STATE OF NEBRASKA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  

STATE OF NEBRASKA ex rel. DOUGLAS  
J. PETERSON, Attorney General,  
Plaintiff,  

vs.  

PIEPER, TODD  
Defendant.  

ORDER ON AGREED SETTLEMENT

A proposed Agreed Settlement was filed with the Department on November 5, 2015.

ORDER

1. The Agreed Settlement is adopted, attached hereto and incorporated by reference.

2. The facts as set out in the Petition are taken as true and adopted herein.

3. The parties shall comply with all of the terms of the Agreed Settlement.

DATED this 20th day of November, 2015.

Thomas J. Safranek, M.D.  
Acting Chief Medical Officer  
Division of Public Health  
Department of Health and Human Services

Civil penalty, if imposed, should be mailed to: DHHS, Division of Public Health, Licensure Unit, ATTN: Diane Pearson, P. O. Box 94986, Lincoln, NE 68509.

CERTIFICATE OF SERVICE

COMES NOW the undersigned and certifies that on the 23rd day of November, 2015, a copy of the foregoing ORDER ON AGREED SETTLEMENT was sent certified United States Mail, postage prepaid, return receipt requested to the Defendant’s Attorney, Jerry Katskee, 10404 Essex Court, Suite 100, Omaha NE 68114, and by e-mail to Ed Vierk, Assistant Attorney General, ago.health@nebraska.gov.

DHHS Hearing Office  
P. O. Box 95026  
Lincoln, NE 68509-5026  
P. (402) 471-4731 F. (402) 742-2374  
dhhs.publichealthhearings@nebraska.gov

7013 2250 0000 5074 0703
STATE OF NEBRASKA
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

STATE OF NEBRASKA ex rel DOUGLAS
J. PETERSON, Attorney General,

Plaintiff,

vs.

TODD PIEPER, D.D.S.,

Defendant.

AGREED SETTLEMENT

The Plaintiff and the Defendant, Todd Pieper, D.D.S., in consideration of the mutual covenants and agreements contained herein, agree as follows:

1. The Defendant, Todd Pieper, D.D.S., was issued a license to practice as a Doctor of Dentistry (#6023) by the Nebraska Department of Health and Human Services Division of Public Health ("Department").

2. The Defendant acknowledges receipt of a copy of the Petition for Disciplinary Action and waives the need for further service of the Petition upon him.

3. Before disciplinary measures may be taken against the Defendant's license, the Defendant is entitled to a hearing as provided by law. The Defendant waives the right to a hearing. The Defendant also waives any right to judicial review of a disciplinary order which approves the terms of this Agreed Settlement.

4. No coercion, threats, or promises, other than those stated herein, were made to the Defendant to induce him to enter into this Agreed Settlement.

5. The Defendant acknowledges that he is not licensed to practice dentistry in any state other than Nebraska.
6. The Defendant acknowledges that he has read the Petition for Disciplinary Action filed by the Attorney General's Office and neither admits nor denies the allegations in the Petition.

7. The Plaintiff and the Defendant consent to the entry of a final disciplinary order by the Chief Medical Officer which finds the allegations of the Petition for Disciplinary Action are true and places a limitation on the Defendant's license to practice Dentistry with the following condition:

   A. The Defendant shall not perform surgical placement of dental implants.

6. The Plaintiff and the Defendant acknowledge that the Defendant may perform non-surgical revisions to existing implants. The Plaintiff and the Defendant also acknowledge that the Defendant shall consult with the dentist who performed surgical placement of said implants in formulation of the treatment plan for non-surgical restoration of the implants. The Plaintiff and the Defendant further acknowledge that the consultation must be documented in the patient's records.

9. The Defendant shall promptly respond to all requests and inquiries by the Department concerning the Defendant's compliance with the condition of this license limitation.

10. The Defendant acknowledges that removal of the license limitation is at the discretion of the Department and upon the approval of the Nebraska Board of Dentistry.

11. In the event the Defendant violates the condition of his license limitation, the Chief Medical Officer, after motion by the Attorney General and a hearing, may take
further disciplinary action against his license to practice dentistry including revocation of his license.

11. If this Agreed Settlement is not approved by the Chief Medical Officer, this Agreed Settlement shall become null and void and will not be admissible for any purpose at any hearing that may be held on this matter.
AGREED TO:

BY: Todd Pleper, D.D.S.
Defendant

State of Nebraska
) /)
County of Scotts Bluff ) ss.
)

This Agreed Settlement is acknowledged before me by, Todd Pleper, D.D.S., on this 20th day of October, 2015.

Notary Public
My Commission Expires:

STATE OF NEBRASKA, ex rel.
DOUGLAS J. PETERSON, Attorney
General,
Plaintiff,

BY: DOUGLAS J. PETERSON,
#18146
Attorney General

By:
Edward Vierk, #22118
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509-8920
(402) 471-3824

Attorneys for the Plaintiff.

PETITION FOR DISCIPLINARY ACTION

The Plaintiff alleges as follows:

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION:


2. At all times relevant herein, the Defendant, Todd Pieper, D.D.S., has been the holder of a license (#6023) issued by the Nebraska Department of Health and Human Services (“Department”) to practice as a Doctor of Dentistry.

3. The Department is the agency of the State of Nebraska authorized to enforce the laws of Nebraska regulating the practice of Dentistry.

4. The Nebraska Board of Dentistry considered the investigation of this matter and made its recommendation to the Attorney General, which recommendation has been considered. Such matters are privileged pursuant to Neb. Rev. Stat. §§ 38-1,105 and 38-1,106 (Reissue 2008).

5. The Defendant has a dental practice in Scottsbluff, Nebraska.
6. On January 11, 2012, Patient #1, an 83 year-old female, came to the Defendant’s dental practice with the complaint that her partial did not fit. Upon examination, the Defendant determined that Patient #1 had no molars or pre-molars to retain the partial.

7. During the January 11, 2012, visit, Patient #1 completed a Patient Information/Medical History form. On the form, Patient #1 noted the following:
   a. “Have you had any serious illnesses or operations?” – Answer: “Y;”
   c. Regarding current conditions – Answer: “Artificial joints,” “cancer,” “heart problems,” “high blood pressure,” “radiation treatment.”

Patient #1 also provided a handwritten list of medications. Among the medications listed was written “Zometa 3x year,” with a line drawn through said entry. Patient #1 also completed a form page titled “Medications.” On said “Medications” form, Patient #1 wrote “Zometa, injection, 3x year,” with a line also drawn through said entry.

8. During the January 11, 2012, visit, the Defendant never asked Patient #1 about her cancer treatments or cancer-related medications, nor did the Defendant ask Patient #1 about whether she had ever taken Zometa. The Defendant also never obtained a blood pressure reading or otherwise evaluated Patient #1’s cardiovascular status prior to treatment.

9. On January 18, 2012, a pre-operative panolypse radiograph was taken and the Defendant determined that Patient #1 had adequate bone present for mini implant placement. The Defendant then placed Eposteal mini implants for teeth #20 and #29.
Extensive decay was present of #22 and #27. Composite restorations were placed on #22 and #27, and were designed to give some retention for the partial. A chair-side reline was also performed on the mandibular partial denture.

10. On October 16, 2012, Patient #1 was examined by Dr. W.B., D.D.S., due to complaints of pain in her right mandible and having bone coming out of her jaw. Dr. W.B.’s diagnosis of Patient #1 noted the right implant had purulent drainage around it with pressure on the buccal. In reviewing Patient #1’s medical history, Dr. W.B. noted that Patient #1 had received IV bisphosphonates on several occasions in the past for treatment of her renal cell carcinoma, and that Patient #1 had received a nephrectomy. When Dr. W.B. asked Patient #1 if she had told the Defendant about these, Patient #1 reported that the Defendant had never asked.

11. On October 23, 2012, Patient #1 returned to Dr. W.B.’s office and removed the implants with just finger pressure, noting that the implants had not integrated.

12. On November 16, 2012, Patient #1 returned to Dr. W.B.’s office for a post-operative visit. Dr. W.B. noted that Patient #1 had exposed bone on the right side and was still complaining of aching.

13. On November 19, 2012, E.P. returned to Dr. W.B.’s office for a follow-up visit. Dr. W.B. noted that Patient #1 had developed exposed bone on both the left and the right side.

14. Dr. T.M., D.D.S., a dental implant expert for the Department reviewed the Defendant’s records of Patient #1 and found that the Defendant failed to meet the appropriate standard of care for the practice of Dentistry as follows:
a. The record of Patient #1's treatment does not adequately support the type of treatment given.

b. Patient #1 presented with a history of cancer and cardiovascular problems, including surgery and medications, yet the Defendant failed to obtain a blood pressure reading prior to surgical procedure. The Defendant's failure to obtain appropriate medical consultation and evaluation placed Patient #1 at risk for the development of bisphosphonate induced osteonecrosis of the jaw.

c. The Defendant used no calibrating devices or modified implant guides to calibrate the positioning of Patient #1's dental implants. Nor does the record reference any diagnostic or planning to confirm the location of the inferior alveolar nerve or mental foramen prior to the placement of the dental implants.

d. There is no indication of the length of the implants, indicating planning in the placement of the implants.

e. There is no indication of any attempt made to obtain x-rays with guidepins to confirm appropriate and safe placement of the implants could be accomplished.

f. There was no record of anesthesia administration for the implant procedure.

15. On January 9, 2014, Patient #2, an 86 year-old patient, came to the Defendant’s practice with a chief complaint that her lower denture was loose and that she
didn’t like the fit. Patient #2 also indicated that her upper denture fit fairly well but that she had to use large amounts of dental adhesive to keep the denture in place.

16. On January 17, 2014, the Defendant placed implants at teeth #’s 3, 5, 7, 10, 12, 20, 23, 26, and 29. During the procedure, Patient #2 began to hemorrhage in the area of #14, and the Defendant informed Patient #2 that a different location would be needed for that implant.

17. On January 22, 2014, Patient #2 was seen for a post-operative visit by the Defendant. During said visit, Patient #2 complained of pain. However, the Defendant made no charting notations regarding Patient #2’s physical condition.

18. On January 28, 2014, Patient #2 was examined by Dr. W.B., D.D.S.. Patient #2 indicated that her primary concern was pain and swelling, intraoral and perioral. Dr. W.B. noted a hole in the area of tooth #15. Dr. W.B. took an x-ray, which indicated five maxillary implants and four mandibular implants placed.

19. Dr. T.M., D.D.S., a dental implant expert for the Department reviewed the Defendant’s records of Patient #2 and found that the Defendant failed to meet the appropriate standard of care for the practice of Dentistry as follows:

   a. Indication for the administration of Amoxicillin in Patient #2, who had reported an allergy to penicillin, noted in a response to a Department inquiry, but not previously recorded in patient charts.

   b. No record for review of the reason for the application or choice of amoxicillin.

   c. Patient #2 presented with a history of stroke and a coronary with stent placement.
d. Too much epinephrine was used in the local anesthetics. Dr. Pieper's records indicate that he used 7 carpules of Lidocaine 2% with epinephrine 1:100,000, which is three (3) times the recommended safe dose at one visit for the cardiovascular medically compromised patients. The Defendant should have sought out physician consultation regarding the status of Patient #2's cardiovascular system. Once the Defendant exceeded the maximum recommended dose, he should have considered rescheduling the patient for additional surgery.

e. The Defendant failed to obtain blood pressure throughout the surgical procedure with a patient with a compromised cardiovascular system.

f. During the surgery, Patient #2 likely had an exposure of the sinus during surgical procedure as evidenced by the loos of integrity of the antrium in the follow up x-ray in the area of the reported bleeding complication. No instructions were given for post-op management of sinus complications, nor was any prescription recommended for management of potential sinus perforation.

g. The panoramic radiograph used to examine the patient shows no calibrating devices in place. There was no indication that any attempt was made to obtain x-rays with guidepins to confirm appropriate and safe placement could be accomplished.
FIRST CAUSE OF ACTION

20. Paragraphs 1 through 19 are incorporated by reference.


22. Neb. Rev. Stat. § 38-179 (Reissue 2008) defines unprofessional conduct as "... any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or occupation or the ethics of the profession or occupation, regardless of whether a person, patient, or entity is injured..."

23. The Defendant’s failure to perform appropriate diagnosis and treatment for Patient #1 and Patient #2 does not conform to the standards of acceptable and prevailing practice of dentistry and is grounds for discipline.

SECOND CAUSE OF ACTION

24. Paragraphs 1 through 23 are incorporated by reference.


27. Title 172 NAC 56-007.02 defines unprofessional conduct as “failure to keep and maintain adequate records of treatment or service.”

28. The Defendant’s failure to record of anesthesia administration for the implant procedure for Patient #1; failure to chart notations regarding Patient #2’s physical condition; and failure to establish treatment plans for Patient #1 and Patient #2 is unprofessional conduct for which his license may be disciplined.
THIRD CAUSE OF ACTION

29. Paragraphs 1 through 28 are incorporated by reference.


31. The Defendant's conduct set forth above constitutes a pattern of negligent conduct which is grounds for discipline.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff prays that the Director set this matter for hearing, order appropriate disciplinary action pursuant to Neb. Rev. Stat. § 38-196 (Reissue 2008), and tax the costs of this action to the Defendant.

STATE OF NEBRASKA, ex rel.
DOUGLAS J. PETERSON,
Attorney General,
Plaintiff,

BY: Douglas J. Peterson, #18146
Attorney General

BY: Edward Vierk, #22118
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