

IN THE MATTER OF
HUN JIN KIM, D.D.S.

Respondent

License Number: 5764

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BEFORE THE MARYLAND
STATE BOARD OF
DENTAL EXAMINERS
Case Number: 2016-188

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CONSENT ORDER

On or about October 3, 2018, the Maryland State Board of Dental Examiners (the “Board”) charged **HUN JIN KIM, D.D.S.** (the “Respondent”), license number 5764, under the Maryland Dentistry Act, codified at Md. Code Ann., Health Occ. (“Health Occ.”) §§ 4-101 *et seq.* (2014 Repl. Vol. & 2017 Supp.) (the “Act”) and the regulations adopted by the Board at Md. Code Regs. (“COMAR”) 10.44.01 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of law:

Health Occ. § 4-315

- (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may ... reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
 - (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
 - (20) Violates any rule or regulation adopted by the Board;

The Board charged the Respondent with violating the following regulations adopted by the Board:

COMAR 10.44.23.03 Unprofessional or Dishonorable Conduct.

- B. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry, dental hygiene, or dental radiation technology:
 - (2) Engaging in conduct which is unbecoming a member of the dental profession;
 - (6) Performing a dental procedure without first obtaining informed consent from the patient or the patient's legal representative;
 - (8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry, dental hygiene, or dental radiation technology [.]

COMAR 10.44.30.02 General Provisions for Handwritten, Typed, and Electronic Health Records.

- B. Dental records shall include:
 - (1) A patient's clinical chart as described in Regulation .03 of this chapter; and
 - (2) Financial records as described in Regulation .04 of this chapter.

COMAR 10.44.30.03 Clinical Charts.

- A. Each patient's clinical chart shall include at a minimum the following:
 - (2) Reasons for the patient's visit;
 - (3) Treatment plans that are signed and dated by both the treating dentist and the patient;
 - (4) Patient's complaints;
 - (5) Diagnosis and treatment notes;
 - (7) Post-operative instructions;

- (10) Identification of medications prescribed, administered, dispensed, quantity, and directions for use;
- (12) Radiographs of diagnostic quality;
- (13) Periodontal charting;
- (14) Laboratory work authorization forms and correspondence to and from laboratories;
- (15) Informed consent;

COMAR 10.44.30.04 Financial Records.

- A. Financial records shall be considered part of the dental records but shall be maintained separately from the patient's clinical chart.
- B. Financial records shall include at a minimum the following:
 - (1) Complete financial data concerning the patient's account, including:
 - (a) Each amount billed to or received from the patient or third-party payor; and
 - (b) The date of each bill and each payment;
 - (2) Copies of all claim forms submitted to third-party payors by the dentist or by the dentist's agent or employee; and
 - (3) Payment vouchers received from third-party payors.

COMAR 10.44.30.05 Violations.

- A. Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

On or about April 3, following a Case Resolution Conference held at the Board's offices, the Respondent and the Board agreed to enter into this Consent Order.

FINDINGS OF FACT

The Board finds the following facts.

1. At all times relevant hereto, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed on October 8, 1974. His license is current through June 30, 2020.

2. At all times relevant hereto, the Respondent has practiced dentistry at a private practice of dentistry located at 12100 Heritage Park Circle, Silver Spring, Maryland 20906 (the "Office").

3. On or about April 29, 2016, the Board received a detailed written complaint (the "Complaint") from a patient of the Respondent (the "Complainant"). The Complaint alleged that the Respondent engaged in hostile and unprofessional behavior over a period of several months in 2015 and 2016 in the context of a heated billing dispute. The Complaint also alleges inadequate or incomplete dental recordkeeping.

4. On or about May 5, 2016, the Board received a referral from the Maryland State Dental Association (MSDA) that cited the Respondent's refusal to cooperate with its voluntary Peer Review mediation process designed to resolve billing disputes. The referral references the Respondent's "unprofessional" behavior during the process, which included yelling at MSDA representatives.

5. Based on the Complaint and the referral from MSDA, the Board began an investigation.

6. On or about June 16, 2016 the Board received the Complainant's dental records from the Respondent in response to a subpoena. Also included was a letter from the

Respondent stating without explanation, "I found her [the Complainant's] record indicated was absolutely incorrect."

7. On or about June 28, 2016, the Board received the Complainant's dental records and a narrative of treatment from a subsequent provider with whom the Complainant sought care after the dispute with the Respondent began.

8. On or about September 29, 2016, in furtherance of the investigation, the Board obtained dental records for six additional patients of the Respondent selected at random. The Board then assigned an independent expert (the "Expert") to review the records.

9. On or about May 16, 2018, the Board received the Expert's report. The Expert concluded that the Respondent's recordkeeping for all six patients was inadequate.

The Complainant's Records

10. The Respondent's dental recordkeeping was inadequate in that he failed to include in the Complainant's chart the following:

- A. Reasons for the patient's visit;
- B. Treatment plans that were signed and dated by both the treating dentist and patient;
- C. Patient's complaints;
- D. Diagnosis;
- E. Post-operative instructions;
- F. Periodontal charting or documentation of hard and soft tissue examination;
- G. Laboratory work authorization forms or correspondence to and from laboratories;

- H. Informed consent;
- I. Appropriate radiographs; and
- J. Past dental history.

11. In addition, the Respondent did not maintain the Complainant's financial records separately from her clinical chart.

12. Finally, although the Complainant appeared to have dental insurance, the patient record contained no evidence, such as claims forms, of any amount billed to or received from insurance.

Patient B

13. The Respondent's dental recordkeeping was inadequate in that he failed to include in Patient B's chart the following:

- A. Reasons for the patient's visit;
- B. Treatment plans that were signed and dated by both the treating dentist and patient;
- C. Patient's complaints;
- D. Diagnosis;
- E. Post-operative instructions;
- F. Periodontal charting or documentation of hard and soft tissue examination;
- G. Identification of medications prescribed, administered, dispensed, quantity and directions for use;
- H. Informed consent; and
- I. Appropriate radiographs.

14. In addition, the Respondent did not maintain Patient B's financial records separately from the clinical chart.

Patient C

15. The Respondent's dental recordkeeping was inadequate in that he failed to include in Patient C's chart the following:

- A. Reasons for the patient's visit;
- B. Treatment plans that were signed and dated by both the treating dentist and patient;
- C. Patient's complaints;
- D. Diagnosis;
- E. Post-operative instructions;
- F. Periodontal charting or documentation of hard and soft tissue examination;
- G. Identification of medications prescribed, administered, dispensed, quantity and directions for use;
- H. Informed consent;
- I. Appropriate radiographs; and
- J. Past dental history.

16. In addition, the Respondent did not maintain Patient C's financial records separately from the clinical chart.

17. Finally, although Patient C appeared to have dental insurance, the patient record contained no evidence, such as claims forms, of any amount billed to or received from insurance.

Patient D

18. The Respondent's dental recordkeeping was inadequate in that he failed to include in Patient D's chart the following:

- A. Reasons for the patient's visit;
- B. Treatment plans that were signed and dated by both the treating dentist and patient;
- C. Patient's complaints;
- D. Diagnosis;
- E. Periodontal charting or documentation of hard and soft tissue examination;
- F. Identification of medications prescribed, administered, dispensed, quantity and directions for use;
- G. Informed consent;
- H. Appropriate radiographs; and
- I. Past dental history.

19. In addition, the Respondent did not maintain Patient D's financial records separately from the clinical chart.

Patient E

20. The Respondent's dental recordkeeping was inadequate in that he failed to include in Patient E's chart the following:

- A. Reasons for the patient's visit;
- B. Treatment plans that were signed and dated by both the treating dentist and patient;
- C. Patient's complaints;

- D. Diagnosis;
- E. Post-operative instructions;
- F. Periodontal charting or documentation of hard and soft tissue examination;
- G. Identification of medications prescribed, administered, dispensed, quantity and directions for use;
- H. Informed consent; and
- I. Past dental history.

21. In addition, the Respondent did not maintain Patient E's financial records separately from the clinical chart.

Patient F

22. The Respondent's dental recordkeeping was inadequate in that he failed to include in Patient F's chart the following:

- A. Reasons for the patient's visit;
- B. Treatment plans that were signed and dated by both the treating dentist and patient;
- C. Patient's complaints;
- D. Diagnosis;
- E. Post-operative instructions;
- F. Periodontal charting or documentation of hard and soft tissue examination;
- G. Identification of medications prescribed, administered, dispensed, quantity and directions for use;
- H. Informed consent;

- I. Appropriate radiographs; and
- J. Past dental history.

23. In addition, the Respondent did not maintain Patient F's financial records separately from the clinical chart.

Patient G

24. The Respondent's dental recordkeeping was inadequate in that he failed to include in Patient G's chart the following:

- A. Reasons for the patient's visit;
- B. Treatment plans that were signed and dated by both the treating dentist and patient;
- C. Patient's complaints;
- D. Diagnosis;
- E. Post-operative instructions;
- F. Periodontal charting or documentation of hard and soft tissue examination;
- G. Identification of medications prescribed, administered, dispensed, quantity and directions for use;
- H. Informed consent;
- I. Appropriate radiographs; and
- J. Past dental history.

25. In addition, the Respondent did not maintain Patient G's financial records separately from the clinical chart.

26. The Expert summarized his findings by stating, “The documentation in each of the charts reviewed failed to meet professional standards of record keeping both before and after June 11, 2012¹... The pattern of poor recordkeeping and lack of diagnostic radiographs is a clear and unmistakable demonstration of a breach of the standard of documentation.”

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions, as described above, constitute violations of the following provisions of the Act, specifically: Health Occ. § 4-315(a): (16) Behaves dishonorably or unprofessionally or violates a professional code of ethics pertaining to the dentistry profession; and (20) Violates any rule or regulation adopted by the Board; and the regulations adopted by the Board, as cited above.

ORDER

Based on the foregoing findings, it is, by a majority of a quorum of the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of **TWO (2) YEARS** under the following terms and conditions:

1. The Respondent shall pay a monetary penalty in the amount of two **thousand five hundred dollars (\$2500.00)** to the Board;
2. Within six (6) months of the effective date of the consent order, the Respondent shall, at his own expense, successfully complete an **in-person one-on-one course, approved by the Board in advance, equivalent to at least six (6) continuing education (C.E.) credits**, focusing on dental recordkeeping; and the Respondent shall submit

¹ On this date, the Board adopted regulations regarding recordkeeping based on the prevailing professional standards.

written verification that satisfies the Board of the successful completion of the course within 30 (thirty) days of completion of the course;

3. At its discretion, the Board may conduct up to three (3) record reviews of the Respondent's records. Each record review shall be conducted by a Board-designated expert, who shall review the records of a selection of patients whom the Respondent treated after completing the course mentioned above. The Board designee shall personally select the records on site at the Respondent's practice, and may do so at either a scheduled or unannounced visit. An unsatisfactory review, as determined in the sole discretion of the Board, shall constitute a violation of the Consent Order;
4. In order to facilitate the record reviews described above, the Respondent shall, on the first day of each month, provide the Board with a copy of his appointment book. The Respondent shall notify the Board beforehand of any changes to his schedule that will result in his absence from the office, unless he is unable to do so by reason of documented emergency or illness; and
5. The Respondent shall comply with the Maryland Dentistry Act;

And it is further

ORDERED that no part of the training or education that the Respondent receives in order to comply with this Consent Order may be applied to his required continuing education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further


ORDERED that after a minimum of two (2) years from the effective date of the Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. In addition, the Respondent shall have the right to petition the Board for termination of probation upon the sale of his ownership interest in the Office. The Board shall grant termination if the Respondent has fully and satisfactorily complied with all probationary terms and conditions and there are no pending investigations or outstanding complaints related to the findings of fact in this Consent Order; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent;

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

6/19/2019
Date


Francis X. McLaughlin
Executive Director
Maryland State Board of Dental Examiners

CONSENT

By this Consent, I, Hun Jin Kim, D.D.S., agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having been apprised of my right to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order and understand its effect.

Date

6/5/19

Jun Jin Kim, D.D.S.
The Respondent

Jun Jin Kim

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF: POTOMAC / MONTGOMERY

I HEREBY CERTIFY that on this 5TH day of JUNE 2019,

before me, a Notary Public of the State and County aforesaid, personally appeared Hun Jin Kim, D.D.S., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Alec N. Aspiotis

Notary Public

My commission expires:

Alec N. Aspiotis
Notary Public State of Maryland
My Commission Expires
June 25, 2019

