth and posterior teeth, and Dr. Maron thought she should have something fixed and permanent. She had eight implants on teeth ## 3–14 done at once, which Dr. Garabedian said would take about two to two and a half hours.

Dr. Garabedian looked at Dr. Kleiman's report and agreed with him that 7.5 mg of Versed is a heavy dose. Dr. Garabedian spoke with Dr. Maron, who said it had been titrated. Versed and other similar drugs can result in general anesthesia if enough is given. The dose was reported as "7.5 mg X 2," which would not be unusual over a two-hour period, but Dr. Maron said it took him one to one and a half hours for this procedure. M.P. was on Klonopin, a benzodiazepine, which a patient can build a tolerance to. These patients need to get more frequent or higher dosing to get sedated.

The only medical history in the records was from a year prior, in May 2012. There was no current medical history. A.P. had temporomandibular joint syndrome and was on prednisone. He agreed that there were no pre-operative X-rays, no discussion of risks, no consultation, no treatment plan, no Panorex (although Dr. Maron said he had it), and no consent form.

The procedure occurred, and the patient was sedated on September 27, 2013, but the chart was dated September 27, 2014, a year later. No implant stickers were found. Dr. Garabedian agreed that eight implants for future restoration with a fixed bridge cannot be done without bone studies.

Dental stent guides are used for positioning of implants, but no stent was used here. Dr. Garabedian asked Dr. Maron about this, and Dr. Maron said he used dentures as his surgical guide. But there was no documentation in the chart that that was what he did. There was also no anesthesia record.

Count 11, Patient T.B.

T.B. was treated by Dr. Taylor for root canals and crown work on teeth ## 8 and 9. Blue Cross/Blue Shield denied the claim. Dr. Garabedian had no concerns about the billing that he saw, as patients sometimes think they have more coverage than they do. The patient owed what he should have paid. Dr. Maron never saw T.B.

The issue here is alteration of the consent form. Further, the patient was repeatedly billed for the cap that kept falling off because the tooth had been filed down too far. It had to be re-cemented every two months, and it is customary to re-cement for free.

Count 12, Patient A.A.

A.A. is a fifty-three-year-old female. Dr. Kleiman noted poor record keeping, as well as questions about veneers and tooth #14, which had been extracted and replaced with an implant. This was not a question of Dr. Maron's work, but treatment by Dr. Taylor. Veneers are not covered by Medicare or Medicaid, and this was explained to the patient.

The patient reported that she was disabled and had poor vision and was taking several medications, including Schedule II CDS painkillers and antidepressants. In February 2010, Dr. Mitgang recommended veneers, and the patient was offered financing. On February 15, 2010, Dr. Maron saw the patient for the first time, extracted #14, and placed an implant. It was listed as a surgical extraction rather than a simple extraction. Dr. Garabedian said there was no reason for this, and none was found in the notes. There was no diagnosis or treatment planning. Dr. Garabedian agreed that this was not an appropriate way to treat a patient.

Count 13, Patient E.D.

E.D. was the sad case of a sixty-year-old woman, who had extractions, implants, and dentures, and later partial removal of her tongue due to tongue cancer. Dr. Maron

had seen her two years before. The likelihood was that there were no signs or symptoms of a tongue lesion when Dr. Maron saw her. E.D. was also later seen by other dentists in the practice, but none saw a tongue issue. The tongue cancer was missed, and the patient had surgery to remove it. There is no excuse not to diagnose it when it occurs.

In October 2011, E.D. had care for an abscessed tooth. The employed dentist said she should have teeth ## 4 through 13 extracted and implants placed at ## 5, 6, 12, and 13. No consent form was in the file.

The patient was uncomfortable, as the temporary denture was too large for her mouth. Each subsequent set of dentures was defective, and she continued to return for services. She complained of a non-healing tongue laceration that was not resolved. The complaint should have been documented in her charts, but it was not. The patient said that she then did not return to that office, and that she had asked for a referral, but she did not get one.

In March 2013 she asked for her records, and had received none by July 2013, even though records are supposed to be released within thirty days. There was not even a note in the chart that she had requested her records.

The pain from the tongue laceration continued and the denture was too large, and she had epulis fissuratum (active redundant tissue at flange of denture). The implants had no attached gingival tissue on the sides. It is not uncommon to have a loss of gingival tissue, and is not necessarily a bad outcome. Usually it is caused by recession of the gums. If a denture is too large, it should be adjusted. If a patient complained about tongue pain and nothing in the records showed that an oral examination had occurred, this is not proper, as the complaint should have been noted and the examination should have been done.

Count 14, Patient C.S.

Here, Dr. Maron did extractions and implants for C.S., an eighty-year-old female. Dr. Kleiman said treatment was not the issue: record keeping was the issue. Dr. Garabedian agreed that no current medical history was taken for the extraction of tooth #14. He agreed that the consent was undated and blank. He agreed that the name on it was wrong and that Dr. Maron's name did not appear. He agreed that no anesthesia record was present and that the surgical record was not helpful. There was no copy of any prescription, nor was the identity of the medication present. The records were not clear.

Dr. Garabedian agreed that the records noted that tooth #3 should have a high noble crown, but the laboratory invoice said non-precious. C.S. and Y.Z. (Count 15) are the only two patients whose records included laboratory invoices. The person creating the invoice could have entered the wrong code. The only two charts in which laboratory records were produced contained errors. Dr. Garabedian did not know the difference in the cost charged to patients.

Count 15, Patient Y.Z.

Y.Z.'s complaint with Perfect Smile was financial. However, the records showed no consent form for the February 2014 removal of teeth ## 4 and 5, with implants at 3 and 4. Y.Z. complained that problems arose from the implants, so Y.Z. went to Dr. Ta. Y.Z. wanted his records. During October 2014, he called Perfect Smile for records seeking the name and size of the implants because Dr. Ta wanted the information. On December 20, 2014, Y.Z. sent a certified letter, and then Dr. Ta called for the records. Dr. Maron's office never produced the records, and that was improper.

The billing mistake was listing the wrong code for the crowns. Procedures should be noted correctly and, usually, the restorative dentist does it. This was not an uncommon mistake, and listing the wrong codes is an understandable mistake. Most complaints are about billing. Most of the time it is a communications error. The oral

surgeon would probably not even know about the mistake. The patient was billed $2,000 and the work was completed.

Count 16, Patient S.A., Jr.

S.A., a seventeen-year-old, had four wisdom teeth removed, which is a common practice in that age group and an appropriate treatment. Dr. Kleiman looked at the Panorex X-ray of August 29, 2013, and S.A.'s mother signed a consent for extraction.

The sedation was IV Versed, which reduces anxiety and causes an amnesia effect and memory loss of procedure. It is a good method of sedation. Pain is a common complaint and is managed with pain medications.

Count 17, Patient S.B.

S.B., a twenty-five-year-old pregnant female, required the extraction of her right upper third molar, under local anesthesia. Her obstetrician said she could have Novocain, but not to give her epinephrine. Dr. Maron gave her epinephrine, and this was a deviation from her doctor's recommendations, but nothing untoward happened as a result. No billing errors were noted.

Dr. Garabedian's FINAL CONCLUSIONS

Dr. Maron was trying to practice in a way that was not humanly possible. He had ten businesses, and his patient record keeping was neither compliant for patients nor legal. With monitoring and supervision, he should be able to provide quality surgical care. He could practice oral surgery effectively under correct conditions—with electronic records, supervision, and monitoring. He practiced in areas where patients could probably not otherwise get care.

Dr. Garabedian was aware that Dr. Maron had no license for general anesthesia, and that a dentist in New Jersey who administers general anesthesia must have a current license. Dr. Garabedian was not familiar with Board rules of administering IV

sedation, which required proper training and continuing education (twenty credits in sedation plus fifty hours of training). The safety precautions for parenteral sedation when doing an IV required a pulse oximeter; continued blood-pressure monitoring; EKG; and capnograph CO2 monitoring. Dr. Garabedian did not ask if Dr. Maron used only a pulse oximeter and a blood-pressure cuff, nor did Dr. Maron tell Dr. Garabedian he did. Until 2012, only a pulse oximeter and blood-pressure cuff were required.

Board rule 8.2 lists the minimum requirements for IV sedation, which were last amended in 2006. The correct way to do anesthesia requires proper working IV access, either to titrate or to give emergency medications. It can be locked or be one with fluid, but IV access must be maintained at all times.

Dr. Garabedian did not see any consistent documentation of medical status in the records. It was present in some cases, but not all.

Dr. Garabedian did not see ASA classifications anywhere. He did not see documentation on airways and support ventilation. He saw no documentation of the monitoring of patients, e.g., EKG, pulse, etc. Nothing in the records showed him that patients were managed in the post-operative period as required. Accurate anesthesia records were not maintained.

Prior to the hearing, Dr. Garabedian spoke with Dr. Maron and reassessed some of his conclusions. Dr. Garabedian took Dr. Maron at his word as he explained his care and treatment of patients, and Dr. Garabedian felt he had no reason not to believe him. Dr. Garabedian agreed that if he had to take over Dr. Maron's practice, he would have no way to know how Dr. Maron administered the Versed. Dr. Garabedian would have to go by the charts, which were deficient. Dr. Garabedian agreed that any subsequent treating doctor would be at a loss and the record would be useless. Dr. Maron's records were horrible: there was no defense or explanation. None of the charts had an anesthesia record.

Dr. Maron went from office to office and was in a hurry. An itinerant practice is not a good way to practice.

Dr. Garabedian saw no updating of medical histories in the records, as provided by rule 8.7. He saw nothing about the chief complaint of a patient. Diagnoses and treatment plans were fragmented. Dr. Garabedian noted that some consent forms had been left blank about the procedures to be performed, and this was improper. He saw some consent forms where the person administering the form was Sandra Moon, a non-dentist, and this was not proper.

Two charts had follow-ups in the wrong years, which raised concerns about the reliability of records produced. Dr. Maron's record keeping was a mess. For patients who were getting crowns, except for Y.Z. and C.S., no copies of prescriptions to the laboratory were present, even though these were required to be in the chart.

Dr. Garabedian had a hard time reading written notations in the records because they were not legible. It was hard to know what Dr. Maron had done without the transcriptions ordered by the Board.

Dr. Garabedian reviewed Dr. Kleiman's report and the charts submitted, as well as Dr. Maron's testimony before the Board. He was aware that Dr. Maron had been called before the Board in 2004 because of patient complaints, but he had not seen a copy of that testimony.

FINDINGS

For testimony to be believed, it must not only come from the mouth of a credible witness, but it also has to be credible in itself. It must elicit evidence that is from such common experience and observation that it can be approved as proper under the circumstances. See Spagnuolo v. Bonnet, 16 N.J. 546 (1954); Gallo v. Gallo, 66 N.J. Super. 1 (App. Div. 1961). A credibility determination requires an overall assessment of the witness's story in light of its rationality, internal consistency and the manner in which it "hangs together" with the other evidence. Carbo v. United States, 314 F.2d 718, 749 (9th Cir. 1963). Also, "'[t]he interest, motive, bias, or prejudice of a witness may affect his credibility and justify the [trier of fact], whose province it is to pass upon the

credibility of an interested witness, in disbelieving his testimony.'" State v. Salimone, 19 N.J. Super. 600, 608 (App. Div.), certif. denied, 10 N.J. 316 (1952) (citation omitted).

I accept the testimony of the patient witnesses and their lay opinions as to the treatment received by Dr. Maron and/or other dentists practicing in one of Dr. Maron's offices. They had previously presented their complaints to the Board, and they testified consistently with their prior statements. There was no reason for them to falsify any statement, nor was any bias demonstrated on cross-examination. They simply described the care and treatment that they received or observed from or by Dr. Maron or others working under his supervision or employ.

As to the testimony of Dr. Kleiman and Dr. Garabedian, their expertise and the quality of their testimony was quite impressive. It is well settled that "'[t]he weight to which an expert opinion is entitled can rise no higher than the facts and reasoning upon which that opinion is predicated.'" Johnson v. Salem Corp., 97 N.J. 78, 91 (1984) (citation omitted). In this regard, it is within the province of the finder of facts to determine the credibility, weight, and probative value of the expert testimony. State v. Frost, 242 N.J. Super. 601, 615 (App. Div.), certif. denied, 127 N.J. 321 (1990); Rubanick v. Witco Chem. Corp., 242 N.J. Super. 36, 48 (App. Div. 1990), modified on other grounds and remanded, 125 N.J. 421 (1991). "The testimonial and experiential weaknesses of the witness, such as (1) his status as a general practitioner, testifying as to a specialty, or (2) the fact that his conclusions are based largely on the subjective complaints of the patient or on a cursory examination, may be exposed by the usual methods of cross-examination." Angel v. Rand Express Lines, Inc., 66 N.J. Super. 77, 86 (App. Div. 1961). Other factors to consider include whether the expert's opinion finds support in the records from other physicians, and the information upon which the expert has based his conclusions. And, the premises upon which the expert's observations are based, coupled with the expert's ultimate conclusions, may be contradicted by rebuttal experts and other evidence of the opposing party. Ibid.

In this matter, two highly qualified experts testified as to care and treatment offered by Dr. Maron. Indeed, both experts agreed that Dr. Maron's care and treatment were faulty in many, if not all, respects. Treatment plans were not made by Dr. Maron

or were made by someone who was not a surgeon. Dr. Maron had little or no discussion or conversation with patients about their treatment plans. Pre-operative X-rays or Panorexes were not taken or were not in the files. Documentation was sparse or lacking. Dates were mixed up. Writing was illegible.

Dr. Maron's administration of sedatives described general anesthesia, not the titration of sedation to achieve a sedative effect. Implants were placed or ended up in the sinus, or were placed without bone-graft material where required. Pressure was placed on patients to have work done that they could not afford or that was inappropriate for them considering their age and/or medical histories and/or financial situations. Credit was offered to patients receiving Medicaid or Medicare who had no reasonable means of repaying the debt. Short shrift was given to patient complaints or concerns. Follow-up care was lacking. Record keeping was so bad that reviewers of the files could not understand what treatment had been performed. The culture of care demonstrated here could not allow enough time for Dr. Maron to accomplish the purposes of the treatment, as he traveled from one office to another.

The essential difference between the experts is that Dr. Garabedian opined that despite his errors, Dr. Maron could be an effective dentist if he worked under supervision and under different conditions, whereas Dr. Kleiman concluded that, given the quantum of errors, Dr. Maron is not fit to practice under any conditions. I accept the testimony of Dr. Kleiman as more persuasive as to the care provided to the patients in the placing of implants. It appeared that Dr. Garabedian had also found fault with these procedures until he spoke with Dr. Maron, and then accepted some of Dr. Maron's proffered excuses for the failure of implants or the justification of the treatment provided, notwithstanding that no documentation of the treatment plan was in the patient record.

As to each count of the Complaint, I accept the **FACTS** as stated by Dr. Kleiman and noted in the documentary evidence and add the following:

Count 1, Respondent's current manner of practice presents a risk to patients.

Both experts agreed and I **FIND** that Dr. Maron's manner of practice presented a risk to patients: care was hurried; no consultations or treatment plans were prepared; no proper consent forms were prepared; records were illegible if they were present at all; sedation was not given properly; patients were pressured to get treatment and costs paid by credit; other medical professionals involved with the patients were not consulted; follow-up care was lacking; implants were placed without sufficient bone to stabilize them; and patient complaints were not addressed.

Count 2, Patient J.B.

J.B. saw Dr. Maron in 2010 for an extraction. The consent failed to identify the tooth being removed. Medications of Vicodin ES and amoxicillin were prescribed without dosages being noted.

On July 23, 2011, J.B. consulted with Dr. Maron about a possible implant after having seen another dentist who advised she would need cadaver bone. She was concerned about the cost and the time. Although she said she would let Dr. Maron know about the treatment, he said he could place the implants right then and there during J.B.'s lunch hour. When she said she did not have the money and while sitting in the chair, the staff produced an application for CareCredit for $2,700. No Panorex or current X-ray was taken. No consent form for the implants was in the file. No cadaver bone was placed, and J.B. was told she did not need it.

After continued pain and discomfort, J.B. went to her regular general dentist in October, who advised her to see the oral surgeon without delay. She called Dr. Maron, who was unable to see her, and so she went to Dr. Corry. He noted only two millimeters of residual alveolus separating the antral floor and located one of the implants penetrating the sinus. No bone-graft material was found. Surgery was performed to remove the implant and to treat the infected area. J.B. did not return to Dr. Maron, although the records he produced indicated a visit later in July, which J.B. denied.

Count 3, Patient M.K.

On December 4, 2012, M.K. sought treatment for an infected lower right molar at The Apprehensive Patient in Shrewsbury, where Dr. Maron worked as an independent contractor. Dr. Maron proposed removal of that tooth and the placement of an implant there, and on the lower left. M.K. declined because she could not afford the cost, and left the office.

A few minutes later, Dr. Maron telephoned her and said he could perform the treatment at a lower cost, including X-rays and putting her to sleep, if she would come to his office at Dowling Dental in Woodland Park. He told her she could apply for credit from a loan company.

On December 8, 2012, she went to Dr. Maron's office. He put her to sleep, and she awoke from the anesthesia unattended in the waiting room. Her fiancé had to help her to the car.

By December 10, 2012, M.K. was in great pain. When she reached Dr. Maron to explain her condition ("pain and hard lumps where the implants were placed"), Dr. Maron called her a hypochondriac. On December 17, 2012, M.K. was finally able to see Dr. Maron at his Red Bank office. He numbed her and did not tell her what he was doing. He denied there was an infection, and said he was moving the implant over to help ease the pain. On December 28, 2012, he saw her at Monmouth Dental Group, took an X-ray, and said she had an infection. He then used pliers on the lumps in her mouth, removing the implants.

M.K. did not see him after that. No records were forthcoming, nor was there any consent form. The records produced did not reflect the numerous complaints of M.K. after the procedure was performed. No pre-operative Panorex was produced.

Monmouth Dental Group had a chart showing that Dr. Maron had seen her on December 28, 2013, not 2012, which was false.

On January 7, 2013, M.K. went to Dr. Haghighi, who took an X-ray, advised of an ongoing infection which required surgery, and told her there were no implants in her mouth.

M.K. also learned that the office had falsely stated her salary when it filed the credit application on her behalf. She also later became aware of a promissory note with a signature that was not hers.

Count 4, Patient M.T., submitted by niece P.T.

M.T. resided in an assisted-living facility. She was treated at Perfect Smile in Red Bank with implants and an overdenture. M.T. had signed papers for a CareCredit loan of $11,000 and a Chase line of credit for $20,000, although she had no income and received Medicaid. Her niece, P.T., came to New Jersey to assist her and found charges in the billing for work that had not been done, including crowns on three teeth and a double charge for the overdenture. Dr. Maron's office admitted the billing errors and credited M.T. with $4,500. The ledger showed that M.T. was not reimbursed in full.

After having difficulty in removing the overdenture that had been prepared by Dr. Maron's office, she went to the Monmouth Medical Center Dental Clinic, where the doctors found that she had only one-half of a lower denture secured with implants, and several loose and painful upper teeth. A cone-beam CT scan showed that the maxillary arch had moderate to severe periodontal disease at almost all the teeth. A draining fistula exuded around the mandibular prosthesis. Surgery was required to remove the implants and the upper natural teeth.

Dr. Maron did not use the mini-implants planned by Dr. Mitgang, the general dentist, because he thought M.T. had good bone. Dr. Maron accepted responsibility for Dr. Mitgang's work. No chart, or progress notes, or transcription was produced by Dr. Maron, nor was there any record of consultation with Dr. Mitgang. Dr. Maron did not follow up after treatment. Dr. Maron admitted the double billing, and that money was returned to M.T. However, this was after a civil action was filed.

Count 5, Patient F.D.

F.D. went to Gentle Dental in Red Bank for a tooth extraction on or around May 17, 2010. She wanted a bridge, but felt pressured into having implants. After Dr. Maron put three needles in her mouth, someone helped her to sign a piece of paper, and she then went to sleep.

She was taking Coumadin at the time. After the procedure, she went home and had continued bleeding. Dr. Maron did not suture her after the surgery. She went to the hospital to have the bleeding stopped, and found that four teeth had been extracted instead of one. The records produced showed that F.D.'s medical history and prescription-drug use had not been updated since 2006. There was no pre-operative consultation with her medical doctor regarding the Coumadin.

When F.D. returned to the office, she asked why four teeth had been removed, and was told it was because they were loose. F.D. was receiving Medicaid, which Dr. Maron claimed she waived. However, the record did not indicate any informed consent of the purported waiver. She was later dunned for over $15,000 from a collection agency for work that was not completed and that she did not want.

Dr. Maron produced a chart that showed that the teeth had been extracted on April 15, 2010, not May. Although he claimed that F.D. had consented, the only consent form was dated April 19, 2010 (four days later), and failed to identify the extractions or implants; it also identified an office employee as having reviewed the document with F.D. The sedation was described as "IV sedation N20 Versed 15 mg," but there was no documentation of vital signs or anesthesia monitoring. Dr. Maron also said that F.D. returned to the office on May 7 and May 17 for two more implants each time, but F.D. had wanted a bridge, not implants. And there had been no consultation with the restorative dentist.

Count 6, Patient N.C.

N.C. went to American Dental Center for a broken tooth and was treated by Dr. Maron. She was given a consent form for oral surgery and anesthesia without having met the dentist. The form was not signed by a doctor or witnessed and stated only "#4 Ext."

N.C. went into the operatory and was followed by a little boy. Dr. Maron did not introduce himself or address her, but rather offered explanations to the child. He administered injections and left the room. Dr. Maron then returned and removed the tooth with pliers. When she complained of pain, Dr. Maron denigrated her. The boy remained present in the operatory during the procedure and touched some instruments. After the procedure was over, Dr. Maron left the room.

N.C. continued to bleed, and found that when she breathed through her nose, air came up from the space where her tooth had been. She returned to work, and her employer immediately sent her to another oral surgeon, who took X-rays and reported laceration of the buccal gingiva and a buccal bony defect. She was treated with a bone graft with membrane placement and had to have follow-up care.

Count 7, Patient J.K.

On May 7, 2012, J.K., who had a medical history of diabetes and high blood pressure and was on medication, consulted with a general dentist employed by Dr. Maron at Perfect Smile. X-rays were taken, and the general dentist recommended extraction of ten teeth, implant surgery, and dentures.

On May 14, 2012, Dr. Maron extracted ten teeth and placed implants at ## 4, 12 and 22. J.K. had to take a CareCredit loan of $8,684 to cover the cost of treatment. Dr. Maron performed all the procedures without consultation with J.K.'s physician. He did not obtain a CT scan or a surgical guide to locate appropriate placement of the implants. On August 27, 2012, Dr. Maron's transcription claimed that he reviewed informed consent, uncovered tooth #27, replaced #21, and prescribed amoxicillin and

Vicodin. There is no consent form for that date. The record showed no follow-up after the procedure.

The general dentist then made dentures, which caused difficulty and pain to J.K. After one of the implants fell out while J.K. was sleeping, J.K. attempted to contact Dr. Maron, but he was unresponsive. J.K. had to pay CareCredit $5,000 in interest.

On May 16, 2013, the general dentist said that the #22 implant was very loose and should be removed by Dr. Maron. On August 13, 2012, J.K. had to take another CareCredit loan of $8,356.

On June 12, 2014, J.K.'s ear, nose, and throat doctor informed the general dentist that an implant had migrated to J.K.'s right sinus. Dr. Maron did not note the need to remove the implant until June 19, 2014, although he should have noted the problem during the surgery. The chart had entries that were not in consecutive order. Dr. Maron did not see J.K. for follow-up care. Here there was poor planning and no diagnostic CT scan or surgical guide, which made the failure of the implant predictable.

Count 8, Patient M.H.

M.H., age seventy-four, was first treated in 2007 at Gentle Dental, a practice owned by Dr. Maron. She took out a CareCredit loan of $4,500 to pay for an over-denture to be prepared by Dr. Mark Weber.[23]

On January 4, 2008, M.H. took out a second CareCredit loan for $8,775 to pay for extractions by Dr. Maron that same day. He extracted teeth ## 4, 5, and 13 and immediately placed implants at those sites. Within a few months, Dr. Taylor, a general dentist employed by Dr. Maron, noted that M.H. was complaining of painful front teeth and an aching sinus. On December 11, 2009, Dr. Maron extracted and immediately placed implants at teeth ## 28 and 29, after M.H. took out a third CareCredit loan of $5,000. The chart contains no consent form for these procedures.

[23] Dr. Weber's license was revoked on May 4, 2012.

On February 22, 2010, a fourth CareCredit loan was taken by M.H., and Dr. Maron removed teeth ## 20 and 21 and immediately placed implants at the sites. The consent form for that date did not identify the teeth to be extracted or that implants were to be placed. The form identified no dentist and just stated "The Perfect Smile" where the dentist's name would be. The witness was an office employee, not a dentist or Dr. Maron. Dr. Maron's ledger dated June 14, 2010, indicated that tooth #31 was extracted that day for $150, but the transcription showed no service that day.

On August 25, 2010, the transcription stated that teeth ## 22, 23, 24, 25, 26, and 27 were extracted. On January 24, 2011, Dr. Maron placed implants at ## 22 and 27. Dr. Maron's employed dentist noted that on that same day Dr. Maron placed an implant at tooth #5. On February 28, 2011, according to his transcription, Dr. Maron extracted #18 and placed an implant.

On March 3, 2011, M.H. reported that she was in pain at the #18 implant site. On March 14, 2011, according to the transcription, Dr. Maron again removed #18 and re-placed the implant. On May 9, 2011, plans were made for a fixed bridge at ## 18 to 28, which included tooth #18, where the implant had been removed and replaced. On June 6, 2011, Dr. Maron examined the site and bone graft and noted for the first time that the area was not dense enough, even though he had already placed five implants in the area. Multiple visits were made by M.H. seeking relief for her discomfort. A consent form dated August 22, 2011, had an "X" marked next to "Bridges" and "Extractions," with nothing specific and no dentist's name.

By December 2011, M.H. had paid $10,000 and owed $750. The office started to harass her and call her often for payment of the balance before completing work on the defective bridge. M.H. then consulted with another dentist, Dr. DiCesare, who found that #30 had a large area of caries; the bridges had poor occlusal relationships and were not fully seated; a large amount of excess cement was at the gingival level; and the situation was not correctable. M.H.'s bite was off; she needed complete replacement; and damage had been done to the existing implants. M.H. returned to the general dentist employed by Dr. Maron to try to create a proper bridge, as she could not

afford to go elsewhere, but as of the date of the complaint she had continued discomfort and did not have a successful bridge.

Dr. Maron waived the $750 balance, and purposely placed two implants (teeth ## 5 and 13) so that they extended into the sinus, although the reason for this was not indicated in the chart, nor had it been disclosed to M.H.

There was no consent form for either of the two times when Dr. Maron did extractions and immediate implants, and no treatment planning. The extraction of tooth #18, implant, re-extraction, and re-implant made no sense, and nothing in the record justified this. The 2011 consent form did not specify the bridge or extraction site or the dentist's name. Dr. Garabedian noted that a dentist would be able to tell if he had penetrated the sinus. Dr. Maron failed to do the work properly; failed to supervise the dentist working in his office; failed to note the complications that had occurred, and failed to perform sinus-floor bone grafting. The treatment was well below the standard of care required.

Count 9, Patient R.P.

R.P., age fifty-eight, went to Amalgamated Dental Center to have one tooth extracted. Dr. Maron, an independent contractor at that office, met with R.P. and denigrated the plan for R.P. to receive a flexi-partial denture. Rather, he promoted his expertise with implants and injected R.P. to numb her mouth. While she was getting numb, he pressed her to get implants, drew a diagram on the dental-tray paper, and assured her that with the placement of two implants, she would be able to have a fixed bridge. He insisted on knowing before he pulled the tooth (#21). When R.P. said she could not afford the implants, Dr. Maron called in the business manager, who was able to arrange for credit to cover the cost of the treatment. R.P. felt pressured into agreeing. Work on the first implant chipped an adjoining tooth.

Dr. Maron took no pre-operative X-rays, failed to prepare a proper diagnosis/treatment plan, and failed to obtain informed consent. The consent form is blank as to any procedure. He did not consult with the restorative dentist, and there

was no surgical guide. The chart lists extraction of tooth #21 and includes two implant stickers, but fails to identify the sites. The ledger lists the implants as teeth ## 19 and 21. The anesthesia was not documented. The transcription indicates that he prescribed amoxicillin and Vicodin with no documentation of quantity or record of the prescriptions under his name or entity.

The transcription of Dr. Maron's treatment note was dated May 7, 2010. R.P., the chart, and the ledger indicate that the work was performed on May 8, 2010. One month after the work, the second implant fell out and R.P. swallowed it.

In October 2010, on a visit for an impression on the first implant, R.P. noted that it was always tender and painful. On December 23, 2010, Dr. Weber told her that the implant must be pulled out. R.P. then complained to the Board about how she was misled by Dr. Maron; that if she had had the opportunity to read and sign the consent form she would not have allowed the implants. She reported being in pain, and that she had paid for an implant she did not receive.

The Board requested Dr. Maron's records on January 15, 2011. The office sent illegible records on January 22, but no narrative until his letter of April 4, 2011, in response to the Board. Dr. Maron claimed that Dr. Weber had designed the treatment plan, and that R.P. had been referred for extraction of tooth #21 and implants at ## 21 and 19. He was unable to follow up with R.P. because his relationship with Weber was terminated. Dr. Maron did not know of the failed implants until after R.P.'s complaint, and he offered to give her a partial refund and further care at his own office. The implants were ultimately removed by Dr. Maron, who claimed that Dr. Weber was responsible for the treatment failure.

It was improper for Dr. Maron to press R.P. to have implants after she expressed reluctance. There were no pre-operative X-rays; no treatment plan; no consent; and no consultation with the restorative dentist. The note of extractions and implant stickers is inconsistent. The Vicodin prescription was incomplete. One implant fell out and the other was always tender and painful. Dr. Maron never arranged for any follow-up care by another surgeon after he severed his relationship with Weber. Dr. Garabedian

agreed that the implant had to be removed and that R.P. should get her money back. There was no surgical guide and the treatment was hasty. The failure to follow up was critical, and Dr. Maron failed in his responsibility to the patient.

Count 10, Patient A.P.

A.P., age sixty-eight, had been a patient at American Dental Center, and returned for a consultation on September 27, 2013. On September 26, 2013, a CareCredit loan was obtained for $20,000. The next day, she saw Dr. Maron, a per-diem independent contractor, for the first time. Dr. Maron suggested that instead of a denture, she should have eight implants from tooth #3 to tooth #14. No current medication history was in the record.

In his response to the Board, Dr. Maron said he used a 23g butterfly needle to put A.P. to sleep and that she was pretty much unconscious. He then placed implants at ## 3, 4, 5, 6, 11, 12, 13, and 14. The transcription he provided said he used Septocaine x4 with IV sedation by Versed 15 mg. The chart and transcription are dated September 27, 2014, one year later. The file contains no implant stickers, and the notes in the chart are not chronological. His handwriting is illegible. A ledger was never produced, and Dr. Maron said the office owed A.P. $6,000 to $7,000. A.P. never returned to the office, as the result of a hospitalization.

Dr. Garabedian agreed there was no current medical history, although A.P. had medical problems. There was no consent form and no pre-operative X-rays to check availability of bone at implant sites. There was no treatment planning or guide or stent. Dr. Maron drilled holes in A.P.'s existing denture, destroying it. The treatment plan and anesthesia care were questionable. Although Dr. Maron said he titrated the Versed, Dr. Garabedian did not find it in the records. There were no implant stickers in the charts.

This was a case at the upper end of complexity. Dr. Kleiman noted the indicia of poor treatment: excessive anesthesia, untrustworthiness of the records; no pre-operative X-rays or Panorex. The post-operative X-ray showed that the right posterior

implant extends significantly into the maxillary sinus. A.P. required a simultaneous sinus-lift bone grafting to accommodate these implants. The dates of the records are not accurate, as Dr. Maron claimed the implants were done on September 27, 2013, but Dr. Maron told the Board it was 2014. The Panorex X-ray, which is clearly post-operative, is dated May 31, 2012, before the surgery.

The anesthesia was excessive and would have induced deep sedation/general anesthesia, for which Dr. Maron had no permit. Given the medications A.P. was taking, she would have needed less anesthesia, not more, to avoid an overdose.

Count 11, Patient T.B.

From March through July 2011 T.B. was treated at Perfect Smile, an office owned by Dr. Maron, for crowns on ## 8 and 9 that had fallen off years after treatment elsewhere. On March 11, 2011, T.B. was given a "Dental Treatment Consent Form." Under "work to be done," which included filings, bridges, crowns, extractions, root canals, X-rays/Exam, Other," T.B. dated and initialed the form and checked off "other." Nothing else was marked.

On March 15, 2011, Dr. Taylor, a dentist employed by Dr. Maron, filed down and recemented crowns at ## 8 and 9. The #8 fell off and T.B. almost swallowed it on May 16. He brought it back to Dr. Taylor; it was recemented; and it fell off again on June 20 and again on July 21, 2011. T.B. was told the crown kept falling off because Dr. Taylor had filed it down too much. T.B. was charged for each of the three visits to recement the crowns.

T.B. complained to the Board on April 5, 2012, and the Board sought T.B.'s records from Dr. Maron. A progress note dated July 16, 2012, said the Board letter was received and a response was received with Dr. Maron's signature. On July 23, 2012, the Board wrote to Dr. Taylor seeking financial information and transcription. According to the transcription, the chart, financial information, and transcription were sent on September 17, 2012. The copies of the chart and transcription show two different

versions of the consent form, which were identical but for the addition of two more checkmarks at “fillings, crowns and X-rays, Exam.” T.B. did not make the changes.

Dr. Maron agreed that the repeated billing was not justified and that he was ultimately responsible. He implied that Dr. Taylor was the one who had altered the form.

Count 12, Patient A.A.

A.A. was disabled with vision impairment and was receiving Medicaid assistance. She went to Perfect Smile in February 2010, an office owned by Dr. Maron, where she was treated by his employed dentist, Dr. Mitgang. She was pressured into applying for credit for dental work she did not want. A.A. was taking several medications, including OxyContin, an antidepressant, and steroids.

Dr. Mitgang performed two root canals, and on February 10, 2010, recommended veneers. Office staff provided CareCredit and Chase Health Advance for financing in the amount of $11,000, listing planned treatment as veneers and an implant on tooth #14.

On February 15, 2010, Dr. Maron saw A.A. for the first time. She was given a Medicaid waiver to accept an implant. Dr. Maron extracted #14 with lidocaine 2% (claiming a code for a surgical extraction) and proceeded with immediate placement of an implant at #14.

Dr. Maron had made no diagnosis or treatment plan, nor was there documentation to support the extraction of tooth #14 as “surgical” rather than a simple extraction. Dr. Maron failed to clarify A.A.’s medication status, particularly since she was taking steroids. The Medicaid waiver was problematic, as she would have no ability to repay a loan.

Count 13, Patient E.D.

E.D., age sixty-two, complained of poor workmanship of a bridge prepared after Dr. Maron's extractions and implants at Perfect Smile from February 2011 through June 2013. In October 2011, E.D. sought care for an abscessed tooth. The general dentist, Dr. Taylor, advised her to have all her upper teeth removed and replaced with implants. On November 18, 2011, Dr. Maron extracted teeth ## 4 through 13 and placed implants at ## 5, 6, 12, and 13 on the same day. Dr. Taylor placed temporary upper dentures, which were too large for E.D.'s mouth.

E.D. made nineteen office visits, as the employed dentist tried to place permanent dentures. Each set was defective. E.D. was not pleased with the work. She also complained repeatedly of a non-healing tongue laceration. On May 15, 2013, while trying a denture, the implant at tooth #4 came out. Although Dr. Maron offered to replace the implant, E.D. was not satisfied with the work. Dr. Maron refused her request for a refund of $10,000 that she had paid. On June 6, 2013, E.D. left the practice. She was never given a refund, even though the implant was not replaced, and she never had a set of dentures that fit well. She requested a copy of her records in March 2013, and had not received them four months later.

E.D. continued to have pain with her tongue, and on August 17, 2017, consulted with Dr. Keller, who found that the denture made by Dr. Maron's office was overextended into the vestibule. The implants had failed to have any attached gingiva on the facial side, leaving muco-gingival defects. Dr. Keller noted a large lesion on the right ventral tongue which he deemed suspicious. E.D. said that Dr. Maron or other dentists in his office had seen the lesion many times and had ignored it. A biopsy on September 14, 2013, revealed the lesion to be 2+ cm squamous-cell carcinoma, well-differentiated, which had to be removed by surgery.

The record contained no consent form for the extractions and implants, and no follow-up in spite of the complaints of the ill-fitting bridge and the tongue pain. Nothing in the chart noted E.D.'s complaints, which should have been documented. Dr. Maron should have been supervising when his patient continued to return for treatment and

was not satisfied. The records provided to the Board were misleading in the description of who was providing services to E.D. The records were also deficient and failed to include E.D.'s contact with Dr. Maron when he offered to replace the implant. Given the size of the lesion and E.D.'s complaints about tongue pain, Dr. Maron and his employed dentists failed to follow up to ensure diagnosis and treatment.

Count 14, Patient C.S.

C.S., age eighty-eight, complained of poor workmanship at Dr. Maron's office, Perfect Smile, during October 2008 to May 2009, by Dr. Benhamu, an employee of Dr. Maron. On October 23, 2008, Dr. Maron extracted tooth #14. The chart showed that she was billed for a high-noble crown, which was not provided. Although Dr. Maron claimed that he gave her 15mg Versed IV in addition to a local anesthetic, the chart had no medication history or anesthesia record. No follow-up was done.

This chart (and Y.Z.'s) included a laboratory order to show the quality of crowns that were ordered, which were billed to the patients, but which were not the high-noble that the patient and carrier thought had been provided. The consent form was undated, unwitnessed, and did not identify the tooth to be removed or the sedation to be used. The consent lists the name of the office rather than Dr. Maron's name. The surgical note is not legible. Amoxicillin and Vicodin were prescribed without documentation of the quantity or keeping a copy of the prescription.

The treatment form from February 10, 2009, showed a root-canal completion on tooth #3 with a charge of $1,350 for a high-noble crown, but the laboratory invoice showed that a non-precious-metal crown was ordered.

Count 15, Patient Y.Z.

Y.Z. was treated by Dr. Maron's employed dentist between January 2013 and February 2014. On January 21, 2013, tooth #27 was prepared for a PFM crown (porcelain fused to non-precious metal). The insurance company was charged $1,350 for "crown porc high noble mtl," using code D2750. The invoice from the laboratory

preparing the crown shows that the order was for the delivery of a PFM non-precious crown for tooth #27. When the crown did not fit, Dr. Maron's office had the crown re-made, again with non-precious metal.

Y.Z. was not aware of this when he consulted with Dr. Maron about implants on February 21, 2014. The chart showed that Dr. Maron entered, "Consult, recommend removal of #4, #5 with implants, #3 and 5 with bridge (1) Exo #4, #5, (2) implant #3 & 5 $2,000 (3) three-unit bridge $3,000 4 months later." There is no consent form in the chart for the extraction, and Y.Z. was required to pay $2,000 prior to placement of the implant.

On March 21, 2014, Dr. Maron charted a note that Y.Z. was without complaint and healing well. On September 5, 2014, he charted "surgical uncovering #2 & 4 with Septocaine." But this should be teeth ## 3 and 5.

Problems arose with the implants, and Y.Z. sought treatment from Dr. Ta. Y.Z. requested his records from Dr. Maron in October 2014. The records were not forthcoming. Y.Z. sent a certified letter to Perfect Smile dated November 20, 2014, and no response was received. Dr. Ta, too, contacted Dr. Maron's office by telephone about obtaining implant information, but none was received.

Both experts agreed that the billing should be correct, and this was not proper, even if it could be considered a "clerical" error; they also noted that it was professionally improper to ignore verbal and written requests for patient records.

Count 16, Patient S.A., Jr.

S.A., Jr., age seventeen, was treated at American Dental Center, where Dr. Maron worked as an independent contractor, for extraction of four third-year molars. His medical history noted asthma and allergies. The record contains a September 10, 2013, pre-certification from the insurance provider for extraction of four teeth under general anesthesia/deep sedation. Dr. Maron charted the use of Septocaine, IV sedation with Versed 15 mg. Dr. Maron had a poor quality Panorex dated August 29,

2013. He prescribed Vicodin without documenting any detail or keeping a copy of the prescription.

S.A., Jr., was so deeply sedated that he had been unable to walk to the car and had to be carried by two assistants. A sibling helped him into his house and he did not awaken for a while. Later, S.A., Jr., found a piece of tooth in the gum, which he removed himself.

Although Dr. Maron claimed to have titrated the Versed, Dr. Garabedian and Dr. Kleiman agreed that the record was devoid of the depth of anesthesia: no indication was given of the length of the procedure or the rate of titration. Both experts agreed that Dr. Maron had coded and billed for general anesthesia. Nothing indicated that S.A., Jr., had his vital signs monitored during the procedure. Nothing in the record indicated that S.A., Jr., met the criteria for discharge after general anesthesia. Dr. Maron had no current permit to administer deep sedation/general anesthesia.

Count 17, Patient S.B.

S.B. consulted with American Dental Center on August 1, 2013, for a toothache. She indicated that she was not pregnant. She was advised that she needed four teeth removed. Dr. Maron's records did not provide documentation as to why she needed four teeth removed when she complained of pain in only one. The record provided no justification as to why four teeth were removed.

S.B. returned on September 16, 2013, and her chart noted that she was in the second trimester of pregnancy. A letter from her obstetrician dated September 13, 2013, confirmed the pregnancy and specified that precautions should be taken with X-rays, and that she could have Novocain without epinephrine, Tylenol with codeine, and amoxicillin. Dr. Maron did not contact the obstetrician.

On September 23, 2013, S.B. signed a consent for removal of four wisdom teeth. The consent form was not signed by Dr. Maron, nor was it witnessed. Dr. Maron's treatment note was not signed, nor is it legible. His transcription of the treatment record

showed that he performed the extractions using Septocaine x5% and prescribed Vicodin 7.5/300 and 21 amoxicillin 500 mg. The quantity of the Vicodin and dosage instructions are not recorded. Further, he used Septocaine, which does contain epinephrine, contrary to the obstetrician's instructions, and he prescribed Vicodin instead of Tylenol with codeine.

Count 18, Fraudulent misrepresentation to insurance carrier

On March 15, 2015, Dr. Maron submitted a provider application to UnitedHealthcare seeking provider status. The applicant was expected to sign an attestation that the information that was provided was truthful and accurate.

To Question 1, which asked, "Have there ever been actions against or investigations resulting in your professional license(s) in any jurisdiction," Dr. Maron checked the box marked "No." Question 6 asked, "Have you been named in, or had a judgment or settlement in a malpractice action within the past five years?" Dr. Maron checked the box marked "No."

Both answers were false. Dr. Maron had been summoned to appear before the Board on October 20, 2004, and again on September 17, 2014, in connection with patient complaints. Demands and subpoenas had been served on him in the course of these matters. He also had been named in multiple civil malpractice actions, some of which he acknowledged in his June 19, 2015, certified response to the Board's demand for Statement Under Oath. According to that answer, he had been the defendant in ten court proceedings filed in various trial courts in this state.

Dr. Maron claimed that he had not completed the application, that it must have been someone else acting on his behalf. Nothing indicated that Dr. Maron attempted to alert the insurance provider that the answers he provided were not correct, or that they should not be relied upon.

Count 19, Failure of the duty to cooperate in a board investigation

The evidence and documents presented here clearly demonstrated that Dr. Maron failed to cooperate in the Board investigation. During the investigation, records were not produced in a timely manner; X-rays, study models, and narratives were not provided. When some documents were finally presented, they were incomplete or different. Some transcriptions of records did not match the handwritten charts that were legible (some were not legible). Even as late as during the hearing, newly found X-rays and other records were produced by Dr. Maron.

Count 20, Patient G.P.

G.P., a sixty-two-year-old woman, was a patient of Dr. Frederick, who recommended an extraction of tooth #14 and replacement with an implant. They discussed doing the procedure in one visit. On the date of surgery, August 17, 2015, G.P. met Dr. Maron for the first time. She had no discussion with him regarding treatment. Dr. Maron proceeded to inject anesthesia and to extract the tooth and place an immediate implant without discussion of the procedure, or the risks or complications. Dr. Maron placed the implant into the sinus on purpose. Dr. Maron had also prescribed Vicodin 7.5/300, but no quantity or dosage was noted.

A note in G.P.'s chart on August 21, 2015, indicated that the "area was healing well." G.P. saw Dr. Frederick in September and November, at which time X-rays were taken, and she was not told that there were any problems. On December 15, 2015, G.P. saw Dr. Frederick for what she thought was going to be the uncovering of the implant for restoration work, but Dr. Frederick told her the implant was too high in the sinus and could not be used as the foundation for a successful restoration.

G.P. went to another dentist, who informed her that the implant could not be used, and an otolaryngologist, who noted that there was a "foreign body left maxillary sinus." The implant was too high from the time it was placed, extending into the sinus at the time of surgery. The crown-to-root ratio was inadequate. G.P. needed a bone graft to increase the height of the bone.

Here, the treatment was based on the general dentist's analysis and consultation, and there was no available pre-operative imaging. Dr. Maron conducted no consultation, and did not execute an informed consent. He placed an immediate dental implant at the time of an extraction in a manner that resulted in an implant not suitable for restoration and use. Record-keeping and documentation were inadequate, and were not accurate concerning dates of visits.

Count 21, Patient Mi.K.

Mi.K. had consulted with Dr. Frederick about an upper-jaw implant that had fallen out, and a problem with his upper bridge. Dr. Frederick suggested replacing the lower bridge, and Mi.K. advised him that another dentist at "Toothsavers" dental office had noted in 2003 that his nerve was very shallow and that he risked nerve damage if he were to have implants placed in his lower jaw.

On November 4, 2013, Mi.K. advised Dr. Maron that he had a shallow nerve in his lower jaw and that he had been advised not to have implants placed there. Dr. Maron showed Mi.K. an X-ray[24] and assured him that he could place implants without nerve damage. (This discussion was not noted in the charts; there are no pre-operative X-rays; and there was no consent form.)

Dr. Maron placed implants at ## 4, 5, 12, 13, and 29 during the visit. Mi.K. had numbness in the lip and chin after the anesthetic wore off. He was told it could take up to seven months to get feeling back. On November 12, 2013, an implant was placed at #21. No consent form was provided. Mi.K.'s numbness became worse. Mi.K. saw Dr. Frederick on November 13 and 14, 2013, and was again told it could take months for the numbness to wear off.

On November 26, 2013, Dr. Maron told Mi.K. that the numbness could take up to seven months to wear off. On December 12 or 17, 2013, Dr. Frederick noted in the

[24] No chart entry for an X-ray is noted; no billing for an X-ray was made; and no X-ray was produced at the hearing.

chart that Mi.K. was still numb on his lower lip and chin, and referred him to the oral surgeon. On April 17, 2014, Dr. Frederick asked if Dr. Maron would back out the lower implants to alleviate Mi.K.'s paresthesia.

On April 28, 2014, Dr. Maron noted, "surgical placement at #5, back out #20 and #28."[25] No consent form was present. The bottom two implants were removed and not replaced. Upper implant #4 fell out, was replaced twice, and ultimately was never replaced. Mi.K. paid $10,300 out of pocket and the insurance company had paid $10,000 for the three removed implants. Mi.K.'s paresthesia never improved, and a subsequent dentist told him it was permanent because the nerve was severed. Mi.K. has trouble pronouncing certain words, he drools, and he experienced distress and humiliation of his loss of oral control.

Dr. Maron knew that it was a high-risk procedure and that he was ultimately responsible. He acknowledged that he should have gotten more diagnostic studies, including a CT scan, and he did not know what had happened to the Panorex he took. No imaging studies were available, nor were any consent forms. The record does not include a treatment plan. Some of the damage may have been able to be ameliorated had Mi.K. received prompt intervention and follow-up after the surgery, but the delay here was more than five months.

LEGAL ANALYSIS

Pursuant to the Dental Practices Act, N.J.S.A. 45:6-1 to -73, the Board possesses broad authority to regulate the practice of dentistry in New Jersey. It is authorized to license, N.J.S.A. 45:6-3, set standards for continuing education, N.J.S.A. 45:6-10.2, and promulgate rules and regulations for the practice of dentistry, N.J.S.A. 45:6-19 to -21. Companion legislation, entitled the Uniform Enforcement Act, N.J.S.A. 45:1-14 to -27, creates uniform standards "for 'license revocation, suspension and other disciplinary proceedings' by professional and occupational licensing boards." In re License Issued to Zahl, 186 N.J. 341, 352 (2006); In re Weber, No. A-5065-11T4 (App.

[25] Teeth ## 20 and 28 are actually the same site as ## 20 and 21 due to confusion caused by lost teeth. The implants are the same.

Div. Jan. 24, 2014), http://njlaw.rutgers.edu/collections/courts/; In re Bamgboye, No. A-2372-10T2 (App. Div. July 31, 2012), http://njlaw.rutgers.edu/collections/courts/. The Board's supervision of dentistry is critical to the "State's fulfillment of its 'paramount obligation to protect the general health of the public.'" Zahl, 186 N.J. at 352 (citation omitted).

The right to an administrative hearing before revocation of a professional and occupational license has "long been imbedded in our jurisprudence," Limongelli v. N.J. State Bd. of Dentistry, 137 N.J. 317, 328 (1993) (citation omitted), and is expressly guaranteed under the Administrative Procedure Act, N.J.S.A. 52:14B-11. At such hearing, the Attorney General must prove the elements of the State's case by a preponderance of the substantial credible evidence, meaning that more likely than not the charges are true. In re Polk License Revocation, 90 N.J. 550, 574 (1982). Here, the Attorney General cites numerous grounds for the State's proposed disciplinary action against Dr. Maron.

N.J.S.A. 45:1-21(c) permits the Board to suspend or revoke a doctor's license upon proof that the licensee "[h]as engaged in gross negligence, gross malpractice or gross incompetence which damaged or endangered the life, health, welfare, safety or property of any person." "Gross malpractice," as that term is used in the Uniform Enforcement Act, requires something much greater than ordinary malpractice in a civil suit for personal injury. In an ordinary malpractice case, the plaintiff must demonstrate that the doctor deviated from an accepted practice standard and that such deviation caused harm to the patient. Germann v. Matriss, 55 N.J. 193 (1970). A showing of "gross malpractice" requires misconduct so "egregious" or "flagrant" as to implicate a much higher magnitude of wrongdoing. In re Polk, 90 N.J. at 565. "Gross neglect" has been equated with "wanton or reckless disregard of the safety of others" or willful misconduct amounting to "heedlessness or reckless[ness]." In re Suspension or Revocation of License of Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977).

N.J.S.A. 45:1-21(d) permits the Board to suspend or revoke a doctor's license upon proof that the licensee "[h]as engaged in repeated acts of negligence, malpractice or incompetence." N.J.S.A. 45:1-21(e) permits the Board to suspend or revoke a

doctor's license upon proof that the licensee "[h]as engaged in professional or occupational misconduct as may be determined by the board." N.J.S.A. 45:1-21(h) permits the Board to suspend or revoke a doctor's license upon proof that the licensee "[h]as violated or failed to comply with the provisions of any act or regulation administered by the board."

The initial and supplemental complaints alleged a total of twenty-one counts against respondent for engaging in unprofessional conduct and unsafe dental practices that continually placed his patients at risk.

I. Failure to Maintain Adequate Patient Records in Violation of N.J.A.C. 13:30-8.7

A. Failure to Obtain Patients' Medical History

The first charge dealt with several violations of N.J.A.C. 13:30-8.7 for failure to maintain adequate patient records. N.J.A.C. 13:30-8.7 provides, in part:

> (a) A contemporaneous, permanent patient record shall be prepared and maintained by a licensee for each person seeking or receiving dental services, regardless of whether any treatment is actually rendered or whether any fee is charged. Licensees also shall maintain records relating to charges made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered.

These patient records must include, among other things, the patient's medical history. N.J.A.C. 13:30-8.7(a)(2). The State alleges that respondent failed to obtain the health history for several patients prior to extracting teeth or putting in implants. For example, when patient F.D. went to Dr. Maron for a tooth extraction in 2010, her medical- and prescription-drug-use history had not been updated since 2006. Dr. Maron did not consult with J.K.'s physician prior to performing dental services, even though J.K. had a history of diabetes and high blood pressure and was on medication. A.P.'s file contained no current medical history, although she had medical problems for which she

was taking medication. Based upon the facts presented, I **CONCLUDE** that respondent has violated N.J.A.C. 13:30-8.7(a)(2) F.D., J.K., and A.P.

B. Failure to Record Patients' Examinations, Treatments, Accurate Dates, and Complaints

The Complaint further alleges that Dr. Maron failed to record patients' examinations and complaints, accurate dates of visits, and specific treatments he performed. N.J.A.C. 13:30-8.7(a)(3) and (a)(5) require licensed dentists to keep a record of the results from a clinical examination and an indication of patient complaints, as well as the dates of each patient visit with a corresponding description of services rendered. Many of respondent's charts were incomplete in this aspect. M.K.'s record did not reflect the complaints she made after her procedure. There were no follow-up notes for E.D. despite her complaints of an ill-fitting bridge and tongue pain, which was later diagnosed as cancer by another doctor. J.B.'s file detailed a post-surgery visit that he denies completely. A.P.'s charts are dated a year after her surgery took place. G.P.'s records were devoid of any accurate dates related to his visits. Furthermore, the majority of Dr. Maron's patient records failed to include any description of the treatment provided, or if they did, it was in illegible handwriting. I **CONCLUDE** that respondent kept inadequate records in violation of N.J.A.C. 13:30-8.7(a)(3) and (a)(5) with regard to patients S.A., A.A., S.B., N.C., E.D., F.D., M.H., M.K., Mi.K. J.K., G.P., A.P., R.P., M.T., C.S., and Y.Z.

C. Failure to Perform Pre-Operative Consultations and Examinations

Respondent was also charged with failure to perform pre-operative consultations and examinations, including not providing diagnosis and treatment plans or establishing records of such plans, in violation of N.J.A.C. 13:30-8.7(a)(4). The Administrative Code requires patient dental records to have "[a] diagnosis and a treatment plan, which shall also include the material treatment risks and clinically acceptable alternatives, and costs relative to the treatment that is recommended and/or rendered." N.J.A.C. 13:30-8.7(a)(4).

Both experts found no documentation of consulting or planning with the patients. Additionally, patients testified that Dr. Maron would not discuss X-rays or any of the procedures to be done. For example, Dr. Maron never followed up with M.T. after her implants and overdenture, and there was no record of a consultation with his associate who initially saw her. N.C. never met Dr. Maron prior to signing a consent form, nor did Maron introduce himself or even address her when he walked into the exam room. M.H. and R.P. underwent a significant amount of treatment, but respondent had not discussed a guide or plan with either of them. The same is true for A.P. and Mi.K., whose files showed no treatment planning or guide. G.P. met with Dr. Maron the day of his surgery, but no discussion took place regarding treatment, the procedure itself, or the risks associated with it. S.B. had four teeth extracted, but was never given an explanation as to why these removals were necessary, as she only complained of one painful tooth. Based on the foregoing, I **CONCLUDE** that Dr. Maron did not provide his patients with appropriate treatment plans, in violation of N.J.A.C. 13:30-8.7(a)(4), with regard to patients A.A., J.B., F.D., M.H., M.K., J.K., Mi.K., G.P., A.P., and R.P.

D. Failure to Maintain Diagnostic Films for Patients

Additionally, the State claims that respondent did not have appropriate diagnostic films for numerous patients. Patient records must include diagnostic X-rays and diagnostic models identified with the patient's name and date. N.J.A.C. 13:30-8.7(a)(6). Records show that Dr. Maron did not have X-rays for J.B., M.K., R.P., A.P., G.P., or Mi.K. Also, during the Board's investigation, Dr. Maron could not provide any X-rays or study models concerning diagnostic treatment for the Board's examination. While some of the X-rays may have been lost due to extenuating circumstances, that could be acceptable if the treatment notes were adequate, but they were not. A dentist should evaluate and treat patients by reviewing diagnostic imaging, and Dr. Maron's poor record keeping is evidence that he did not do this. Based on the facts, I **CONCLUDE** that respondent violated N.J.A.C. 13:30-8.7(a)(6).

E. Failure to Properly Prescribe Medications

The Complaint further alleges that Dr. Maron prescribed medications in violation of N.J.A.C. 13:30-8.7(a)(7), which states that records must include "[t]he date and a description of any medications prescribed, dispensed or sold including the dosage or a copy of any written prescriptions." Respondent's patient records indicate that J.B., R.P., C.S., S.A., Jr., S.B., and G.P. were all prescribed narcotics after treatments without documentation of the quantity or dosage. I **CONCLUDE** that respondent has violated N.J.A.C. 13:30-8.7(a)(7) with regard to these patients.

F. Illegible Patient Records

The Complaint also alleges that respondent's records were illegible. Under N.J.A.C. 13:30-8.7(a)(14),

> [i]f written notations appear in the patient record, the notations shall be legible, written in ink and contain no erasures or white-outs. If incorrect information is placed in the record, it shall be crossed out with a single non-deleting line and shall be initialed and dated by the licensee on the date the change was made. If additions are made to the record, the additions shall be initialed and dated by the licensee on the date the change was made.

Both experts agreed, and Dr. Maron indeed agreed, that the written notations in respondent's patient records were illegible and impossible to read. Dr. Garabedian stated that it would have been difficult to understand what Dr. Maron did without transcriptions ordered by the Board. Dr. Maron himself testified that he was a horrible record keeper. Based upon the evidence provided, I **CONCLUDE** that respondent has violated N.J.A.C. 13:30-8.7(a)(14).

G. Failure to Provide Patient Access to Dental Files

Dr. Maron is further accused of failing to provide patients access to their dental records. N.J.A.C. 13:30-8.7(e)(1) requires a dentist to provide legible copies of patient

records to the patient within fourteen days of receiving a written request. Y.Z. and E.D. requested copies of their records from Dr. Maron. Y.Z. even sent a certified letter requesting his records, but was never provided with his charts. Based on this fact, I **CONCLUDE** that respondent has violated N.J.A.C. 13:30-8.7(e)(1).

II. Failure to Obtain Informed Consent

The second charge involved respondent's failure to obtain any informed consent from patients for specific procedures. "[D]eviation from the standard of care and failure to obtain informed consent are simply sub-groups of a broad claim of medical negligence." Howard v. Univ. of Med. & Dentistry of N.J., 172 N.J. 537, 545 (2002) (quoting Teilhaber v. Greene, 320 N.J. Super. 453, 463 (App. Div. 1999) (citations omitted)). Physicians have an obligation to provide material information that will enable a patient to evaluate the options available and the risks associated with a procedure prior to subjecting him to a course of action. Perna v. Pirozzi, 92 N.J. 446, 459 (1983).

The standard of care for informed consent is whether the physician disclosed risks that a reasonable person would have considered material in deciding whether or not to undergo the recommended treatment. Id. at 460 n.2. Dr. Maron violated this standard over a period of five years with multiple patients. J.B., M.K., F.D., J.K., M.H., A.P., G.P., and Mi.K. were all missing consent forms in their records. The consent forms for C.S., T.B., M.K., J.B., and M.H. bore no description of the procedure, failed to identify the teeth extracted or implanted, did not state the type of sedation used, were undated and unwitnessed, or did not list the name of the surgeon. F.D.'s consent form was signed after the date respondent stated he performed surgery, and an office employee helped F.D. sign this form after she was sedated. Therefore, I **CONCLUDE** that respondent did not obtain informed consent for multiple procedures, in violation of accepted standards, with regard to J.B., G.P., C.S., M.H., Mi.K., J.K., A.P., M.K., F.D., and T.B.

III. Failure to Provide Safe Anesthesia

Respondent was also charged with failing to provide safe anesthesia to patients. N.J.A.C. 13:30-8.1A(a) states that only a dentist who possesses a general-anesthesia permit issued by the Board can administer any pharmacological agent that causes deep sedation. Deep sedation is defined as

> an induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation or verbal command.
>
> [N.J.A.C. 13:30-8.1A(a).]

Any dentist who uses the terms "sleep," "sleeplike-state," or similar words is considered to have induced deep sedation by pharmacological agents as defined in N.J.A.C. 13:30-8.1A(a). N.J.A.C. 13:30-8.1A(b). Dr. Maron contends that he utilized parenteral conscious sedation; however, the evidence shows that he put patients in a deeply sedated state, and he used words such as "put to sleep" when testifying about these practices in front of the Board. He did not have a permit to practice general anesthesia and did not believe he needed a permit to put patients in deep sedation.

Testimony from patients supports the fact that respondent used general anesthesia during procedures. For example, M.K. was put to sleep for her treatment, and she woke up in the waiting room completely unattended. A.P. testified that Dr. Maron used a butterfly needle to put her to sleep, and she was unconscious due to the large amount of sedation drugs used. S.A., Jr., was so deeply sedated that he had been unable to walk to the car and had to be carried by two office assistants. Based on the facts presented, I **CONCLUDE** that respondent administered general anesthesia to patients instead of the titration of sedation to achieve a sedative effect, in violation of N.J.A.C. 13:30-8.1A.

Administering general anesthesia without meeting the minimum training and procedures required is a deviation from the normal standards of care under N.J.A.C.

13:30-8.3(a). Prior to using general anesthesia, a complete medical history, which includes previous medications and allergies, must be obtained and maintained in patient records. N.J.A.C. 13:30-8.3(l). Furthermore, specific records documenting the type of pharmacological agent used, dosage, and duration must be kept. Ibid. Any dentist who administers general anesthesia without obtaining a permit or failing to comply with the rules under N.J.A.C. 13:30-8.3 is "deemed to have engaged in professional misconduct and/or gross malpractice or negligence." N.J.A.C. 13:30-8.3(p). As stated previously, Dr. Maron did not have appropriate medical records for F.D., J.K., and A.P., but still performed surgical procedures on them using general anesthesia. Additionally, anesthesia records were missing from multiple patient files, including those of S.A., Jr., C.S., R.P., and F.D. I therefore **CONCLUDE** that respondent has violated the standards for using general anesthesia under N.J.A.C. 13:30-8.3.

Dr. Maron is also alleged to have violated the parenteral conscious sedation (PCS) standards set forth in N.J.A.C. 13:30-8.2. The Administrative Code states:

> Prior to the administration of a PCS agent for the purpose of controlling pain, a physical evaluation of the patient shall be made by the permit holder and a complete medical history shall be obtained which shall include previous medications, allergies and sensitivities. The patient history shall be maintained in the files of each dentist for a period of not less than seven years. Specific records on the use of PCS shall be kept as part of every patient chart and shall include the type of agent, the dosage, and the duration of sedation.
>
> [N.J.A.C. 13:30-8.2(k).]

Dr. Maron stated that he practiced PCS on his patients. The testimony from both expert witnesses and multiple patients indicated that respondent did not conduct physical evaluations or obtain medical history prior to administering the PCS sedation agent. As previously mentioned, Dr. Maron's patient files did not have anesthesia records at all, nor did those files include complete medical histories for the majority of patients. N.J.A.C. 13:30-8.2 requires a dentist to evaluate patients and obtain a complete medical history prior to utilizing PCS. Further, Dr. Maron failed to provide a safe environment for surgical procedures by permitting his son to be present in the

operatory with patient N.C. Based upon the facts, I **CONCLUDE** that respondent violated this regulation with regard to S.A., A.A., S.B., N.C., E.D., F.D., M.H., M.K., Mi.K., J.K., G.P., A.P., R.P., M.T., C.S., N.C., and Y.Z.

IV. Violations of N.J.S.A. 45:1-21, Grounds for Board Refusal to Renew License

Respondent is also charged with several violations of N.J.S.A. 45:1-21, which states in relevant part:

> A board may refuse to admit a person to an examination or may refuse to issue or may suspend or revoke any certificate, registration or license issued by the board upon proof that the applicant or holder of such certificate, registration or license:
>
> . . . .
>
> b. Has engaged in the use or employment of dishonesty, fraud, deception, misrepresentation, false promise or false pretense;
>
> c. Has engaged in gross negligence, gross malpractice or gross incompetence which damaged or endangered the life, health, welfare, safety or property of any person;
>
> d. Has engaged in repeated acts of negligence, malpractice or incompetence;
>
> e. Has engaged in professional or occupational misconduct as may be determined by the board;
>
> f. Has been convicted of, or engaged in acts constituting, any crime or offense involving moral turpitude or relating adversely to the activity regulated by the board.

A. Fraudulent Misrepresentation to an Insurance Carrier

The Complaint alleges that respondent participated in fraudulent misrepresentation to an insurance carrier in violation of N.J.S.A. 45:1-21(b), engaging in

fraud, dishonesty or deception; (e), engaging in professional misconduct; and (f), engaging in any act constituting an offense involving moral turpitude. Dr. Maron submitted an application to UnitedHealthcare with false answers regarding if there had been any actions, investigations, or malpractice settlements against him. He had in fact been summoned to appear before the Board twice in connection with patient complaints and had also been named in multiple malpractice suits. Dr. Maron did not attempt to correct his answers on the application. Based on the facts adduced, I **CONCLUDE** that respondent engaged in fraud and dishonesty in violation of N.J.S.A. 45:1-21(b), (e), and (f).

B. Deceptive Billing and False Loan Applications

Additionally, the State alleges that Dr. Maron participated in deceptive billing of and false completion of loan-application papers for his patients in violation of N.J.S.A. 45:1-21(b), engaging in fraud, dishonesty, or deception; (c), engaging in gross negligence, malpractice, or incompetence which endangered the health, safety, or property of any patient; (e), engaging in professional misconduct; and (f), engaging in any act constituting an offense involving moral turpitude.

Testimony from multiple patients showed that Dr. Maron or his office double-billed patients and incorrectly charged patients for work that was never completed and products that were never provided. T.B. experienced double billing from respondent's office, C.S. was billed for high-noble crowns that were never provided, and Y.Z. was billed for high-noble crowns but only received non-precious-metal crowns. J.B. was billed for services not rendered. P.T. was falsely billed for four crowns and double dentures. F.D. was billed $15,000 from a collection agency for work that was not completed and that she did not want.

Moreover, Dr. Maron or his office pressured patients into taking out large loans for dental work, regardless of their age, limited income, or Medicaid status. For example, P.T., a ninety-two-year-old receiving Medicaid, signed papers for a CareCredit loan of $11,000 and a Chase line of credit for $20,000. Patient A.A. was also pressured into applying for credit even though she was receiving Medicaid. Respondent's office

falsely exaggerated M.K.'s salary when filing a credit application on her behalf, and the promissory-note signature was not hers. I **CONCLUDE** that respondent engaged in deceptive billing practices that damaged patients M.K., M.T., J.B., M.H., Mi.K., J.K., R.P., C.S., G.P., R.P., and Y.Z., in violation of N.J.S.A. 45-1.21(b), (c), (e), and (f).

C. Gross Negligence, Malpractice, and Failure to Supervise Employees

Lastly, respondent was charged with gross negligence, malpractice, and failure to supervise employees in violation of N.J.S.A. 45:1-21(c), and with repeatedly engaging in acts of negligence, malpractice, or incompetence which endangers the welfare of patients in violation of N.J.S.A. 45:1-21(d). Dr. Maron was responsible for the conduct of those in his employ and cannot escape responsibility by claiming no knowledge of billing or insurance errors. See In re Friedlander, M.D., BDS 03637-11, Initial Decision (August 29, 2014), adopted in part, modified in part, Bd. of Med. Exam'rs (November 24, 2014), http://njlaw.rutgers.edu/collections/oal/. To do so would record professional accounting for misconduct a nullity. Here, patients J.B., M.H., M.K., Mi.K., J.K., R.P., C.S., G.P., R.P., M.T., and Y.Z. were not billed appropriately for services rendered.

Further, in addition to prescribing medications without proper dosage notation and keeping inadequate records, Dr. Maron provided inferior dental work that damaged patients' teeth. Only one half of P.T.'s lower denture put in place by Dr. Maron was secured with implants, several natural teeth were loose and painful, and surgery was required to remove both the implants and affected upper teeth. M.H.'s bridges were not fully seated, and a large amount of excess cement got into the gingival level, both of which were not able to be corrected. R.P. had a chipped tooth after Dr. Maron's hasty insertion of an implant. E.D. visited Dr. Maron nineteen times to fix defective dentures, and each time she was there, a lesion on her tongue that she complained of (and which turned out to be cancerous) was ignored by dentists in the office.

Dr. Maron had to constantly recement T.B.'s crowns that had fallen off because they were originally too big for his teeth. S.A., Jr., found a piece of tooth in his gums, which he removed himself. G.P. had implants placed into the sinus on purpose,

rendering his implant too high and unusable. Mi.K.'s nerve was severed by placing implants in his shallow lower jaw, causing permanent paresthesia. Based upon this evidence, I **CONCLUDE** that respondent was repeatedly grossly incompetent while performing dental procedures and endangered the health and welfare of his patients in violation of N.J.S.A. 45-1.21(c) and (d), including patients J.B., F.D., M.H., M.K., Mi.K., J.K., G.P., A.P., M.T., J.B., and E.D.

V. Failure to Cooperate with Board Investigation

Respondent is further charged with failure to cooperate with the Board investigation. Under N.J.S.A. 45:1-18, the Board has the authority to investigate a dentist who engaged in unlawful or unsafe activity:

> Whenever it shall appear to any board, the director or the Attorney General that a person has engaged in, or is engaging in any act or practice declared unlawful by a statute or regulation administered by such board, or when the board, the director or the Attorney General shall deem it to be in the public interest to inquire whether any such violation may exist, the board or the director through the Attorney General, or the Attorney General acting independently, may exercise any of the following investigative powers:
>
> > a. Require any person to file on such form as may be prescribed, a statement or report in writing under oath, or otherwise, as to the facts and circumstances concerning the rendition of any service or conduct of any sale incidental to the discharge of any act or practice subject to an act or regulation administered by the board;
> >
> > . . . .
> >
> > e. Examine any record, book, document, account or paper prepared or maintained by or for any professional or occupational licensee in the regular course of practicing such profession or engaging in such occupation or any individual engaging in practices subject to an act or regulation administered by the board. Nothing in this subsection shall require the notification or consent of the person to whom the

> record, book, account or paper pertains, unless otherwise required by law.

Dr. Maron did not produce patient records in a timely manner once requested from the Board. When documents were finally produced, transcriptions of records did not match handwritten charts, and some handwritten charts were not legible. Furthermore, some patient X-rays, study models, and narratives, including those of patients S.A., F.D., M.K., Mi.K., R.P., and M.T., were not provided or were completely inadequate. Based on these facts, I **CONCLUDE** that respondent has violated N.J.S.A. 45:1-18.

CONCLUSION

Based upon the conclusions of law set forth above, that Dr. Maron conducted his dental practice in a grossly negligent and incompetent manner in violation of the pertinent New Jersey regulations, the inquiry is then on the appropriate disposition. The complainant seeks revocation of Dr. Maron's license and other relief, including fines, costs, and investigative fees.

Dr. Maron contends that revocation is not appropriate given the likelihood that he can be rehabilitated, and that revocation would be a disparate penalty when compared with other dentists similarly situated.

Dr. Maron cites the following recent settlements and cases before the Board in support of his position:

1. Dr. Alan Cohn—civil penalty, restitution and continuing remedial education for inadequate diagnostic records and sedation monitoring.

2. Dr. Robert Carter—monetary penalty for inadequate diagnostic records and maintenance of records.

3. Dr. Robert Kudla—civil penalty, continuing remedial education, and Board expenses for inadequate diagnostic records and record keeping.

4. Dr. Ira S. Port—restitution, civil penalty and continuing remedial education for inadequate diagnostic records, and failure to apprise patient of treatment changes, and implant failure.

5. Dr. Yan Lui—civil penalty, cost of Board's investigation, restitution, and continuing remedial education for inadequate diagnostic records, execution of treatment, insurance-submission defects, and failure to complete continuing education.

6. Dr. Ping Cai—(previously indicted for Medicaid fraud and having successfully completed the PreTrial Intervention Program with restitution)—one-year suspension (thirty days active), disposal of CDS, continuing education, pass an ethics course, civil penalty, and billing review for deviating from generally accepted dental standards with regard to twelve patients, including failure to account for medical histories, failure to document treatment plans, and not obtaining informed consent.

7. Dr. Ahmad Sedehi—one-year suspension (four months active), continuing remedial education, pass an ethics course, restitution, costs of Board investigation, and civil penalty for inadequate diagnostic records, no treatment plans, no charting, and performing multiple extractions without appropriate diagnostic information from radiographs.

8. Dr. Steven Weiner—one-year suspension on probation, cessation of restorations, and civil penalties for inadequate diagnostic records, failure to make treatment plans, failure to take radiographs, and failure to maintain patient records.

9. Dr. Mohammad Rabah—three-year suspension (twelve months active), participate in Professional Assistance Program of New Jersey, monetary penalties, and completion of an ethics course for abandoning a sedated patient after oral surgery and self-administering of CDS during the workday.

10. Dr. Anthony Mancino—Final Order and Decision after hearing before the OAL in which the administrative law judge recommended revocation of dental license for violation of the terms of a 1999 Consent Order—three-year suspension (four months active), civil penalties of $80,000, plus attorneys' fees and costs of $85,000 (which includes costs of investigation, hearing, experts' fees, and transcripts at the OAL).

In additional mitigation of a penalty, Dr. Maron and his expert, Dr. Garabedian, cite his providing dental services to an underserved segment of the population, the elderly, at reduced rates. However, no proof was presented that this population was in fact underserved or was in need of, or indeed received, reduced rates.

While Dr. Maron contended that he could practice effectively and safely, that he was well trained, and that he now understood the importance of legible and correct records, the evidence offered here that he can practice effectively and safely is not sufficient.

Rather, the evidence showed that Dr. Maron's practice was so overextended that it was almost impossible for him to provide quality, thorough, and thoughtful care to his patients. The number of procedures he claimed to do in a year was daunting. Treatment plans were prepared by the referring dentist, if at all. Treatment was discussed while patients were already in the chair receiving anesthesia. Treatment options were not discussed, nor were more reasonable treatment options explored with the patients. Medical histories were either not taken or not updated, or were ignored. Informed consent was not given by patients. In some cases, Dr. Maron did not even review the consent with the client, leaving it to others, if it was done at all. X-rays were inadequate or missing. Patient records were totally illegible and lacked the stickers for an implant that was placed. Numerous implants failed, some dangerously so, by migrating into the sinus, or by patients swallowing them. Prescriptions for medications were given to patients without dosage or quantity. Clients were billed for precious-metal crowns when they received non-precious. Consultation, diagnosis, and treatment were well below accepted standards. Dr. Maron's records, including anesthesia records,

were not complete or were missing. Anesthesia records were sorely lacking. While he claimed he titrated Versed, the patients were clearly well sedated and "put to sleep." Some records were not contemporaneous with treatment or had been altered. Oversight of employees was lacking.

One particular concerning aspect of Dr. Maron's practice was his treatment of elderly patients. Without treatment planning or discussion of ability to pay, elderly patients were encouraged, indeed almost compelled, to have implants placed without pre-operative diagnosis, review, or consent. Cheaper or more realistic options for improved dental care were ignored or not discussed with patients. Medicaid beneficiaries, whose benefits are subsistence level and income-tested, were coerced into taking CareCredit loans which exceeded their ability to repay under any circumstances. Such actions were clearly predatory to this vulnerable population.

Respondent's repeated acts of negligence and gross negligence, his professional misconduct, his dishonesty and deception, and his lack of providing appropriate and determined care for his patients warrant the severest possible sanction, namely, revocation of his license. Notwithstanding that other dentists with similar complaints may have had periods of suspensions and fines imposed by the Board with no revocation of their licenses, here, Dr. Maron has demonstrated a complete and utter disregard for the well-being of his patients. Patients' complaints were ignored; follow-up care was slighted; treatment plans were absent; records were woeful.

In addition to revocation, the complainant seeks imposition of maximum penalties for each separate unlawful act as set forth in Counts 1 through 21; imposition of costs of investigation, fact- and expert-witness fees, transcript fees, and attorney fees and costs; and reimbursement to patients or third-party payers of all monies found to be unlawful, as set forth in appendix table 2.

N.J.S.A. 45:1-25 (violations, penalties) provides, in part:

> a. Any person who engages in any conduct in violation of any provision of an act or regulation administered by a

> board shall, in addition to any other sanctions provided herein, be liable to a civil penalty of not more than $10,000 for the first violation and not more than $20,000 for the second and each subsequent violation. For the purpose of construing this section, each act in violation of any provision of an act or regulation administered by a board shall constitute a separate violation and shall be deemed a second or subsequent violation under the following circumstances:
>
> > (1) an administrative or court order has been entered in a prior, separate and independent proceeding;
> >
> > (2) the person is found within a single proceeding to have committed more than one violation of any provision of an act or regulation administered by a board; or
> >
> > (3) the person is found within a single proceeding to have committed separate violations of any provision of more than one act or regulation administered by a board.
>
> . . . .
>
> d. In any action brought pursuant to this act, a board or the court may order the payment of costs for the use of the State, including, but not limited to, costs of investigation, expert witness fees and costs, attorney fees and costs, and transcript costs.

Dr. Maron's multiple acts of N.J.S.A. 45:1-21(b), (c), (e), and (f) resulted in a total of eighteen such violations.

He failed to maintain appropriate diagnostic and dated radiographs, in violation of both N.J.A.C. 13:30-8.7(a)(6) and accepted dental practices, for a total of ten violations.

Repeated acts of negligence involved patients J.B., F.D., M.H., M.K., Mi.K., J.K., G.P., A.P., M.T., and E.D., in violation of N.J.S.A. 45:1-21(d), for a total of ten such violations.

Deficient treatment was rendered to J.B., F.D., M.H., M.K., Mi.K., J.K., G.P., A.P., M.T., and E.D., for a total of ten violations.

The charges concerning the lack of informed consent and the failure to provide patients with appropriate treatment plans or to establish appropriate records of such plans, in violation of both N.J.A.C. 13:30-8.7(a)(4) and accepted dental practices, are considered repeated acts of negligence as discussed above.

Respondent failed to submit records and statements under oath to the Board at its directive, in two instances, in violation of N.J.S.A. 45:1-18 and the related regulations.

In light of respondent's unprofessional conduct and the many other violations he committed, a substantial penalty is warranted. Accordingly, he should be liable for a civil penalty of $150,000.

In addition, respondent should reimburse those patients and/or their parents who testified as to their out-of-pocket expenses related to, or caused by, his negligence or his failure to provide services and/or treatment for which payment was made, as determined by this decision, as per the annexed table in the total amount of $89,935.22.

Finally, pursuant to N.J.S.A. 45:1-25(d), respondent should reimburse petitioner its investigation costs ($1,113.75); enforcement-bureau costs ($5,475.47); expert-witness fees and costs ($18,750); travel costs ($54); transcript costs ($5,528); and reasonable attorney fees and costs ($272,935).

ORDER

Based upon the foregoing, it is hereby **ORDERED** that:

(1) the license issued by the Board to respondent, Dr. Maron, to practice dentistry in the State of New Jersey shall be and is hereby **REVOKED**;

(2) respondent is liable for civil penalties totaling $150,000;

(3) respondent shall reimburse those patients and/or their parents who testified as to their out-of-pocket expenses related to or caused by his negligence or his failure to provide services and/or treatment for which payment was received, as determined by this decision and set forth in the annexed table, totaling $89,935.22;

(4) pursuant to N.J.S.A. 45:1-25(d), respondent shall reimburse petitioner its investigation costs, expert-witness fees and costs, reasonable attorney fees and costs, and transcript costs in the total amount of $303,856.22 (investigation costs—$1,113.75; enforcement-bureau costs—$5,475.47; expert-witness fees and costs—$18,750; travel costs—$54, transcript costs—$5,528; and reasonable attorney fees and costs—$272,935).

I hereby **FILE** my Initial Decision with the **BOARD OF DENTISTRY** for consideration.

This recommended decision may be adopted, modified or rejected by the **BOARD OF DENTISTRY**, which by law is authorized to make a final decision in this matter. If the Board of Dentistry does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **EXECUTIVE DIRECTOR, BOARD OF DENTISTRY, 124 Halsey Street, P.O. Box 45005, Newark, New Jersey 07101**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

May 6, 2019
DATE

SUSAN M. SCAROLA, ALJ
(Ret., on recall)

Date Received at Agency: _____

Date Mailed to Parties: _____

SMS/cb

APPENDIX

WITNESSES

For petitioner:

Dr. Michael Kleiman, D.M.D.

Patient S.A., Jr.

Patient M.K. (now M.S.)

S.S. (patient M.K.'s husband)

Patient J.B.

Patient Mi.K.

Patient T.B.

Patient G.P.

P.T., for patient M.T. (now deceased)

For respondent:

Valerie Schwab

Dr. Andrew Maron

Dr. Hamlet Garabedian

EXHIBITS

For petitioner:

Count 1—Dr. Maron's Manner of Practice

- P-1 Michael A. Kleiman, D.M.D., curriculum vitae
- P-2 Dr. Kleiman's July 19, 2015, expert report
- P-2A "Principles of Ethics and Code of Professional Conduct of the American Dental Association"
- P-2B "Code of Professional Conduct of the American Association of Oral and Maxillofacial Surgeons"
- P-2C CDT Manual, excerpts for Code 7140 and 7210 (see also transcript P-3, pp 113–116 at 81a)

P-3 September 17, 2014, Board investigative inquiry transcript, In re Andrew Dr. Maron, D.D.S.

P-3A Transcript cost for 2014, $1,113.75

P-4 ID Board Investigative Inquiry of October 20, 2004

P-5 Jonathan Eisenmenger, Executive Director, State Board of Dentistry, June 16, 2015, Certification of inactive status of Dr. Maron's general anesthesia permit

P-5A Mr. Eisenmenger's e-mail, 11/30/15

P-6 Dr. Maron's curriculum vitae

P-7 Attorney General's letter, January 26, 2016, to Medical Center of Ocean County

P-7A February 14, 2017, response e-mail from Catherine Wallace, CPCS, Manager, Medical Staff Service, Ocean Medical Center

Count 2—Patient J.B.

P-8 Patient J.B.: patient complaint

P-9 Dr. Maron letters re J.B., Dr. Maron transcription and treatment chart (see also P-3 transcript, pp 173–180)

P-10 Board correspondence and record of J.B.'s subsequent treating surgeon Dr. Corry

P-10A X-ray photocopy for J.B.: Dr. Corry 10/4/2011

P-11 X-ray photocopies for J.B.: Dr. Feldman 10/5/09, 6/8/10, 10/28/10, 10/3/11, 10/28/10, 10/3/11 (see also transcript P-3, pp 173–180)

Count 3—Patient M.K.

P-12 Patient M.K.: Patient complaint and attachments (self-photographs: (two) dated 12/10/12, Springstone Finance documents, photograph dated 12/28/12, prescriptions, St. Barnabas hospital documents 1/7/13

P-13 M.K. certification 7/28/15

P-14 S.S. Certification 7/28/15

P-15 Board letter and Dr. Haghighi record for M.K. as subsequent treating dentist

P-15A Dr. Haghighi's X-rays for M.K.: 1/7/2013

P-16 Board correspondence, Dr. Maron letter re M.K., Dr. Maron's transcription, treatment chart from Shrewsbury Office

P-17 Dr. Maron's transcription and treatment chart for M.K. from Eatontown office

P-18 Dr. Maron X-ray for M.K.: 12/28/12 from Eatontown office (see also transcript P-3, pp 182–196)

Count 4—Patient M.T. (deceased)

P-19 Certification of P.T., patient M.T.'s family complaint, record of subsequent treating dentists at Monmouth Dental Clinic

P-19A Family supplemental correspondence, January–February 2016 e-mails from P.T., niece of M.T.

P-20 Dr. Maron letter re M.T., transcription and treatment chart

P-20A Package of signatures for comparing CareCredit application 1/18/2010 at pg MT0028 with "waiver" statement January 29, 2010, at pg MT0019, found in Dr. Maron's chart

P-21 Dr. Maron office X-rays for M.T.: 2/15/10 (see also transcript P-3, pp 196–200)

P-22 Board correspondence to subsequent dentists at Monmouth Medical Center Dental Clinic re M.T., 1/28/11 response by oral surgeon Dr. Gary Brousell, 11/23/10 response from chief general practice resident Dr. Ryan Sheridan with images, Diagnostic Workup and Treatment Plan, 11/24/10 response from consultant Dr. Mitchel Friedman and Treatment Plan

P-23 Medical Center Clinic, M.T. X-rays photo 8/6/10, 8/23/10 (total 3 pgs)

Count 5—Patient F.D., believed to be deceased

P-24 Patient F.D.: patient complaint to Monmouth County Dep't of Consumer Affairs and Monmouth DCA letters to F.D. and to Dr. Maron

P-25 Board and Dr. Maron correspondence and F.D. treatment chart, transcription

P-26 Dr. Maron X-rays of F.D.: 4/22/08, 6/7/10 (see also transcript, P-3, pp 28–69)

P-27 Enforcement Bureau report with Keansburg Pharmacy Profile of F.D.

Count 6—Patient N.C.

P-28 Patient N.C. complaint

P-29 Dr. Maron office correspondence re N.C., two versions of transcription, Rx copy and N.C. treatment chart

P-30 Dr. Maron X-rays for N.C.: 2/27/14

P-31 Dr. Nathan Ostler's chart for N.C., X-ray photo dated 8/1/2014 and letters as subsequent treating dentist

Count 7—Patient J.K.

P-32 Patient J.K. complaint

P-33 Dr. Maron correspondence re J.K., transcription and J.K. treatment chart

P-34 Dr. Maron X-rays for J.K.: 5/7/12 (2), 5/14/12, 6/13/13, 6/12/14, 6/19/14

Count 8—Patient M.H.

P-35 Patient M.H./MPH complaint

P-36 Dr. Maron correspondence re M.H. transcription and treatment chart

P-37 Dr. Maron X-rays for M.H.: 2/22/10, 1 sheet (7/10/09, 3/14/11, 2/21/11, 6/6/11), 1 sheet (1/10/11, 6/28/10, 3/3/11, 7/11/11) (see also transcript, P-3, pp 95–100)

P-38 Dr. DiCesare letter and M.H. chart as subsequent treating dentist

P-39 Dr. DiCesare X-rays photocopy 1/27/12 for M.H.

Count 9—Patient R.P. (deceased)

P-40 Patient R.P. complaint, Patient R.P.'s second letter and attached consent form

P-41 Dr. Maron's correspondence re R.P., Dr. Maron treatment chart (no X-rays produced by Dr. Maron) (see also transcript P-3, pp 110–136)

Count 10—Patient A.P.

P-42 Dr. Maron's undated correspondence re A.P.'s implants on 9/27/13, transcription and A.P. treatment chart purporting to list procedure as on 9/27/14

P-43 Dr. Maron X-rays for A.P.: 9/18/09, 5/31/12 (see also transcript P-3, pp 69–95 and P-24D and P-24E)

Count 11—Patient T.B.

P-44 Patient T.B. complaint, with bill attachments

P-45 Dr. Maron letter re T.B., office correspondence, photocopy X-rays, office treatment chart, first submission consent form, second submission consent form, transcription (see also transcript P-3, pp 100–105)

P-46 (reserved)

P-47 T.B.'s Certification 4/25/15

County 12—Patient A.A.

P-48 Patient A.A. complaint

P-49 Board letter, Dr. Maron letter re A.A., Dr. Maron transcription and A.A. treatment chart

P-50 Dr. Maron X-rays for A.A.: 2/5/10, 3/8/10

P-51 Rona Henderson, Monmouth County ADL Aide Certification re A.A. 5/2/16 (see also transcript P-3, pp 136–157)

Count 13—Patient E.D.

P-52 Patient E.D. complaint

P-53 Dr. Lara Dalessio letter re E.D., Dr. Maron letter, Dr. Maron narrative, E.D. treatment chart

P-54 Dr. Maron office X-rays for E.D. 2/19/11, 8/23/11, 10/20/11, 11/18/11, 3/22/12, 5/15/13 (see also transcript P-3, pp 164–173)

P-55 Dr. Michael Keller's record re E.D. and correspondence as subsequent treating dentist, ENT and oncologists' records, George Sandau, M.D., Aileen Chen, M.D., and Assistant Professor Brett A. Miles, D.D.S., M.D. at Mount Sinai Hospital (see also transcript, P-3, pp 164–173)

P-56 E.D. e-mail February 1, 2016, noting Florida resident

Count 14—Patient C.S. (deceased)

P-57 Patient C.S. complaint

P-58 Dr. Michael Benhamu's letter re C.S.

P-59 Dr. Maron's narrative re C.S., transcription and office treatment chart (no X-rays produced by Dr. Maron)

P-60 February 23, 2016, letter and e-mail, certification, from daughter D.S. as Executrix of the Estate of C.S.

Count 15—Patient Y.Z.

P-61 Patient Y.Z. complaint letters with letters from subsequent treating dentist Dr. Ta and her office; Board subpoena for record and Demand for Statement in Writing Under Oath, Dr. Maron narrative

P-62A Dr. Maron initial transcription

P-62B Dr. Maron revised transcription 20B-2, Dr. Maron office treatment chart for Y.Z. (pages produced not in chronological order, claim/bill for tooth #27, lab invoice for #27

P-63 (reserved)

Count 16—Patient S.A., Jr.

P-64 Dr. Maron statement re patient S.A., Jr., Dr. Maron transcription and S.A., Jr., treatment chart

P-65 Dr. Maron X-rays for S.A., Jr.: 11/18/06, 5/11/09, 8/29/13

P-66 Horizon BCBS claim and payment record re S.A., Jr.

P-67 Patient S.A., Jr.,'s 4/10/16 Certification (see also transcript P-3, pp 160–164 and P-24D and P-24E)

Count 17—Patient S.B.

P-68 Dr. Maron statements re patient S.B., Dr. Maron treatment chart for S.B., transcription (no X-rays produced by Dr. Maron) (see also transcript, P-3, pp 158–160)

Count 18—Misrepresentation to Insurance Provider

P-69 Dr. Maron's March 23, 2015, application for provider status to UnitedHealthcare (4-page excerpt)

P-70 Board of Dentistry Investigative Inquiry transcript 9/17/14, excerpt, pp 1–4 (single sheet)

P-71 Board of Dentistry Investigative Inquiry transcript 10/20/04, excerpt, pp 1–4

P-72 Dr. Maron attorney letter 6/18/15 with Dr. Maron's certified responses to Board's Demand for Statement in Writing and Under Oath, excerpt, 4 pp

Count 19—Failure to Cooperate in Board Investigation

P-73 Dr. Maron's failure to respond to Board correspondence seeking production of patient records within a specified time period, and Dr. Maron's failure to comply with those investigative demands:

- 10/10/14 letter from counseling deputy to Attorney Schechner noting numerous items which Dr. Maron had failed to produce
- 4/15/15 deputy's certified mail letter to Mr. Schechner noting failure to respond to Board questions
- 4/17/15 deputy letter to Mr. Schechner seeking copy of Dr. Maron's general anesthesia permit and PCS permit for the then current cycle
- 4/21/15 letter to Mr. Schechner regarding missing material and illegible material in the Y.Z. chart
- 6/24/15 letter to counsel noting failure to answer questions and requests by the Board, and omitting chart information required by Board rules

Count 20—Patient G.P.

P-74 G.P. complaint to Board January 17, 2016; Patient's February 3, 2016, letter to Board; patient's July 9, 2016, letter with Monmouth Dental Group's August 17, 2015, treatment plan

P-75 Board subpoena August 1, 2016, to G.P.'s subsequent treating dentist Jean Bichara, D.D.S.; copy of Dr. Bichara's chart at "Champagne Smiles" with X-rays; consultation report May 3, 2016, of Arun Kumar, M.D.

P-76 Board letter January 26, 2016, to Donald S. Frederick, D.D.S., of Monmouth Dental Group; response with copy of the G.P. dental chart of

Monmouth Dental Group office of Dr. Maron and Dr. Frederick, including August 14, 2015, consultation and photocopy of X-ray from office of Endodontic Associates, P.A.

P-77 Dr. Maron's X-rays of G.P.

Count 21—Patient Mi.K.

P-78 Mi.K., excerpts from litigation: "Plaintiff's paper Discovery Responses" from civil litigation submitted April 5, 2016, by Attorney Ratkowitz and "Plaintiff's Answers to Supplemental Interrogatories Propounded by Defendant Andrew Dr. Maron, D.D.S.

P-78 Attorney Sanfilippo's July 7, 2016, letter to attorney Lustbader, reporting Mi.K.'s answers to Supplemental Interrogatory Questions SM4, SM10, Notice to Produce Questions 7, 21, 29, 30

P-79 Dr. Maron's May 17, 2016, response to Interrogatories by Dr. Frederick, containing Dr. Maron's transcription of Dr. Maron's chart notes of 11/4/13, 11/8/13, 11/12/13, 11/14/13 and 4/28/14

P-80 Tooth Savers chart for Mi.K. for treatment 2002–2009, including chart note dated August 23, 2003

P-81 (reserved)

P-82 Attorney General's subpoena to Dr. Maron for records of Mi.K., with transcription; attorney response with Dr. Maron records

P-83 Attorney General's subpoena to Dr. Frederick for records of Mi.K., with transcription of Dr. Frederick's notes; response with records

P-84 Dr. Kleiman's Supplemental Report December 9, 2016

P-85 Dr. Kleiman's expert fee vouchers:

P-85A	Interim voucher for initial work on expert Report	$8,250.00
P-85B	Completion of initial report	$3,900.00
P-85C	Supplemental Report	$1,350.00
P-85D	Trial preparation, conferences, two days' testimony time	$5,250.00
	Total:	$18,750.00

P-86 Enforcement Bureau documents:

P-86A Enforcement Bureau costs regarding Pharmacy Profile of patient F.D. $557.36

P-86B Enforcement Bureau Report 9/15/15 research for Dr. Maron to serve him with documents, personal service of Verified Complaint and Order to Show Cause [reserved: Attachments]

P-86C Costs of 9/15/15 Report: $1,374.89

P-86D (reserved) [Enforcement Bureau 10/1/13 Memorandum re receipt of information from confidential source] (Not in Evidence)

P-86E Enforcement Bureau Report 4/1/15 (Not in Evidence)

P-86F Costs of 4/1/15 Report: $3, 543.22

Total Bureau costs: $5,475.47

P-87 Orders, package, Board of Dentistry:

Order to Show Cause 9/2/15

Order 9/21/15

Order 10/21/15

Order 12/2/15

P-88 Travel costs of fact witnesses, pkg:

JB: $12.00

GP: $12.00

MK and SS: $18.00

Mike K: $12.00

SA: $ (reserved)

P-89 OAL transcript vouchers total $5,528 (reserved)

P-90 Attorney General's fee certification

Respondent's Exhibits

R-1 S.A. Consent for Oral Surgery and Anesthesia, dated September 23, 2013

R-2 S.A. Panorex, August 29, 2013

R-3 Panorex for M.K., November 12, 2012

R-4 Panorex for M.K., November 29, 2012

R-5 Pre-op Panorex F.D., December 7, 2009

R-6 Continuing Education Certificates (12 pages)

R-7 2013 – 2015 Permit for Anesthesia

R-8 C.V. of Dr. Hamlet Garabedian, DMD, MD, FACS

R-9 Expert Report of Dr. Hamlet Garabedian, DMD, MD, FACS