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BEFORE THE
DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KHUONG HUU NGUYEN** **2780 Cardinal Road, Suite A** **San Diego, CA 92123** **Dental License Number 44965** **Oral Conscious Sedation Certificate for Minor Patients Number 444** **Fictitious Name Permit Number 10353** Respondent.	Case Number: **4402019000317** **ACCUSATION**

PARTIES

1. Karen M. Fischer (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Dental Board of California, Department of Consumer Affairs.

2. On or about November 21, 1997, the Dental Board of California issued Dental License Number 44965 to Khuong Huu Nguyen (Respondent). The Dental License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2022, unless renewed.

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3. On or about August 15, 2001, the Dental Board of California issued Oral Conscious Sedation Certificate for Minor Patients Number 444 to Respondent. The Oral Conscious Sedation Certificate for Minor Patients was in full force and effect at all times relevant to the charges brought herein and will ~~expire on~~ September 30, 2022, unless renewed.

4. On or about March 11, 2013, the Dental Board of California issued Fictitious Name Permit Number 10353 to Respondent. The Fictitious Name Permit was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2022, unless renewed.

JURISDICTION

5. This Accusation is brought before the Dental Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

6. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

7. Section 1670 states:

> Any licentiate may have his license revoked or suspended or be reprimanded or be placed on probation by the board for unprofessional conduct, or incompetence, or gross negligence, or repeated acts of negligence in his or her profession, or for the issuance of a license by mistake, or for any other cause applicable to the licentiate provided in this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

STATUTORY PROVISIONS

8. Section 725 of the Code states, in pertinent part:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist,

podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

. . . .

9. Section 810 of the Code states, in pertinent part:

(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code.

. . . .

10. Section 550 of the Penal Code states, in pertinent part:

(a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud.

. . . .

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

. . . .

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

. . . .

11. Section 1647.14 states, in pertinent part:

(a) A physical evaluation and medical history shall be taken before the administration of oral conscious sedation to a minor. Any dentist who administers, or orders the administration of, oral conscious sedation to a minor shall maintain records of the physical evaluation, medical history, and oral conscious sedation procedures used as required by the board regulations.

. . . .

12. Section 1680 states:

Unprofessional conduct by a person licensed under this chapter [Chapter 4 (commencing with section 1600)] is defined as, but is not limited to, any one of the following:

(a) The obtaining of any fee by fraud or misrepresentation.

. . . .

(n) The violation of any of the provisions of this division.

. . . .

(p) The clearly excessive prescribing or administering of drugs or treatment, or the clearly excessive use of diagnostic procedures, or the clearly excessive use of diagnostic or treatment facilities, as determined by the customary practice and standards of the dental profession.

. . . .

13. Section 1682 states, in pertinent part:

In addition to other acts constituting unprofessional conduct under this chapter [chapter 4 (commencing with section 1600)], it is unprofessional conduct for:

. . . .

(c) Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment required by the board.

. . . .

REGULATORY PROVISIONS

14. California Code of Regulations, title 16, section 1044.45 states, in pertinent part:

A facility in which oral conscious sedation is administered to patients pursuant to this article shall meet the standards set forth below.

. . . .

(c) The following records shall be maintained:

(1) An adequate medical history and physical evaluation, updated prior to each administration of oral conscious sedation. Such records shall include, but are not limited to, an assessment including at least visual examination of the airway, the age, sex, weight, physical status (American Society of Anesthesiologists Classification), and the rationale for sedation of the

minor patient as well as written informed consent of the patient or, as appropriate, parent or legal guardian of the patient.

(2) Oral conscious sedation records shall include baseline vital signs. If obtaining baseline vital signs is ~~prevented~~ by the patient's physical resistance or emotional condition, the reason or reasons must be documented. The records shall also include intermittent quantitative monitoring and recording of oxygen saturation, heart and respiratory rates, blood pressure as appropriate for specific techniques, the name, dose and time of administration of all drugs administered including local and inhalation anesthetics, the length of the procedure, any complications of oral sedation, and a statement of the patient's condition at the time of discharge.

COST RECOVERY

15. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

PATIENT JQ

16. On or about July 30, 2018, the Board received a complaint from MN, on behalf of her minor daughter, JQ, and opened an investigation into the matter.

17. MN alleged in her complaint that Respondent double-billed her for the treatment he performed on her daughter, by charging her a "co-pay" of $800.00 for "behavior management and oral conscious sedation," and then billing Medi-Cal Dental for the same charge. MN also alleged that Respondent did not complete the work that he billed for, because a subsequent treating dentist was unable to verify the work Respondent allegedly completed when MN took her daughter for a second opinion.

18. On or about June 8, 2018, MN took JQ to Respondent's office for an examination and potential treatment. MN stated that her daughter, JQ, had swollen gums and had been crying in

pain, and Respondent was the only dentist she found who accepted Medi-Cal Dental and was willing to see JQ immediately. Respondent showed MN one cavity on JQ's X-rays, and claimed that JQ had six additional cavities. MN asked Respondent why he didn't show her all of the cavities, and Respondent told her "because I am a doctor, I know." Respondent's records for JQ document that he allegedly provided treatment to ten teeth (A, B, C, H, I, J, K, T, L, and S), including one pulpotomy (L).

19. On or about June 14, 2018 (six days later), MN took JQ to another dentist for a second opinion. This dentist, Dr. PD, found cavities on some of the teeth that Respondent allegedly worked on, and charged Medi-Cal Dental for. Dr. PD was unable to verify via X-ray all of the work Respondent claimed to have completed and billed for. Dr. PD's dental notes for JQ indicate that only three teeth were observed to have been treated by Respondent (teeth C, L, and S). In addition, decay was found between teeth S and T.

20. On or about August 28, 2018, the Board investigator (investigator) requested the dental records for JQ from Respondent and her subsequent treating dentist. The investigator received a faxed copy of JQ's patient dental records from Respondent on or about September 18, 2018, which included a narrative prepared by Respondent outlining the treatment he performed for JQ. On or about September 21, 2018, the investigator received a hard copy of JQ's records from Respondent, including a flashdrive of JQ's x-rays.

21. On October 6, 2020, the investigator requested additional documents from Respondent as she was unable to locate certain documents in the patient dental records previously sent by Respondent more than two years prior. The additional documents requested included a copy of the oral conscious sedation record for JQ, a copy of the informed consent form, signed and dated by MN for the treatment rendered to JQ, a copy of progress notes for JQ that includes the teeth treated, the materials used, and the treatment performed on each tooth, and a copy of all financial documents concerning billing to Medi-Cal Dental both sent and received.

22. On October 12, 2020, the investigator received a telephone call from Anna at Respondent's office, who stated that Respondent had already sent in the records for JQ the first time the Board asked for them. The investigator told Anna that she was unable to locate the

specific documents listed in the request from October 6, 2020, and reviewed the missing documents with Anna. Anna stated that she had helped Respondent prepare the documents for the Board and that she was sure everything had already been sent. Anna stated that she would review the patient file, consult with Respondent, and get back to the investigator.

23. On October 14, 2020, Respondent called the investigator to request an extension to produce the additional records requested on October 6, 2020. The original due date was October 23, 2020, but the investigator agreed to extend the due date to November 6, 2020. On November 12, 2020, the investigator received in the mail a copy of JQ's dental records from Respondent. The investigator noted that new documents were included, including a page titled "Oral Sedation Record," two pages titled "Patient Progress Notes," and an "Explanation of Benefits" page from Medi-Cal Dental. These three documents were not included with the initial patient records submitted to the Board, and the investigator still did not receive a copy of an Informed Consent form for the treatment rendered, signed and dated by MN. It took Respondent more than five weeks to provide these "new" records, despite the original request made more than two years prior.

24. On February 18, 2021, the investigator received a copy of JQ's insurance records from Medi-Cal Dental. The records showed that Respondent billed and received payment for treatment to ten teeth, as follows:

1. Tooth A: MODL, Resin 4+s composite, posterior;
2. Tooth B: MODL, Resin 4+s composite, posterior;
3. Tooth C: MILF, Resin 4+s w/incis angle, anterior;
4. Tooth H: MILF, Resin 4+s w/incis angle, anterior;
5. Tooth I: MODL, Resin 4+s composite, posterior;
6. Tooth J: MODL, Resin 4+s composite, posterior;
7. Tooth K: MODL, Resin 4+s composite, posterior;
8. Tooth L: Therapeutic pulpotomy (exc rest);
9. Tooth S: MODL: Resin 4+s composite, posterior; and
10. Tooth T: MODL, Resin 4+s composite, posterior.

25. The investigator asked Respondent why the subsequent treating dentist who performed an exam six days after JQ was seen by Respondent only observed treatment to three teeth. The investigator asked why Respondent billed and received payment for ten teeth, when it appeared that only three teeth had received treatment. Respondent stated that he used a technique called the "Sliced Method," which uses a flowable composite that covers the entire tooth. Respondent stated that a small bur is used to slice off any decay, and the tooth is covered in the flowable composite. Respondent stated that the flowable composite is clear, so the subsequent treating dentist may not have realized that the entire tooth was covered. Respondent failed to explain why the subsequent treating dentist would not have noticed the restorations upon touching the teeth with a dental explorer. Additionally, the subsequent radiograph shows the restorations on teeth C, L, and S as radio-opaque. If the flowable composite allegedly used by Respondent on all ten teeth is clear and not visible on radiograph, it should not appear on teeth C, L or S. Respondent stated that the reason the billing on Medi-Cal Dental showed four surfaces on each of the ten teeth was because the entire tooth was being covered by the flowable composite. However, if all surfaces of the teeth were covered with flowable composite, Respondent should also have charged for the buccal surfaces of all of the molars, yet he did not. Covering all surfaces with flowable composite can cause problems with occlusion (eating and biting). There is no indication that Respondent checked JQ's bite after the restorations were allegedly placed. The progress notes provided by Respondent fail to note that flowable composite was used, fail to provide a brand name of any flowable composite used, and fail to note that the "sliced method" was used.

26. Respondent stated that Medi-Cal Dental is very disorganized, and that when he first called, he was told that sedation and behavior management were not covered, but when MN called them, they told her that it was covered. Respondent stated that he called again, and was told that sedation was covered, but not behavior management. Respondent claimed that since there had been a "miscommunication," he decided to refund the fee to MN. This statement contradicts an earlier statement made by Respondent regarding the $800.00 refund to MN, wherein Respondent claimed that MN was "very derogatory and disrespectful" in her request for

a refund for the "sedation and behavior management" charge that she paid. Respondent stated that MN did not "appreciate" the "quality work and service" that was rendered, and he felt that he no longer wanted her to be part of their practice. Respondent claimed that MN was reimbursed "so she can seek treatment for her daughter elsewhere," not because there was a "miscommunication."

27. On March 18, 2021, the investigator spoke with AK, a S/UR Liaison at Medi-Cal Dental. AK advised the investigator that back in 2017-2018, Medi-Cal Dental completed a Profiling Audit on Respondent. Twenty patient files were reviewed, and the consultant found 76 instances where the treatment billed was not found to be medically necessary or dental work was found to be below the standard of care. As a result, Respondent was currently being sanctioned by Medi-Cal Dental due to the consultant's findings, from October 2018 to the present (March 2021). AK advised that Respondent is on his third consecutive round of sanctions because he has not been able to get his errors down to an acceptable number, although he has improved slightly with each round. JQ's patient file was not one of the twenty that had been reviewed during the Profiling Audit.

28. On or about February 7, 2021, a Board retained expert reviewed this matter. Per his review, Respondent's treatment plan of June 8, 2018, for JQ called for pulpotomies on teeth A, B, I, J, K, L, S, and T, with placement of stainless steel crowns. Teeth C and H were also to have pulpotomies performed and composite restorations placed. However, the actual treatment was much less invasive. Tooth L was the only tooth that received a pulpotomy. Teeth C and H had two surface composites placed, with the ledger saying that the restorations included an incisal edge on both teeth. All primary molars, except tooth L, received occlusal composites.

29. Respondent's radiographs of JQ before treatment and the corresponding treatment plan do not match. Based on these radiographs, the expert's findings were:

1. Tooth A- no dental decay present;
2. Tooth B- possible distal dental decay;
3. Tooth C- one surface of dental decay;
4. Tooth H- incisal and either facial or lingual dental decay;

5. Tooth I- distal dental decay;

6. Tooth J- possible mesial dental decay;

7. Tooth K- possible mesial dental decay;

8. Tooth L- distal deep dental decay;

9. Tooth S- no apparent dental decay; and

10. Tooth T- no apparent dental decay.

30. Respondent's treatment plan was to perform pulpotomies on all ten teeth which he stated had dental decay. Three of those teeth had no dental decay on the radiographs, and two had possible dental decay, but it is uncertain based on the radiographs.

31. A subsequent examination, performed six days later, does not coincide with the treatment Respondent charged for. The only treatment found by the subsequent treating dentist and that can be seen on radiographs are: Tooth C-facial composite, Tooth L-pulpotomy and distal occlusal composite, and Tooth S-occlusal composite. Respondent charged for Teeth A, B, I, J, K, S, and T as all having composites placed, with Teeth C and H having composites that included the incisal edge (higher fee that a one surface composite), and Tooth L having a pulpotomy and composite placed. Only two of these charges could be accounted for six days later.

32. When a tooth has no obvious dental decay, there is no reason to prepare a treatment plan with anything as invasive as a pulpotomy. Every tooth that Respondent diagnosed with dental decay was diagnosed with a need for pulp treatment. Only one tooth appeared to need this treatment, based on the radiographs.

33. Respondent failed to charge only for the actual treatment performed. Of the ten teeth that Respondent charged for treatment, only three teeth had actual treatment performed. Respondent did not chart which tooth surfaces were actually restored.

34. Respondent failed to chart appropriately with respect to JQ's vital signs. No baseline levels during treatment were recorded, including blood pressure or pulse. The only vital sign recorded for JQ was her weight. There is no charting to support poor behavior from JQ, nor a need for sedation. Respondent failed to obtain the proper consent for sedation, as oral sedation is not the only available option for behavior management. There is no documentation that MN was

provided with all available options, including the potential use of nitrous oxide. Respondent charged MN a sedation fee that was not an allowable patient charge per Medi-Cal Dental.

Patient DC

35. On or about May 28, 2019, the Board received a complaint from CE, on behalf of her minor son, DC, and opened an investigation into the matter.

36. CE stated that her son's regular pediatric dentist, Dr. RS, was not open on Fridays. CE did not want to wait over the weekend, because her son was in pain, and she believed it was an emergency. CE alleged in her complaint that Respondent completed unnecessary dental treatment on her son in this emergency situation. CE also alleged that some of the dental treatment provided by Respondent was of poor quality, and that she was improperly charged $300.00 for "behavior management," when her son was very cooperative. CE also questioned why Respondent would place a cap on top of an old filling, and why all of the work that Respondent claimed was necessary had to be done on the same day, when the only reason why she brought her son to see Respondent was for an emergency for one infected tooth.

37. CE advised that she called Respondent's office on a Thursday afternoon, and explained that she needed to bring her son in to the dentist as soon as possible, due to an abscess above one of her son's front teeth. CE told Respondent's office staff that she had a regular dentist for her son, but she (her son's regular dentist) was not open on Fridays, and CE was hoping for an emergency appointment.

38. The next day, on or about July 13, 2018, CE brought her son in to Respondent's office to have the emergency abscess treated. After performing this treatment, Respondent advised CE that her son DC needed a lot of additional work. Respondent told CE that the tooth below the abscess had to be extracted, as did the tooth on the other side of his mouth in the same location. Respondent told CE that if she did not have the healthy tooth removed on the other side, the "same thing would happen" on that side. Respondent told CE that the adult teeth coming in were pushing on the baby tooth, causing the abscess. Respondent explained that CE's son required a lot of additional treatment, including treatment of "very big cavities" in five of his

baby molars. CE was surprised, because her son was at the dentist in November 2017, and DC only needed one small filling on a baby molar, and everything else was fine.

39. CE was concerned because Respondent kept pushing her that all of the work had to be done right then. CE told Respondent that she was concerned about so much work being done at one time, but Respondent continued to insist that the work had to be done now.

40. Neither Respondent nor his office staff questioned CE about what her son ate or drank that morning. CE's son ate breakfast that morning, but no one asked.

41. CE stated that the sedation medication didn't appear to be working on her son. CE stated that her son kept playing normally, and showed no signs of being drowsy. He told CE that he "felt fine." CE questioned why Respondent gave her son the medication because he had never needed it in the past with his regular dentist, and he was always very cooperative. CE questioned why Respondent required that her son take sedation medication before Respondent knew if her son needed it or not.

42. When DC came out after treatment with Respondent, CE was "shocked" to see that in addition to the removal of two teeth, her son had five new silver crowns in his mouth. CE believed that her son would be receiving fillings as he did at his regular dentist, Dr. RS. CE was also informed that Respondent had performed five baby root canals on DC, also.

43. On or about July 5, 2019, the Board sent a letter to Respondent to request a copy of DC's patient dental records. On or about July 22, 2019, the Board received a copy of the dental records from Respondent.

44. On or about September 10, 2020, the investigator sent a letter to Dr. RS to request a copy of the patient dental records for DC. On or about September 28, 2020, the investigator received a copy of the patient dental records, along with a written narrative. Dr. RS indicated when she last saw DC in December 2017, he received one restoration. Dr. RS stated that "while there were one or two areas that might be considered 'incipient' lesions, when she last saw DC he had no pending treatment needs and was placed on a 6-month recall schedule. When Dr. RS saw DC for his next visit in May 2019, she was "surprised (and a little dismayed) to see that another provider had placed five stainless steel crowns and extracted the two maxillary primary lateral

incisors." CE had advised Dr. RS that Respondent told her that DC had a lot of cavities, needed a lot of treatment, had to be sedated with something stronger than laughing gas, and had to have all of the treatment in one day.

45. Dr. RS informed DC's parents that an amalgam restoration had been left underneath the crown on tooth L. If there was any recurrent caries under or around the restoration, it would have been missed. Dr. RS advised that she would keep an eye on it for now, as the tooth was asymptomatic, and no other pathology was visible on the radiographs. Both parents advised Dr. RS that they felt that "something wasn't right" about the amount of treatment DC allegedly needed according to Respondent, and why he had to be heavily sedated. Dr. RS stated that DC was always very cooperative and compliant with her, and only got better as he got older.

46. Dr. RS opined that there was really only one scenario to account for the extensive treatment and behavior management approach utilized by Respondent, and that is that DC must have presented with extensive caries and pulpally involved teeth. Dr. RS stated that she could not account for the extraction of the primary lateral incisors. Dr. RS also stated that she found it very hard to believe that DC's oral condition and behavior had deteriorated to such an extent, but she would also "hate to believe that a fellow pediatric dentist would be taking advantage of a kid just to make some money…If he did that to [DC], how many other kids got the same treatment?"

47. On or about September 30, 2020, the investigator confirmed that "behavior management" and "oral conscious sedation" were covered under Medi-Cal Dental.

48. On or about October 6, 2020, the investigator sent a letter to Respondent requesting the following documents that she was unable to locate in the patient dental records previously provided by Respondent for DC: a copy of the oral conscious sedation record for DC; a copy of the informed consent form, signed and dated by DC's parent, for the treatment rendered to DC; a copy of the progress notes for DC; and a copy of all financial documents concerning billing to Medi-Cal Dental both sent and received.

49. On or about October 12, 2020, the investigator received a telephone call from Anna at Respondent's office, who stated that Respondent had already sent in the records for DC the first time the Board asked for them. The investigator told Anna that she was unable to locate the

specific documents listed in the request from October 6, 2020, and reviewed the missing documents with Anna. Anna stated that she had helped Respondent prepare the documents for the Board and that she was sure everything had already been sent. Anna stated that she would review the patient file, consult with Respondent, and get back to the investigator.

50. On or about October 14, 2020, Respondent called the investigator to request an extension to produce the additional records requested on October 6, 2020. The original due date was October 23, 2020, but the investigator agreed to extend the due date to November 6, 2020. On November 12, 2020, the investigator received in the mail a copy of DC's dental records from Respondent. The investigator noted that new documents were included, including a page titled "Oral Sedation Record," three pages titled "Patient Progress Notes," and an "Explanation of Benefits" page from Medi-Cal Dental. These three documents were not included with the initial patient records submitted to the Board, and the investigator still did not receive a copy of an Informed Consent form for the treatment rendered, signed and dated by CE. It took Respondent more than five weeks to provide these "new" records, despite the original request made more than one year prior.

51. On March 18, 2021, the investigator spoke with AK, a S/UR Liaison at Medi-Cal Dental. AK advised the investigator that back in 2017-2018, Medi-Cal Dental completed a Profiling Audit on Respondent. Twenty patient files were reviewed, and the consultant found 76 instances where the treatment billed was not found to be medically necessary or dental work was found to be below the standard of care. As a result, Respondent was currently being sanctioned by Medi-Cal Dental due to the consultant's findings, from October 2018 to the present (March 2021). AK advised that Respondent is on his third consecutive round of sanctions because he has not been able to get his errors down to an acceptable number, although he has improved slightly with each round. DC's patient file was not one of the twenty that had been reviewed during the Profiling Audit.

52. On or about March 30, 2021, a Board retained expert reviewed this matter. Per his review, the following treatment was allegedly provided to DC by Respondent: sealant was placed on teeth numbers 3, 19, and 30, tooth A had a therapeutic pulpotomy and a stainless steel crown

was placed, teeth D and G were extracted, and teeth J, K, L, and T had therapeutic pulpotomies with stainless steel crowns placed.

53. Based on the radiographs, tooth D had an obvious abscess on the buccal tissue and translucency in the area of the root. Tooth G appeared within normal limits radiographically, was asymptomatic, and exhibited no pathology.

54. The radiographs show that tooth A and tooth J had dental decay on their respective mesial surfaces; however, there was no appearance of pulpal involvement by the dental decay. There was no need for these teeth to be treated with a pulpotomy and stainless steel crowns.

55. The radiographs show that teeth K, L, and T had no apparent decay. There was no need for any treatment on these teeth.

56. DC was cooperative, and there was no apparent need for sedation. Respondent listed the charge as "Behavior Management;" when in fact, non-IV conscious sedation was performed. This was misleading. Respondent failed to ascertain if DC had consumed any food or liquids in the prior four hours before sedating him. Respondent failed to list all potential risks of sedation on the informed consent document. The informed consent document listed numerous procedures, many of which were marked as though they would be part of DC's treatment. Only the treatments that were planned should have been marked on the informed consent.

57. Other than oxygen saturation at the onset of treatment, Respondent failed to monitor or chart DC's vital signs during treatment. Respondent failed to monitor or chart DC's blood pressure or pulse. DC's chart indicates that Respondent was unable to take a blood pressure, but fails to state a reason. Respondent failed to chart what "local anesthetic" was given to DC at 11:30 am, and whether it was in addition to the Septocaine given at 11:45 am.

58. A single carpule of Septocaine appears inadequate for four quadrants of dental treatment that included pulpotomies, crowns, and extractions.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

59. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code section 1670 for gross negligence in his profession as set forth in paragraphs 16 through 58, and as follows:

a. Respondent charged Medi-Cal Dental for treatment that was not performed on minor patient JQ;

b. Respondent sedated minor patient DC, who was cooperative;

c. Respondent failed to verify if minor patient DC had eaten or drank anything in the four hours prior to sedating him;

c. Respondent failed to list all potential risks for sedation in the informed consent for minor patient DC;

d. Respondent failed to monitor or chart minor patient DC's vital signs, other than his oxygen saturation at the beginning of the treatment.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

60. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code section 1670 for incompetence in his profession as set forth in paragraphs 16 through 58, and as follows:

a. Respondent failed to correctly diagnose dental decay on minor patient JQ;

b. Respondent used only one carpule of Septocaine in his treatment of minor patient DC, which is inadequate for four quadrants of treatment that included pulpotomies, crowns, and extractions.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

61. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code section 1670 for repeated acts of negligence in his profession, as set forth in paragraphs 16 through 58, and as follows:

a. The acts of gross negligence detailed in the First Cause for Discipline, incorporated by reference as though fully set forth;

b. Respondent was negligent when he knowingly charged a sedation fee for minor patient JQ, when disallowed by Medi-Cal Dental;

c. Respondent was negligent in that he failed to follow Oral Sedation Guidelines with respect to patient monitoring when treating minor patient JQ;

d. Respondent failed to provide a reason why minor patient JQ required sedation;

e. Respondent listed a charge for "behavior management," when non-IV conscious sedation was performed on minor patient DC;

f. Respondent was negligent in that instead of marking only the procedures to be performed on the informed consent for minor patient DC, he marked the majority of procedures on the form;

g. Respondent failed to properly chart minor patient DC's non-IV oral conscious sedation when he failed to list the "local anesthetic" given at 11:30 am, and failed to chart if this was in addition to the Septocaine administered at 11:45 am.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Administering of Drugs or Treatment)

62. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code sections 725, subsection (a), 1670, and 1680, subdivision (p), for the excessive administering or drugs or treatment in his treatment of patient DC, as set forth in paragraphs 16 through 58, and as follows:

a. Respondent extracted tooth G on minor patient DC, which was asymptomatic and exhibited no pathology, which is excessive treatment;

b. Teeth A and J on minor patient DC had dental decay on their respective mesial surfaces. There was no need for these teeth to be treated with pulpotomies and stainless steel crowns, this was excessive treatment;

c. Teeth K, L, and T on minor patient DC had no apparent dental decay radiographically. There was no need for any dental treatment on these teeth. The performance of pulpotomies and placement of stainless steel crowns on these teeth is excessive treatment.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Obtaining Fee by Fraud and Misrepresentation)

63. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code sections 1670 and 1680, subsection (a), in that Respondent obtained a fee from a patient and/or a patient's insurance company by fraud and misrepresentation, as set forth in paragraphs 16 through 58, and as follows:

a. Respondent charged MN a disallowed "co-pay," and deliberately billed Medi-Cal Dental for dental work he claimed to have performed on minor patient JQ, when in fact the work had not been performed; and

b. Respondent performed multiple unnecessary procedures on minor patient DC, and subsequently billed and accepted payment from Medi-Cal Dental for these procedures.

SIXTH CAUSE FOR DISCIPLINE

(Present False or Fraudulent Claim for Payment Under a Contract of Insurance)

64. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code sections 810 and 1670, in that Respondent presented false or fraudulent claims to for payment to Medi-Cal Dental as set forth in paragraphs 16 through 58, and as follows:

a. Respondent presented false or fraudulent claims for payment to Medi-Cal Dental for dental work he claimed to have performed on minor patient JQ, when in fact the work had not been performed;

b. Respondent performed multiple unnecessary procedures on minor patient DC, and subsequently billed and accepted payment from Medi-Cal Dental for these procedures.

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SEVENTH CAUSE FOR DISCIPLINE

(Failure to Follow Oral Conscious Sedation Guidelines)

65. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code section 1647.14, subsection (a) and California Code of Regulations, title 16, section 1044.5, subsections (C) (1) and (C) (2), in that he failed to follow applicable oral conscious sedation guidelines in his treatment of minor patients JQ and DC, as set forth in paragraphs 16 through 58, and as follows:

a. Respondent failed to take a physical evaluation and medical history before he administered oral conscious sedation to minor patient JQ, and failed to maintain records of the physical evaluation, medical history, baseline and intermittent quantitative monitoring, oral conscious sedation procedures used, and details of the procedure as required; and

b. Respondent failed to monitor or chart minor patient DC's vital signs, other than his oxygen saturation at the beginning of the treatment.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Properly Continuously Monitor Patients Undergoing Oral Conscious Sedation)

66. Respondent's dental license, oral conscious sedation certificate for minor patients, and fictitious name permit are subject to disciplinary action under Code sections 1670 and 1682, in that he failed to continuously monitor minor patients JQ and DC while they were undergoing oral conscious sedation with a pulse oximeter or similar or superior monitoring equipment, as set forth in paragraphs 16 through 58.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Dental Board of California issue a decision:

1. Revoking or suspending Dental License Number 44965, issued to Khuong Huu Nguyen;

2. Revoking or suspending Oral Conscious Sedation Certificate for Minor Patients Number 444, issued to Khuong Huu Nguyen;

3. Revoking or suspending Fictitious Name Permit Number 10353, issued to Khuong Huu Nguyen;

3. Ordering Khuong Huu Nguyen to pay the Dental Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: 7/19/21

Karen M. Fischer

KAREN M. FISCHER
Executive Officer
Dental Board of California
Department of Consumer Affairs
State of California
Complainant

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