

**BEFORE THE MINNESOTA  
BOARD OF DENTISTRY**

In the Matter of  
Keith F. Ostrosky, D.D.S.  
License No. D10143

**STIPULATION AND ORDER FOR  
STAYED SUSPENSION AND LIMITED  
AND CONDITIONAL LICENSE**

The Minnesota Board of Dentistry ("Board") is authorized pursuant to Minn. Stat. ch. 150A, § 214.10, and § 214.103 to license and regulate dentists, to refer complaints against dentists to the Attorney General for investigation, and to take disciplinary action when appropriate.

After receiving a complaint against Keith F. Ostrosky, D.D.S. ("Licensee"), the Board's Complaint Committee ("Committee") reviewed the complaint and referred it to the Minnesota Attorney General's Office for investigation. Thereafter, the Committee received and reviewed the report of the investigation. On March 17 and May 12, 2011, the Committee held two disciplinary conferences with Licensee and his attorney. As a result, the Committee and Licensee have agreed that the matter may now be resolved by this stipulation and order.

**STIPULATION**

IT IS HEREBY STIPULATED AND AGREED by and between Licensee and the Committee as follows:

A. Jurisdiction. Licensee holds a license to practice dentistry in the State of Minnesota from the Board and is subject to the jurisdiction of the Board with respect to the matters referred to in this stipulation. Licensee states that he does not hold a license to practice dentistry in any other jurisdiction and does not hold any other professional or occupational licenses.

B. Facts. Licensee agrees that for the purposes of this Stipulation and Order, the Board may consider the following facts as true:

#### **Background**

1. On January 2, 1997, Licensee entered into an Agreement for Corrective Action ("1997 ACA") with the Committee. Licensee's 1997 ACA was based upon inadequate recordkeeping and failure to release a patient's dental record. Among other things, Licensee submitted to the Committee a document regarding his office procedures dated August 4, 1997. Besides other procedural information, this document indicated that instruments and charts will not be placed on patients at anytime. On September 4, 1997, Licensee successfully completed all of the requirements of his 1997 ACA.

2. On February 18, 2000, Licensee entered into an Agreement for Corrective Action ("2000 ACA") with the Committee. Licensee's 2000 ACA was based upon substandard recordkeeping.

3. On October 14, 2002, Licensee entered into an Amended Agreement for Corrective Action ("2002 Amended ACA") which replaced his 2000 ACA. Licensee's 2002 Amended ACA was based upon substandard infection control and improper use of billing codes. On October 25, 2005, Licensee successfully completed all of the requirements of his 2002 Amended ACA.

4. In March and April 2010, the Committee received subsequent complaints which were referred to the Minnesota Attorney General's Office for investigation. An investigative report including patient records obtained from Licensee was submitted to and reviewed by the Committee. On March 17 and May 12, 2011, the Committee held two disciplinary conferences with Licensee and his attorney to discuss the issues described below.

### **Substandard Diagnostic and Restorative Care**

5. Licensee failed to provide appropriate diagnostic and restorative care when providing dental treatment to one or more of his patients. Examples include the following:

a. For patient 4, who was formerly employed as a dental assistant in his dental practice, Licensee failed to provide appropriate restorative treatment. On April 1, 2004, Licensee inappropriately placed a Fuji filling in tooth #29-DO for patient 4, instead of placing a permanent restoration. Since this date, the filling material in tooth #29 for patient 4 has been wearing away, as seen on the February 5, 2009, bitewing radiographs.

b. For patient 6, Licensee failed to provide appropriate restorative treatment, as follows:

1) On March 31, 2008, Licensee inappropriately placed Fuji fillings in teeth #14-OL and #15-MODB for patient 6, instead of placing permanent restorations. On April 9, 2009, about 12 months later, Licensee placed a crown on tooth #14 for patient 6 due to a cusp fracturing on this tooth.

2) On October 22, 2009, and February 23, 2010, at least 19 months later, Licensee saw patient 6 who complained of pain in tooth #15 having the Fuji filling. Licensee recommended endodontic treatment and a crown to patient 6, but the patient declined. On April 15, 2010, patient 6 saw a subsequent dental provider who indicated that tooth #15 had a large Fuji filling and recommended endodontic treatment for this tooth. Patient 6 decided to have tooth #15 extracted.

c. For patient 7, Licensee failed to provide an appropriate diagnosis and restorative treatment, as follows:

1) For patient 7, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in tooth #2 on the following dates: DOLB on February 7, 2006; MBD on June 28, 2006; and DOL on April 17, 2007. On March 31, 2009, patient 7 saw a subsequent dental provider who placed a crown on tooth #2.

2) On March 7, 2006, Licensee inappropriately placed a Fuji filling in tooth #15-DOLB for patient 7, instead of placing a permanent restoration. On October 24, 2006, about seven months later, Licensee saw patient 7 who complained of pain in tooth #15 having the Fuji filling. Licensee provided endodontic treatment and a crown to tooth #15 for patient 7.

3) On September 5, 2006, Licensee examined and recommended to patient 7 replacing her existing bridge from teeth #21-#23 due to leakage. However, on March 27, 2008, patient 7 saw a subsequent dental provider who diagnosed no apparent decay or margin leakage with the patient's aforementioned bridge.

d. For patient 8, Licensee failed to provide an appropriate diagnosis, treatment plan, and restorative treatment, as follows:

1) For patient 8, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in tooth #20 on the following dates: MO on December 6, 2005; DOL on July 30, 2007; MLD on September 25, 2007; and MBD on January 20, 2009.

2) For patient 8, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in tooth #21 on the following dates: MO on December 6, 2005; DOL on July 30, 2007; and MID on January 20, 2009.

3) For patient 8, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in tooth #28 on the following dates: DO on March 3, 2004; MOL on July 12, 2007; and DOLB on April 9, 2009.

4) For patient 8, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in tooth #30 on the following dates: OB on March 3, 2004; OB on April 6, 2006; OB on August 8, 2006; and OBL on April 9, 2009.

5) For patient 8, Licensee failed to provide an appropriate diagnosis and treatment plan including options that addressed the patient's entire dental and health conditions for a long-term prognosis or Licensee failed to provide adequate restorative treatment at each appointment. From 2004 to 2009, Licensee repeatedly placed Fuji or composite fillings in teeth #6, #7, #8, #9, #10, and #11 for patient 8, as follows: #6-DL on June 29, 2004, DBL on June 21, 2007, MID on January 8, 2009; #7-MBL on June 29, 2004, DLB on June 13, 2006, MBL on January 8, 2009; #8-MLB on August 25, 2005, MID on November 16, 2005, MILB on June 13, 2006, DLB on June 21, 2007, MIDBL on November 25, 2008, DLB on July 29, 2009; #9-MID on November 16, 2005, MBL on January 9, 2006, MIBL on May 14, 2007, DLB on January 8, 2008, MIDL on November 11, 2008; #10-DBL on August 25, 2005, MLD on November 16, 2005, DLB on January 8, 2008, DILB on November 25, 2008, MLB on July 29, 2009; and #11-DBL on June 29, 2004, MBL on January 9, 2006, MID on August 8, 2006, DLB on July 12, 2007. On April 29, 2008, Licensee performed endodontic treatment on tooth #11 for patient 8.

6) For patient 8, Licensee failed to provide appropriate diagnostic care. On October 30, 2008, Licensee took a periapical radiograph of teeth #29 and #30 for patient 8. However, Licensee failed to provide diagnoses of the apical radiolucent areas near

teeth #29 and #30 for patient 8 or refer the patient to an endodontist. Despite this lack of information, Licensee placed a crown on tooth #29 for patient 8 on April 9, 2009.

e. For patient 9, Licensee failed to provide appropriate restorative treatment, as follows:

1) For patient 9, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in tooth #5 on the following dates: DOL on February 3, 2005; and MOD on April 24, 2008.

2) For patient 9, Licensee inappropriately placed a Fuji filling in tooth #15-DOL, instead of placing a permanent restoration, on April 25, 2007. On December 1, 2009, Licensee placed a crown on tooth #15 for patient 9 after the patient complained about this tooth being rough to her tongue.

3) For patient 9, Licensee inappropriately placed a Fuji filling in tooth #18-MOBL, instead of placing a permanent restoration, on October 6, 2004. On January 27, 2010, Licensee provided a MODBL build-up on tooth #18 for patient 9 before proceeding with a crown after the patient fractured tooth #18.

4) For patient 9, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in tooth #28 on the following dates: DOL on June 2, 2009; and DOL on November 9, 2009.

f. For patient 14, Licensee failed to provide appropriate restorative treatment, as follows:

1) For patient 14, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in teeth #3, #5, #18, #20, #21, #28, #30, and #31 on the following dates: #3-MOLB and #5-DOL on February 8, 2005; #18-MOLB on

February 15, 2005; #20-DOB on April 17, 2008; #21-DOL on March 19, 2007; #28-DO on March 2, 2005; #30-OB on March 2, 2005, MOBL on May 3, 2006; and #31-OBL on May 4, 2005. For patient 14, Licensee provided endodontic treatment on tooth #30 in December 2006 and placed crowns on the following teeth: #3 in January 2008 due to fractured cusp; and #30 in January 2007.

2) On February 23, 2010, patient 14 saw a subsequent dental provider who diagnosed the following: teeth #3 and #5 needed endodontic treatment due to apical abscesses; and need restorative treatment on teeth 18-MOB, #20-DO, #21-DO, #28-DO, #31-MOB due to the washing away of existing restorations in these teeth.

g. For patient 15, Licensee failed to provide appropriate restorative treatment. On May 14, 2007, Licensee inappropriately placed a Fuji filling in tooth #12-MOD for patient 15, instead of placing a permanent restoration. On January 12, 2010, about three years later, Licensee saw patient 15 who complained of pain in tooth #12 having the Fuji filling and started endodontic treatment on this tooth.

h. For patient 18, Licensee failed to provide appropriate restorative treatment, as follows:

1) On April 25, 2007, Licensee inappropriately placed the following Fuji fillings in teeth #3-MOB, #4-DO, and #15-OB for patient 18, instead of placing permanent restorations in these teeth. Several months later, patient 18 claims that she experienced the following with these teeth: huge gap where food got stuck; pain when chewing; and temperature sensitivity.

2) On March 25, 2010, patient 18 saw a subsequent dental provider who diagnosed that the patient's teeth #3, #4, and #15 needed permanent composite restorations to replace the existing glass ionomer fillings placed by Licensee.

i. For patient 19, Licensee failed to provide appropriate restorative treatment, as follows:

1) For patient 19, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in teeth #18, #19, #30, and #31 on the following dates: #18-OBL and #19-OBL on June 5, 2007; and #30-OBL and #31-OBL on July 10, 2007. On June 11, 2009, about two years later, Licensee saw patient 19 who complained of pain in tooth #31 having the Fuji filling and started endodontic treatment on this tooth.

2) On March 11, 2010, patient 19 saw a subsequent dental provider who examined the patient's teeth noting that the fillings in teeth #18, #19, and #30 were possibly glass ionomer fillings and were coming out of the teeth. The subsequent dental provider also diagnosed the presence of decay in teeth #18, #19, and #30 for patient 19 and placed the following permanent composite restorations: #18-OB; #19-OB; and #30-DO.

j. For patient 20, Licensee failed to provide an appropriate diagnosis and restorative treatment, as follows:

1) For patient 20, Licensee performed an examination and obtained four bitewing radiographs on September 11, 2008. However, Licensee failed to provide a diagnosis and treatment plan for patient 20 that addressed the carious lesion on the mesial aspect of tooth #15.

2) For patient 20, Licensee inappropriately placed the following Fuji fillings, instead of placing permanent restorations, in teeth #2, #3, and #14 on the following dates: #2-DOBL and #3-OBL on October 20, 2008; and #14-OBL on September 29, 2008 and June 11, 2009.

3) On December 14, 2009, and May 26, 2010, patient 20 saw a subsequent dental provider who diagnosed the following needed treatment: place composite restorations in teeth #2-DOL, #3-OL, and #14-OL due to washed out existing fillings; and tooth #15 an MO composite restoration or possible endodontic treatment due to deep decay.

#### **Substandard Endodontic Care**

6. Licensee failed to provide appropriate endodontic care when providing dental treatment to one or more of his patients. Examples include the following:

a. Licensee failed to provide an appropriate endodontic diagnosis or make a referral to an endodontic specialist. For patient 5, Licensee took a periapical radiograph of tooth #19 on March 24, 2008. However, Licensee failed to provide a diagnosis of the apical abscess on the distal root of tooth #19 or refer the patient to an endodontist when patient 5 experienced reoccurring endodontic pathosis or symptoms after having previous endodontic treatment on tooth #19 in January 2006.

b. Licensee failed to consistently document an adequate treatment plan and the patient's informed consent prior to providing endodontic treatment on the following patients: patient 3 for teeth #3 and #19; patient 5 for teeth #19 and #20; patient 6 for teeth #2 and #19; patient 7 for tooth #15; patient 9 for tooth #14; and patient 10 for teeth #2 and #15.

c. Licensee failed to consistently document pertinent endodontic treatment information such as the medications used to disinfect the canals during instrumentation

when providing endodontic treatment on the following patients: patient 3 for teeth #3 and #19 in February and July 2005; patient 5 for teeth #19 and #20 in December 2005 and June 2001; patient 7 for tooth #15 in October 2006; patient 9 for tooth #14 in September 2004; and patient 10 for teeth #2 and #15 in August 2008 and November 2002.

d. Licensee failed to document that he used rubber dam isolation when providing endodontic treatment to the following patients: patient 3 for teeth #3 and #19; patient 5 for teeth #19 and #20; patient 6 for teeth #2 and #19; patient 7 for tooth #15; patient 9 for tooth #14; and patient 10 for teeth #2 and #15.

#### **Improper Administration of Local Anesthetic**

7. Licensee provided dental care which fell below the accepted standards in the practice of dentistry when he failed to properly administer local anesthetic to one or more of his patients, as follows:

a. For patient 7, Licensee failed to administer local anesthetic to the patient prior to performing endodontic treatment on tooth #15 in October and November 2006.

b. For patient 11, Licensee failed to administer local anesthetic to the patient prior to performing endodontic treatment on tooth #12 in September and October 2007.

c. For patient 18, Licensee administered local anesthetic to the patient prior to placing restorations in three teeth in April 2007. However, patient 18 claims that halfway through the procedure she began experiencing pain and Licensee failed to properly administer additional local anesthetic to her.

d. For patient 19, Licensee failed to administer local anesthetic to the patient prior to performing endodontic treatment on tooth #31 in June 2009. At other endodontic appointments for tooth #31 in 2009, Licensee administered local anesthetic to patient 19;

however, the patient claims that Licensee failed to properly administer enough anesthetic to her, since the procedures were very painful.

e. For patient 20, Licensee administered local anesthetic to the patient prior to providing treatment in 2008 and 2009. However, patient 20 claims that Licensee failed to consistently wait until the local anesthetic administered to her was fully effective before he would proceed with treatment causing her to be in pain.

#### **Unprofessional Conduct / Inappropriate Behavior**

8. Licensee engaged in personal conduct that brings discredit to the profession of dentistry when he made suggestive, lewd, lascivious, or improper advances towards one or more female patients, as follows:

a. Patient 6 stated that Licensee placed dental instruments on her chest near to her breasts while he provided dental treatment to her on more than one occasion from 2007 to 2009.

b. Patient 7 stated that Licensee's right forearm came in contact with her right breast while he provided dental treatment to her on more than one occasion in 2006 and 2007. Additionally, during treatment, Licensee placed dental instruments on patient 7's chest a couple of inches away from her breast nipples. Furthermore, Licensee participated in a personal and sexual relationship with patient 7 while she was a patient of record in 2007.

c. Patient 13 stated that Licensee pushed his forearm down against her right breast while he provided dental treatment to her on more than one occasion in 2009. Additionally, during treatment, Licensee placed dental instruments on patient 13's chest near to her breasts. Furthermore, patient 13 commented that Licensee was always in a hurry and rushed while providing treatment to her.

d. Patient 14 stated that Licensee placed dental instruments including the suction tube on her chest while he provided dental treatment to her on more than one occasion from 2005 to 2009.

e. Patient 15 stated that Licensee brushed his forearm across her breasts while he provided dental treatment to her on more than one occasion in the last few years. Additionally, during treatment, Licensee placed dental instruments including the air/water syringe and suction tube on patient 15's chest about two inches away from her breast nipples and he subsequently touched her breasts when retrieving instruments from the patient's chest area. Furthermore, patient 15 stated that Licensee pulled the patient napkin closer to her neck while providing dental treatment to her.

f. Patient 16 stated that Licensee rested his forearm against her chest while he provided dental treatment to her on two occasions in 2006 and 2010. Additionally, Licensee approached patient 16 from behind placing his hands on her waist while she stood at the appointment desk in 2010.

g. Patient 19 stated that Licensee laid his entire right forearm on her right breast and moved his arm in a rubbing motion for about three minutes while he provided dental treatment to her on more than one occasion in 2007 and 2009. Additionally, during treatment, Licensee placed dental instruments on patient 19's chest near to her breasts and he subsequently touched her breasts when retrieving instruments from the patient's chest area.

h. Patient 20 stated that Licensee rested his hand or arm on her chest while he provided dental treatment to her on more than one occasion in 2008 and 2009. Additionally, during treatment, Licensee placed dental instruments on patient 20's chest near to her cleavage and he subsequently touched her breasts when grabbing instruments from the

patient's chest area. Moreover, patient 20 commented that Licensee was always in a hurry and rushed while providing treatment to her. Furthermore, Licensee asked patient 20 out on a date on more than one occasion while she was a patient of record in 2009.

i. One or more employees stated having observed inappropriate behavior by Licensee with patients while he provided dental treatment on more than one occasion including: having his right forearm in contact with a female patient's breasts; placing dental instruments on male and female patients' chests; pulling or scrunching the patient napkin to uncover the breast area on female patients; and tickling pediatric patients.

**Unprofessional Conduct / Improper Prescribing**

9. Licensee improperly or in an unauthorized manner prescribed, dispensed, administered, or personally used or made improper or unauthorized use of a legend drug, other chemical, or controlled substance, as follows:

a. From May 2007 to March 2010, Licensee ordered from Henry Schein Company the following drugs:

<b>DATE ORDERED</b>	<b>QUANTITY</b>	<b>DRUGS ORDERED</b>
May 17, 2007	100 tablets	naproxen sodium 550 mg
September 24, 2007	1	clindamycin topical lotion 1% 60 mL
October 22, 2007	100 capsules	tetracycline hydrochloride 250 mg
	1	Retin-A cream 0.1%
December 12, 2007	600 capsules	tetracycline hydrochloride 250 mg
August 7, 2008	100 tablets	naproxen sodium 550 mg
November 20, 2008	100 tablets	naproxen sodium 550 mg
August 25, 2009	100 tablets	hydrocodone/APAP 7.5/750 mg
December 3, 2009	100 tablets	hydrocodone/APAP 7.5/750 mg
	100 tablets	naproxen sodium 550 mg
December 15, 2009	10 capsules	Tamiflu 75 mg
	100 tablets	penicillin VK 500 mg
March 31, 2010	100 tablets	penicillin VK 500 mg
	100 tablets	naproxen sodium 550 mg

b. During the investigation, Licensee admitted to the investigator that he ordered naproxen sodium for himself to treat his joints, which means that Licensee improperly prescribed naproxen sodium for himself. Licensee also told the investigator that he probably ordered the Retin-A cream for his son who has acne, which means that Licensee improperly prescribed Retin-A for his son.

c. Licensee admitted to the investigator during the investigation that he does not keep on file at his office from which dispensing is taking place a record of drugs received, administered, dispensed, sold, or distributed, as required by Minnesota Rules part 6800.9954. Licensee stated that he only documents the administration of drugs to a patient in the patient's chart.

#### **Substandard Recordkeeping**

10. Licensee failed to make or maintain adequate patient records. Examples include the following:

a. Licensee failed to consistently document a complete record of the patient's existing oral health status such as dental caries, missing or unerupted (impacted) teeth, restorations, oral cancer evaluation, hard/soft tissue examination, and periodontal conditions for patients 1 through 8.

b. Licensee failed to make or maintain adequate radiographic records for patients 2, 3, 4, 7, and 8, as follows: the radiographic records failed to contain a sufficient number of radiographs to make a proper diagnosis; radiographs taken were of poor diagnostic quality; or some records were missing radiographs.

c. Licensee failed to consistently document his diagnoses for dental treatment for patients 1 through 8.

d. Licensee failed to consistently document appropriate treatment plans for providing dental treatment for patients 1 through 8.

e. Licensee failed to consistently obtain the patient's informed consent prior to performing dental services for patients 1 through 8.

f. Licensee failed to consistently document all medications used and all materials placed during treatment procedures for patients 1, 2, 5, and 6 such as the antibiotic pre-medication and all dental materials used in dental procedures.

g. Licensee failed to properly transfer the patient's dental record including radiographs upon the patient's request in a timely manner for patients 14 and 20.

11. Following the March 17, 2011, conference with Licensee and his attorney, the Committee requested that Licensee submit to the Committee additional patient records that demonstrate his current recordkeeping standards. After the May 12, 2011, conference, the Committee reviewed the seven patient records submitted by Licensee. Based upon this review, the Committee has determined that Licensee's patient records still fail to comply with the requirements of adequate recordkeeping due to the lack of documentation regarding existing restorations, treatment plans, and informed consent.

#### **Substandard Safety and Sanitary Conditions**

12. Licensee failed to maintain adequate safety and sanitary conditions for his dental office regarding hazardous waste. For example, Licensee failed to properly dispose of scrap amalgam from an amalgam capture device in the basement of his dental practice since installing the device in September 2003.

### **Unprofessional Conduct / Improper Billing**

13. Licensee engaged in unprofessional conduct and improper billing of patients, third-party payers, and others relating to the practice of dentistry when he billed for certain dental services not actually rendered or followed other improper billing procedures for services rendered, as follows:

a. Licensee improperly billed the patient an additional fee for using Fuji material as a base/liner when this procedure is part of an already covered dental procedure, as follows:

1) For patient 1, Licensee improperly billed the patient an additional fee of \$11.00 for Fuji base material when the base was already covered as part of the restoration procedure for tooth #3 on April 21, 2005.

2) For patient 3, Licensee improperly billed the patient an additional fee of \$11.00 for Fuji base material when the base was already covered as part of the build-up procedure for tooth #3 on March 17, 2005.

3) For patient 5, Licensee improperly billed the patient an additional fee of \$12.00 for Fuji base material when the base was already covered as part of the restoration procedure for teeth #6 and #7 on February 9, 2010.

4) For patient 15, Licensee improperly billed the patient an additional fee of \$12.00 for Fuji base material when the base was already covered as part of the build-up procedures for teeth #12 and #13 on February 16, 2010.

b. Licensee improperly billed the patient for a resin-based composite restoration when he actually used Fuji II restorative material which is typically a base/liner and used for class III and class V restorations, as follows:

1) For patient 6, Licensee improperly billed the patient for resin-based composite restorations when he actually placed Fuji II restorative material in teeth #14-OL and #15-MODB on April 2, 2008.

2) For patient 9, Licensee improperly billed the patient for resin-based composite restorations when he actually placed Fuji II restorative material in the following teeth and dates: #5-DOL on February 7, 2005 and MOD on April 24, 2008; #15-DOL on April 25, 2007; #18-MOBL on October 6, 2004; and #28-DOL on June 2 and November 9, 2009.

3) For patient 14, Licensee improperly billed the patient for resin-based composite restorations when he actually placed Fuji II restorative material in the following teeth and dates: #3-MOLB and #5-DOL on February 8, 2005; #18-MOLB on February 15, 2005; #20-DOB on April 17, 2008; #21-DOL on March 19, 2007; #28-DO on March 2, 2005; #30-OB on March 2, 2005, MOBL on May 3, 2006; and #31-OBL on May 4, 2005.

4) For patient 20, Licensee improperly billed the patient for resin-based composite restorations when he actually placed Fuji II restorative material in the following teeth and dates: #2-DOBL and #3-OBL on October 20, 2008; and #14-OBL on September 29, 2008 and June 11, 2009.

c. Licensee improperly billed the patient an additional fee based upon the crown type when providing prosthodontic treatment, instead of charging a single fee for service, as follows:

1) For patient 1, Licensee improperly billed an additional laboratory fee for a Lava crown of \$250.00, besides billing the patient \$950.00 for a porcelain/icon substrate crown on tooth #4 on September 30, 2009.

2) For patient 2, Licensee improperly billed an additional laboratory fee for a Lava crown of \$250.00, besides billing the patient \$950.00 for a porcelain/icon substrate crown on tooth #23 on September 14, 2009.

3) For patient 7, Licensee improperly billed an additional laboratory fee for a Lava crown of \$234.60, besides billing the patient \$908.82 for a porcelain/icon substrate crown on tooth #29 on December 27, 2007.

4) For patient 15, Licensee improperly billed an additional laboratory fee for a Lava crown of \$239.00, besides billing the patient \$926.00 for a porcelain/icon substrate crown on tooth #14 on May 27, 2008.

d. Licensee improperly billed the patient for a certain type of crown when he actually provided a different type of crown during treatment, as follows:

1) For patient 1, Licensee billed the patient for a Lava crown as indicated in the patient's progress notes for tooth #4 on September 30, 2009. However, Licensee actually requested and received a generic zirconium type of crown for patient 1's tooth from the dental laboratory.

2) For patient 2, Licensee billed the patient for Lava crowns as indicated in the patient's progress notes for teeth #27 and #30 on September 23, 2008, and tooth #23 on September 14, 2009. However, Licensee actually requested and received a generic zirconium type of crowns for patient 2's teeth from the dental laboratory.

3) For patient 8, Licensee billed the patient for a Lava crown as indicated in the patient's progress notes for tooth #29 on February 17, 2009. However, Licensee actually requested and received a generic zirconium type of crown for patient 8's tooth from the dental laboratory.

4) For patient 20, Licensee billed the patient for a Lava crown as indicated in the patient's progress notes for tooth #4 on November 13, 2008. However, Licensee actually requested and received a generic zirconium type of crown for patient 20's tooth from the dental laboratory.

C. Violations. The Committee concludes that the practices described above constitute violations of Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200 A (unprofessional conduct); Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200 B (repeated performance of dental treatment which falls below accepted standards); Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200 C (suggestive, lewd, lascivious, or improper advances toward patients); Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200 I (perpetrating fraud upon patients, third party payers, or others relating to the practice of dentistry); Minn. Stat. § 150A.08, subd. 1(5) (improperly or in an unauthorized manner prescribed, dispensed, administered, or personally used, or made other improper or unauthorized use of, a legend drug, chemical, or controlled substance as defined in Minn. Stat. chs. 151 or 152); Minn. Stat. § 150A.08, subd. 1(10) and Minn. R. 3100.6200 K and 3100.6300 (failure to maintain adequate safety and sanitary conditions for a dental office); Minn. Stat. § 150A.08, subd. 1(13) and Minn. R. 3100.9600 (failure to make or maintain adequate dental records on each patient); and are sufficient grounds for the disciplinary action specified below.

D. Disciplinary Action. Licensee's license to practice dentistry in the State of Minnesota is hereby **SUSPENDED**. The suspension is **STAYED** based upon Licensee's compliance with all of the limitations and conditions set forth in paragraph E. below.

E. Limitations and Conditions of Stayed Suspension. Licensee and the Committee recommend that the Board issue an order which places LIMITATIONS and CONDITIONS on Licensee's license to practice dentistry in the State of Minnesota as follows:

#### **LIMITATIONS**

Licensee's license shall be subject to the following limitations:

1. Fuji Restorations in Permanent Teeth. Licensee is prohibited from placing Fuji filling material into permanent teeth for patients until he successfully completes the composite restorations course described in paragraph 4.c. below and submits the required written report to the Committee for review and acceptance. At that time, Licensee may petition the Committee for removal of the limitation.

#### **CONDITIONS**

Licensee's license shall be subject to the following terms, conditions, and requirements:

2. Attendants with Female Patients. Immediately upon the effective date of this Order, Licensee must have another female present in the operatory at all times when he is providing any type of dental service to a female patient.

3. Review of Stipulation and Order. Within 30 days after the effective date of this Order, Licensee shall have each current partner, associate, or employee in Licensee's practice review a copy of this stipulation and order, then sign and date a written verification regarding having reviewed this document. The signed verification shall be submitted to the Board. Thereafter, within 10 days of hire or new association, Licensee shall inform the Board in writing of the hire or new association and within 30 days he shall submit to the Board a signed verification from the new staff person verifying that the staff person has received and reviewed a copy of this stipulation and order.

4. Legend Drugs. Within 90 days after the effective date of this Order, Licensee shall submit to the Committee a copy of his prescription log from his practice where he is required to maintain a record of drugs received, administered, dispensed, sold, or distributed at his dental office, as required by Minn. R. 6800.9954. The prescription log submitted by Licensee must be reviewed and accepted by the Committee. In addition, Licensee is prohibited from prescribing, administering, or dispensing any legend drugs for Licensee's own use or for his family members' use.

5. Coursework. Licensee shall successfully complete the coursework described below. **All coursework must be approved in advance by the Committee.** Licensee is responsible for locating, registering for, and paying for all coursework taken pursuant to this stipulation and order. Moreover, Licensee must provide each instructor with a copy of this stipulation and order prior to commencing a course. Licensee's signature on this stipulation and order constitutes authorization for the course instructor(s) to provide the Committee with a copy of the final examination and answers for any course Licensee takes. Licensee's signature also authorizes the Committee to communicate with the instructor(s) before, during, and after Licensee takes the course about Licensee's needs, performance and progress. None of the coursework taken pursuant to this stipulation and order may be used by Licensee to satisfy any of the continuing dental education/professional development requirements of Minn. R. 3100.5100, subpart 2. The coursework is as follows:

a. Professional Boundaries. Within 90 days after the effective date of this Order, Licensee shall arrange to enroll in an individualized professional boundaries training course taught by John Hung, Ph.D., L.P. in Edina, Minnesota, or another equivalent course approved in advance by the Committee. The course shall address professional boundaries

including inappropriately placing dental instruments on a patient's chest, intentional or unintentional touching of a female patient's breasts, and having a sexual relationship with a female patient. Licensee's signature on this stipulation and order is authorization for the Committee to communicate with the instructor/practitioner before, during, and after Licensee takes the course about his needs, performance, and progress. Licensee's signature also constitutes authorization for the instructor/practitioner to provide the Committee with copies of all written evaluation reports. Successful completion of the boundaries course shall be determined by the Committee based on input from Dr. Hung or the instructor/practitioner of an equivalent course.

b. AADB Sexual Boundary Guidelines. Within 90 days after the effective date of this Order, Licensee shall successfully complete the on-line study course entitled "AADB Guidelines on Unprofessional Conduct Involving Sexual Boundary Violations" sponsored by the American Association of Dental Boards. Licensee must provide proof of course completion by submitting a copy to the Committee for review and acceptance.

c. Composite Restorations. Within six months after the effective date of this Order, Licensee shall successfully complete a minimum of four hours of one-on-one instruction in posterior composite restorations through the University of Minnesota School of Dentistry or another accredited dental institution that focuses on proper placement of posterior composite restorations, proper use of Fuji material, and reducing sensitivity issues associated with restorations.

d. Endodontics. Within nine months after the effective date of this Order, Licensee shall personally attend and successfully complete at least one full-day course in endodontics through the University of Minnesota School of Dentistry or another accredited

dental institution. The endodontic course shall focus on diagnosis, treatment planning, and proper recordkeeping.

e. Treatment Planning / Recordkeeping. Within twelve months after the effective date of this Order, Licensee shall personally attend and successfully complete the treatment planning / recordkeeping course entitled “Dental Patient Management: Dental Records and Treatment Planning Fundamentals” offered at the University of Minnesota School of Dentistry or an equivalent course.

f. Local Anesthesia. Within eighteen months after the effective date of this Order, Licensee shall personally attend and successfully complete a comprehensive local anesthesia course relating to the practice of dentistry and administering local anesthesia to patients. The local anesthesia course shall focus on: common techniques for administering local anesthetic; appropriate selection of local anesthetic agent considering efficacy, safety, and individual patient and pain management needs; and maximum dosage of local anesthetic agent.

6. Written Coursework Report. Within 30 days after completing each coursework above, Licensee shall submit to the Board the following information:

a. a transcript or other documentation verifying that Licensee has successfully completed the course;

b. a copy of all materials used and distributed in the course; and

c. a written report summarizing how Licensee has implemented this knowledge into Licensee’s practice. Licensee’s report shall be typewritten in Licensee’s own words, double-spaced, at least two pages but no more than three pages in length, and shall list references used to prepare the report. All reports are subject to approval by the Committee.

d. Within Licensee's composite restorations report, in addition to the aforementioned information in paragraphs 5.a. to 5.c., Licensee shall also elaborate on his practice protocol for placing posterior composite restorations in permanent teeth for patients including the appropriate use of Fuji material and permanent composite material.

e. Within Licensee's local anesthesia report, in addition to the aforementioned information in paragraphs 5.a. to 5.c., Licensee shall also elaborate on his practice protocol for administering local anesthesia to patients in his office when providing operative and endodontic treatment.

7. Civil Penalty. The Board imposes a civil penalty in the amount of \$30,000 for the conduct described above. The civil penalty shall be paid by Licensee by the time Licensee petitions to have the conditions removed from Licensee's license. Payments from Licensee shall be made by cashier's check or money order made payable to the Minnesota Board of Dentistry and shall be delivered personally or by mail to the Minnesota Board of Dentistry, c/o Marshall Shragg, Executive Director, 2829 University Avenue S.E., Suite 450, Minneapolis, Minnesota 55414.

8. Other Conditions.

a. Licensee shall comply with the laws or rules of the Board of Dentistry. Licensee agrees that failure to comply with the Board's laws or rules shall be a violation of this stipulation and order.

b. Licensee shall fully and promptly cooperate with the Board's reasonable requests concerning compliance with this stipulation and order, including requests for explanations, documents, office inspections, and/or appearances at conferences. Minn. R. 3100.6350 shall be applicable to such requests.

c. In Licensee's practice of dentistry, Licensee shall comply with the most current infection control requirements of Minn. R. 3100.6300 and 6950.1000 through 6950.1080, and with the Centers for Disease Control and Prevention, Public Health Service, and United States Department of Health and Human Services.

d. In the event Licensee should leave Minnesota to reside, Licensee shall notify the Board in writing of the new location within five days. Periods of residency outside of Minnesota will not apply to the reduction of any period of Licensee's discipline in Minnesota.

F. Removal of Stayed Suspension. Licensee may petition to have the stayed suspension removed from Licensee's license at any regularly scheduled Board meeting no sooner than one year after the effective date of this Order provided that Licensee has complied with all of the limitations and conditions of his stayed suspension. Moreover, Licensee's petition must be received by the Board at least 30 days prior to the Board meeting. Licensee has the burden of proving that Licensee has complied with the limitations and conditions of this stipulation and order and that Licensee is qualified to practice without a stayed suspension. Licensee's compliance with the foregoing requirements does not create a presumption that the stayed suspension should be removed. Upon consideration of the evidence submitted by Licensee or obtained through Board investigation, the Board may remove, amend, or continue the stayed suspension imposed by this Order.

G. Fine for Violation of Order. If information or a report required by this stipulation and order is not submitted to the Board by the due date, or if Licensee otherwise violates this stipulation and order, the Committee may fine Licensee \$100 per late report or other violation. Licensee shall pay the fine and correct the violation within five days after service on Licensee of

a demand for payment and correction. If Licensee fails to do so, the Committee may impose additional fines not to exceed \$500 per violation. The total of all fines may not exceed \$5,000. Licensee waives the right to seek review of the imposition of these fines under the Administrative Procedure Act, by writ of certiorari under Minn. Stat. § 480A.06, by application to the Board, or otherwise. Neither the imposition of fines nor correction of the violation will deprive the Board of the right to impose additional discipline based on the violation.

H. Order of Removal of Stayed Suspension. If the Committee has probable cause to believe Licensee has failed to comply with or has violated any of the requirements for staying the suspension as outlined in paragraph E. above, the Committee may remove the stay pursuant to the procedures outlined in paragraph I. below, with the following additions and exceptions:

1. The removal of the stayed suspension shall take effect upon service of an Order of Removal of Stayed Suspension (“Order of Removal”). Licensee agrees that the Committee is authorized to issue an Order of Removal, which shall remain in effect and shall have the full force and effect of an order of the Board until the Board makes a final determination pursuant to the procedures outlined in paragraph I. below or until the complaint is dismissed and the order is rescinded by the Committee. The Order of Removal shall confirm the Committee has probable cause to believe Licensee has failed to comply with or has violated one or more of the requirements for staying the suspension of Licensee’s license. Licensee further agrees an Order of Removal issued pursuant to this paragraph shall be deemed a public document under the Minnesota Government Data Practices Act. Licensee waives any right to a conference or hearing before removal of the stayed suspension.

2. The Committee shall schedule the hearing pursuant to paragraph I. below to be held within 60 days of service of the Order of Removal.

I. Additional Discipline for Violation of Order. If Licensee violates this stipulation and order, Minn. Stat. ch. 150A, or Minn. R. ch. 3100, the Board may impose additional discipline pursuant to the following procedure:

1. The Committee shall schedule a hearing before the Board. At least ten days prior to the hearing, the Committee shall mail Licensee a notice of the violation alleged by the Committee and of the time and place of the hearing. Within seven days after the notice is mailed, Licensee shall submit a response to the allegations. If Licensee does not submit a timely response to the Board, the allegations may be deemed admitted.

2. At the hearing before the Board, the Committee and Licensee may submit affidavits made on personal knowledge and argument based on the record in support of their positions. The evidentiary record before the Board will be limited to such affidavits and this stipulation and order. Licensee waives a hearing before an administrative law judge and waives discovery, cross-examination of adverse witnesses, and other procedures governing administrative hearings or civil trials.

3. At the hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Licensee's practice, or suspension or revocation of Licensee's license.

J. Other Procedures for Resolution of Alleged Violations. Violation of this stipulation and order is a violation of Minn. Stat. § 150A.08, subd. 1(13). The Committee may attempt to resolve an alleged violation of the stipulation and order through the procedures of Minn. Stat. § 214.103, subd. 6. Nothing herein limits (1) the Committee's right to initiate a proceeding against Licensee pursuant to Minn. Stat. ch. 14, or (2) the Committee's and the Board's right to temporarily suspend Licensee pursuant to Minn. Stat. § 150A.08, subd. 8, based

on a violation of this stipulation and order or based on conduct of Licensee before or after the date of this stipulation which is not specifically referred to in paragraph B. above.

K. Attendance at Conferences. Licensee and his attorney attended two conferences with the Committee on March 17 and May 12, 2011. The following Committee members attended both conferences: Joan Sheppard, D.D.S.; David Linde, D.D.S.; and Teri Youngdahl, L.D.A. Assistant Attorney General Nathan Hart represented the Committee at both conferences. Licensee was represented by John M. Degnan in this matter who has advised Licensee regarding this stipulation and order.

L. Waiver of Licensee's Rights. For the purpose of this stipulation, Licensee waives all procedures and proceedings before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or the rules of the Board, including the right to dispute the facts contained in this stipulation and order and to dispute the adequateness of discipline in a contested proceeding pursuant to Minn. Stat. ch. 14. Licensee agrees that upon the application of the Committee without notice to or an appearance by Licensee, the Board may issue an order imposing the discipline specified herein. The Committee may participate in Board deliberations and voting concerning the stipulation. Licensee waives the right to any judicial review of the order by appeal, writ of certiorari, or otherwise.

M. Board Rejection of Stipulation and Order. In the event the Board in its discretion does not approve this stipulation or a lesser remedy than specified herein, this stipulation and order will be null and void and may not be used for any purpose by either party hereto. If this stipulation is not approved and a contested case proceeding is initiated pursuant to Minn. Stat. ch. 14 and section 150A.08, Licensee agrees not to object to the Board's initiation of the

proceeding and hearing the case on the basis that the Board has become disqualified due to its review and consideration of this stipulation and the record.

N. Record. This stipulation, related investigative reports and other documents constitute the entire record of the proceedings herein upon which the order is based. The investigative reports, other documents, or summaries thereof may be filed with the Board with this stipulation. Any reports or other material related to this matter which are received after the date the Board approves the stipulation and order shall become a part of the record and may be considered by the Board in future aspects of this proceeding.

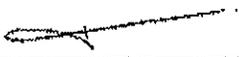
O. Data Classification. Under the Minnesota Data Practices Act, this stipulation and order is classified as public data. Minn. Stat. § 13.41, subd. 4. All documents in the record shall maintain the data classification to which they are entitled under the Minnesota Government Data Practices Act, Minn. Stat. ch. 13. Data does not, to the extent they are not already public documents, become public merely because they are referenced herein. Pursuant to federal rule (45 C.F.R. parts 60 and 61), the Board must report the disciplinary action contained in this stipulation and order to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

P. Entire Agreement. Licensee has read, understood, and agreed to this stipulation and is freely and voluntarily signing it. This stipulation contains the entire agreement between the parties hereto. Licensee is not relying on any other agreement or representations of any kind, verbal or otherwise.

Q. Service and Effective Date. If approved by the Board, a copy of this stipulation and order will be served personally or by first class mail on Licensee. The order will be effective and deemed issued when it is signed by the President or Vice-President of the Board.

LICENSEE

COMPLAINT COMMITTEE

  
\_\_\_\_\_  
KEITH F. OSTROSKY, D.D.S.

By:

  
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MARSHALL SHRAGG, MPH  
Executive Director

Dated: 9-15-11, 2011

Dated: September 23<sup>rd</sup>, 2011

**ORDER**

Upon consideration of the foregoing Stipulation and based upon all the files, records, and proceedings herein,

The terms of the Stipulation are approved and adopted, and the recommended disciplinary action set forth in the Stipulation is hereby issued as an Order of this Board effective this 23<sup>rd</sup> day of September, 2011.

MINNESOTA BOARD  
OF DENTISTRY

By:

  
DAVID LINDE, D.D.S.  
President