

**BEFORE THE IOWA DENTAL BOARD OF THE STATE OF IOWA**

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**IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST**

**MASIH SAFABAKHSH, D.D.S, RESPONDENT**

**FILE NO. #10-059, #10-101,  
#11-031, #11-127, #11-142, #12-068**

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**EMERGENCY ADJUDICATIVE ORDER**

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**COMES NOW** the Iowa Dental Board, and finds that on July 13, 2012 it was presented with evidence which establishes that Respondent's continued practice of dentistry constitutes an immediate danger to the public health, safety, and welfare. The Board has conducted a full investigation of this matter. A summary of the evidence obtained in that investigation is as follows:

**FINDINGS OF FACT**

1. Respondent is a general dentist engaged in the practice of dentistry in Cedar Rapids, Iowa.
2. In December 2011, Respondent was charged by the Board with failure to maintain a satisfactory standard of competency, and gross malpractice in the practice of dentistry.
3. In December 2011, the Board issued an Emergency Adjudicative Order suspending Respondent's ability to initiate orthodontic treatment for any new patients, and suspended his use of a dental bur or other cutting tool to attain separation of teeth for the placement of orthodontic appliances.

4. Iowa Code Section 153.34(8) provides that a ground for discipline includes failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry.
5. The Board received a complaint from a third party payee regarding patient T.A. The complaint stated that a subsequent treating dentist submitted authorization to replace a crown placed by Respondent one month earlier because a radiograph clearly shows the crown on tooth #19 does not fit properly and margins are open. A Board consultant reviewed this case and concluded that patient T.A. was not treated within the standard of care for the following reason:
  - a. Radiographs provided in the complaint show the mesial crown margin on tooth #19 is an open margin and there appears to be decay on the distal margin.
6. The Board received a complaint from multiple staff persons at Respondent's dental office regarding a patient who had a medical emergency after being administered sixteen (16) carpules of local anesthetic. The complaint stated that the patient had to be transported to the hospital via ambulance. A Board consultant reviewed this case and concluded that patient L.S. was not treated within the standard of care for the following reasons:
  - a. Administering sixteen (16) carpules of 3% Carbocaine to a patient far exceeds the maximum dosage as provided by the manufacturer's guidelines.

- b. According to the manufacturer's guidelines, 5.3 carpules of 3% Carbocaine is the maximum safe dosage.
  - c. Respondent's excessive use of Carbocaine was a contributing factor to patient L.S.'s medical emergency.
  - d. Following L.S.'s medical emergency an email was sent to all staff in Respondent's office stating that an ambulance was not to be called by anyone unless requested by a doctor or patient. This protocol does not meet the standard of care.
7. After review of the medical emergency of patient L.S., the following concerns were identified:
- a. Respondent and his staff stated that patients in the practice are regularly administered between 10-16 carpules of local anesthetic.
  - b. Respondent was asked if he was aware of current guidelines for Carbocaine dosing. Respondent stated he was unaware of the current guidelines for Carbocaine dosing.
  - c. Staff advised that Respondent instructed that the patient record be changed to reflect that only six carpules of 3% Carbocaine were administered instead of the 16 that were administered to patient L.S.
8. The Board received a complaint from patient A.M. A Board consultant reviewed this case and concluded that patient A.M. was not treated within the standard of care for the following reasons:

- a. Root canal therapy performed on tooth #12 was completed without the use of a rubber dam. The standard of care requires a rubber dam be used when performing root canal therapy.
  - b. There is radiographic evidence of a pin protruding out of the distal aspect of tooth #12, which does not meet the standard of care.
  - c. Respondent admitted that a rubber dam was not used on this patient.
9. The Board received a complaint from a subsequent treating dentist regarding patient J.T. The complaint stated that clinical notes from Respondent indicate that a MOL alloy was placed in tooth A, and a DOL alloy was placed in tooth B. The subsequent treating dentist expressed concern for the following reasons:
  - a. No lingual component of the restorations could be seen, and both teeth shared one solid amalgam restoration.
  - b. The placement of one restoration spanning two teeth does not meet the standard of care.
10. A Board consultant reviewed the care provided to patient J.T. Following review, the consultant concluded that the care provided by Respondent to teeth A and B did not meet the standard of care due to the following:
  - a. The radiograph dated 12-7-10 was not of diagnostic quality to treatment plan interproximal decay.
  - b. Respondent fraudulently documented his treatment by stating he performed an MOL on tooth A and a DOL on tooth B.

- c. Respondent placed one alloy restoration between tooth A and B. The standard of care is to place two separate restorations.
- d. Placing one restoration between two teeth is below the standard of care because it also makes it very difficult for a patient to floss this area.

11. In October 2011, multiple patient records were subpoenaed from Respondent. These records were reviewed by a Board consultant who concluded that Respondent is not practicing to an acceptable standard of care for the following reasons:

- a. Respondent on multiple occasions billed for services that were not performed or not documented.
- b. Respondent on multiple occasions performed root canal therapy on patients without the use of a rubber dam.
- c. Use of a rubber dam is the only method of isolating a tooth that meets the standard of care during root canal procedures.

12. In January 2011, multiple orthodontic records were subpoenaed from Respondent following receipt of a complaint. Respondent's clinical records were reviewed by a Board consultant who is an orthodontist. The consultant concluded in several cases that Respondent did not practice to an acceptable standard of care for the following reasons:

- a. Respondent's clinical records lack evidence of adequate orthodontic diagnosis and treatment plan.
- b. Respondent's intraoral photographs were of non-diagnostic quality.

- c. Respondent on multiple patients fails to mention or appropriately treat occlusion discrepancies.

### **CONCLUSIONS OF LAW**

13. The facts set forth above indicate that Respondent cannot safely continue to engage in the practice of dentistry.
14. The facts set forth above establish that Respondent's continued practice of dentistry poses an immediate danger to the public health, safety and welfare.
15. The facts set forth above establish that Respondent appears to have repeatedly violated Board statutes and rules by failing to maintain a reasonably satisfactory standard of competency in the practice of dentistry, in violation of Iowa Code Section 153.34(8) (2011) and 650 Iowa Administrative Code 30.4(16); failing to maintain records in a manner consistent with the protection of the welfare of the patient, in violation of 650 Iowa Administrative Code Section 27.11 (2011); with making misleading, deceptive, untrue or fraudulent statements in the practice of dentistry, or engaging in unethical conduct or practice harmful or detrimental to the public, in violation of Iowa Code Sections 147.55(3) and 272C.10(3) (2011).
16. The Board concludes that this matter has been fully investigated and that this investigation has been sufficient to ensure that the Board is proceeding on the basis of reliable information. Respondent's records have been reviewed by Board consultants, who identified numerous violations of the standard of care.
17. Specific circumstances which pose an immediate danger to the public health, safety, and welfare have been identified and determined to be ongoing.

Respondent's continued practice of dentistry poses an immediate danger to his patients' dental health.

18. The Board does not believe the imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare for the reasons identified in paragraphs 5-12, above.
19. The Board finds that the immediate suspension of Respondent's ability to practice dentistry is necessary to avoid immediate danger to the public health, safety, and welfare, until this case is finally resolved.

#### **ORDER**

**IT IS HEREBY ORDERED**, in accordance with Iowa Code Section 17A.18A (2011) and 650 IAC 51.30, that the dental license of Respondent, Masih Safabakhsh, D.D.S., is suspended from the practice of dentistry. Respondent shall immediately cease and desist from the practice of dentistry. Respondent shall be notified immediately of this Order pursuant to 650 IAC 51.30(3).

A hearing on this Emergency Adjudicative Order and the Statement of Charges, which have been filed concurrently with this Order, shall be held on August 16 & 17, 2012 at 9:00 a.m. The hearing will be held at the Board office, located at 400 S.W. 8<sup>th</sup> Street, Suite D, Des Moines, Iowa.

  
LYNN D. CURRY, D.D.S.  
Vice Chairperson  
Iowa Dental Board  
400 S.W. 8<sup>th</sup> Street, Suite D  
Des Moines, Iowa 50309-4687

cc: Theresa O'Connell Weeg  
Assistant Attorney General  
Iowa Attorney General's Office  
2<sup>nd</sup> Floor Hoover Bldg.  
Des Moines, IA 50319

**BEFORE THE DENTAL BOARD  
OF THE STATE OF IOWA**

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**IN THE MATTER OF** )  
**MASIH SAFABAKHSH, D.D.S.** )  
**RESPONDENT.** )

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**NOTICE OF HEARING  
AND STATEMENT OF CHARGES**

**COMES NOW** the Iowa Dental Board (Board) and files this Notice of Hearing and Statement of Charges pursuant to Iowa Code sections 17A.12(2), 17A.18(3), and 650 Iowa Administrative Code (IAC) 51.6. Respondent was issued Iowa dental license number 07660 on June 18, 1993. Respondent's license is current and will next expire on August 31, 2012. Respondent's address as reported to the Board is 1515 Blairs Ferry Road NE, Cedar Rapids, Iowa 52402.

**A. TIME, PLACE AND NATURE OF HEARING**

1. Hearing. A disciplinary contested case hearing shall be held on August 16 & 17, 2012, before the Iowa Dental Board. The hearing shall begin at 9:00 a.m. and shall be located in the conference room at the office of the Iowa Dental Board, 400 SW 8<sup>th</sup> Street, Ste. D, Des Moines, Iowa.

2. Answer. Within twenty (20) days of the date you are served this Notice of Hearing and Statement of Charges you are required by 650 IAC 51.12(2) to file an Answer. The Answer should specifically admit, deny, or otherwise answer all allegations contained in sections C and D of this Notice of Hearing and Statement of Charges. Pleadings shall be filed with the Board at the following address: Iowa Dental Board, 400 SW 8<sup>th</sup> Street, Ste. D, Des Moines, Iowa 50309.

3. Presiding Officer. The Board shall serve as presiding officer, but the Board may request an Administrative Law Judge make initial rulings on pre-hearing matters, and be present to assist and advise the Board at hearing.

4. Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 650 IAC chapter 51. At hearing, you may appear personally or be represented by legal counsel at your own expense. You will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf on issues of material fact, cross-examine witnesses present at the hearing, and examine and respond to any documents introduced at hearing. If you need to request an alternative time or date for hearing, you must comply with the requirements of 650 IAC 51.18. The hearing may be open to the public or closed to the public at your discretion.

5. Pre-hearing Conference. Any party may request a pre-hearing conference to discuss evidentiary issues related to the hearing. The Board's rules regarding pre-hearing conferences are contained at 650 IAC chapter 51.17.

6. Prosecution. The Office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Copies of pleadings should be provided to counsel for the State at the following address: Theresa O'Connell Weeg, Assistant Attorney General, Iowa Attorney General's Office, 2<sup>nd</sup> Floor, Hoover State Office Building, Des Moines, Iowa 50319.

7. Communications. You may not contact Board members in any manner, including by phone, letter, or e-mail, about this Notice of Hearing and Statement of

Charges. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in the case. You should direct any questions to Melanie Johnson, J.D., Executive Director at 515-281-5157.

## **B. LEGAL AUTHORITY AND JURISDICTION**

1. Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147, 153, and 272C.
2. Legal Authority. If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code Chapters 17A, 147, 153, and 272C and 650 IAC chapters 30 and 51.
3. Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code Section 17A.12(3) and 650 IAC 51.22.

## **C. SECTIONS OF STATUTES AND RULES INVOLVED**

### **COUNT I**

Respondent is charged under Iowa Code Section 153.34(8) (2011) with failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry.

### **COUNT II**

Respondent is charged under Iowa Code Section 153.34(5) (2011) with obtaining a fee by fraud or misrepresentation.

### **COUNT III**

Respondent is charged under Iowa Code Section 153.34(4) (2011) with willfully or repeatedly violating the rules of the Board by failing to maintain records in a manner consistent with the protection of the welfare of the patient, in violation of 650 Iowa Administrative Code Section 27.11.

### **COUNT IV**

Respondent is charged under Iowa Code Sections 147.55(3) and 272C.10(3) (2011) with making misleading, deceptive, untrue or fraudulent statements in the practice of dentistry, or engaging in unethical conduct or practice harmful or detrimental to the public.

#### **D. FACTUAL CIRCUMSTANCES**

1. Respondent is a general dentist engaged in the practice of dentistry in Cedar Rapids, Iowa.
2. Iowa Code Section 153.34(8) provides that a ground for discipline includes failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry.
3. The Board received a complaint from a third party payee regarding patient T.A. The complaint stated that a subsequent treating dentist submitted authorization to replace a crown placed by Respondent one month earlier because a radiograph clearly shows the crown on tooth #19 does not fit properly and margins are open. A Board consultant reviewed this case and concluded that patient T.A. was not treated within the standard of care for the following reason:

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  - d. Following L.S.'s medical emergency an email was sent to all staff in Respondent's office stating that an ambulance was not to be called by anyone unless requested by a doctor or patient. This protocol does not meet the standard of care.
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  - c. Staff advised that Respondent instructed that the patient record be changed to reflect that only six carpules of 3% Carbocaine were administered instead of the 16 that were administered to patient L.S.
6. The Board received a complaint from patient A.M. A Board consultant reviewed this case and concluded that patient A.M. was not treated within the standard of care for the following reasons:
  - a. Root canal therapy performed on tooth #12 was completed without the use of a rubber dam. The standard of care requires a rubber dam be used when performing root canal therapy.
  - b. There is radiographic evidence of a pin protruding out of the distal aspect of tooth #12, which does not meet the standard of care.
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  - a. Respondent on multiple occasions billed for services that were not performed or not documented.

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  - c. Respondent on multiple patients fails to mention or appropriately treat occlusion discrepancies.

#### **E. SETTLEMENT**

This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 650 IAC Chapter 51.19. If you are interested in pursuing settlement of this matter, please contact Melanie Johnson, J.D., Executive Director, at 515-281-5157.

#### **F. PROBABLE CAUSE FINDING**

On this 13<sup>th</sup> day of July, 2012, the Iowa Dental Board found probable cause to file this Notice of Hearing and Statement of Charges.

  
LYNN D. CURRY, D.D.S. —  
Vice Chairperson  
Iowa Dental Board  
400 SW 8<sup>th</sup> Street, Suite D  
Des Moines, IA 50309

cc: Theresa O'Connell Weeg  
Assistant Attorney General  
Iowa Attorney General's Office  
2<sup>nd</sup> Floor Hoover Bldg.  
Des Moines, IA 50319