IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Dong Hwang, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D46354	*	**Case Number: 2016-0784B**

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CONSENT ORDER

On August 21, 2017, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board"), charged Dong Hwang, M.D. (the "Respondent"), License Number D46354, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* (2015 Repl. Vol. & 2016 Supp.) The Respondent was charged under the following provisions of Health Occ. § 14-404(a):

...

(3) Is guilty of:

...

(ii) Unprofessional conduct in the practice of medicine;

...

(19) Grossly overutilizes health care services;[1]

...

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;

...

[1] The charge of gross overutilization was based on the totality of the records reviewed, and not on a single patient.

(40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On December 20, 2017, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

I. FINDINGS OF FACT

Panel B finds:

Background

1. At all times relevant, the Respondent has been licensed to practice medicine in the State of Maryland. The Respondent was initially licensed on or about July 1, 1994, and his license is presently active through September 30, 2018.

2. The Respondent is board-certified in general surgery and is a sole practitioner in Gaithersburg, Maryland who performs general and colon and rectal surgeries. He holds privileges at Surgery Center A and Hospital A, both located in Montgomery County, Maryland.

3. On or about March 30, 2016, the Board received a written complaint from a former patient of the Respondent (identified as "Patient 1" in the charges) who had scheduled a screening colonoscopy with the Respondent at Facility A in September 2015. During the screening colonoscopy, Patient 1 alleges that: 1) the Respondent performed additional procedures that she was not aware she needed; and 2) she was billed in

excess of $30,000.00 for Facility A's fee, the anesthesia fee, and the Respondent's fee.[2]

4. On receipt of Patient 1's complaint, the Board initiated an investigation.

5. On or about April 5, 2016, the Board notified the Respondent of Patient 1's complaint, requested a written response to the allegations, and subpoenaed Patient 1's medical and billing records.

6. On or about June 22, 2016, the Board notified the Respondent it had initiated a full investigation, and enclosed a subpoena for the medical and billing records of nine additional patients that had been randomly selected from the Respondent's surgery schedule from July 2015 through May 2016.

7. In furtherance of its investigation, the Board transmitted the 10 patient records cited in ¶¶ 5 and 6 and other relevant documents obtained during the course of the investigation, for a peer review to be conducted by two physicians board-certified in colon and rectal surgery, the results of which are set forth in pertinent part below.

8. On or about February 22, 2017, Board staff sent the Respondent copies of the peer review reports and provided him with an opportunity to file a supplemental response with the Board.

9. On or about March 13, 2017, the Respondent submitted a supplemental response to the Board, in which he acknowledged his record-keeping was poor, but denied that he had violated the standard of quality medical or surgical care.

[2] The majority of the charges were due to Facility A's fees and out of network costs from her insurance provider, not the Respondent's fee. Patient 1 was able to ultimately negotiate more reasonable fees.

PRIOR DISCIPLINARY HISTORY

10. On or about September 28, 2010, the Board charged the Respondent pursuant to Health Occ. § 14-404(a)(22) for violating the standard of quality medical and surgical care of a surgical patient to whom the Respondent had failed to ensure an expeditious transfer to a hospital following a postoperative emergency event.

11. On May 26, 2011, the Respondent entered into a Consent Order with the Board agreeing to a reprimand in order to resolve the pending charges.

FINDINGS OF FACT RELATING TO PRESENT INVESTIGATION

Patient 1

12. In July 2015, Patient 1, a female in her 60s, was referred by her primary care physician to the Respondent for a screening colonoscopy. According to Patient 1, she was not experiencing any abnormal gastrointestinal symptoms.[3]

13. On September 14, 2015, Patient 1 saw the Respondent in his office for a consultation to "consider a screening colonoscopy"[4] and inconsistent with Patient 1's recollection, the Respondent documented that Patient 1 had been complaining of "bleeding, dyspepsia, constipation and a change in bowel habits for a three-month duration." The Respondent did not document the characteristics of severity of Patient 1's symptoms.

14. The Respondent documented on September 14, 2015, that Patient 1 had Grade 3 hemorrhoids, a fissure, and a rectal prolapse.

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[3] On June 16, 2016, Board staff interviewed Patient 1 and she stated that she had no symptoms and this was strictly for a screening colonoscopy. Moreover, she did not cite any symptoms in her written complaint filed with the Board. She stated she was undergoing an "elective, screening colonoscopy" and that she was at the time a "healthy...female." Her primary care physician saw her on July 13, 2015, and documented that she had no gastrointestinal symptoms including a change in bowel habits, bleeding, constipation or heartburn.

[4] On September 14, 2015, Patient 1 documented on the registration form, "consider screening colonoscopy."

15. Patient 1 stated during her interview with Board staff that the Respondent did not examine her on September 14, 2015. She stated that she met with the Respondent in his office and signed a consent form for a screening colonoscopy and other procedures as may be needed. She stated that she had a history of a hemorrhoid but denied having any active symptoms at the time she met with the Respondent, and did not have a history of a rectal prolapse or an anal fissure.[5]

16. On September 28, 2015, the operating room data form stated that the Respondent had performed a colonoscopy with biopsy and hemorrhoidectomy. The duration of the procedure was 17 minutes.[6]

17. The Respondent's post-operative dictation was inconsistent with the operating room data form. Besides the two procedures listed in ¶ 16, the Respondent dictated in his operative note that he had also performed a repair of Patient 1's rectal prolapse and an anal fissurectomy. The Respondent failed to describe the findings or how he had purportedly conducted the repairs and excisions.

18. The standard of quality care requires that the entire pathological tissue be excised when performing a hemorrhoidectomy, fissurectomy and resection of rectal prolapse. The pathology documents do not support that the Respondent submitted the tissue in its entirety for any of these procedures.

19. The Respondent billed Patient 1's insurance company for two colonoscopies: one utilizing a snare for a polypectomy and the other one utilizing a biopsy. Because

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[5] The only Consent forms provided to the Board by the Respondent were dated September 28, 2015, the date of the procedure and the Consent form had a sticker placed for the procedure performed which stated, "Colonoscopy with possible biopsy and/or polypectomy, Hemorrhoidectomy, Fissurectomy, and Repair of Rectal Prolapse."

[6] Peer Reviewer Two opined "it would seem unlikely to be able to perform a colonoscopy and multiple surgical procedures in seventeen minutes."

the Respondent performed both of these procedures purportedly during the same colonoscopy, the Respondent's billing was duplicative.

20. On January 12, 2016, Patient 1 wrote a letter to the Respondent asking him how he had repaired her anal fissure as this procedure had been billed to the insurance company, and he had failed to mention this procedure in his operative report. The Respondent failed to respond to Patient 1's query.

21. The Respondent's actions and inactions as outlined in pertinent part above constitute evidence of a failure to meet the standard of quality medical and surgical care in violation of Health Occ. § 14-404(a)(22), inadequate documentation in violation of Health Occ. § 14-404(a)(40), unprofessional conduct in the practice of medicine in violation of Health Occ. § 14-404(a)(3)(ii) and gross overutilization of health care services in violation of Health Occ. § 14-404(a)(19).

Patient 6

22. Patient 6, a female patient in her 50s, saw the Respondent on March 28, 2016 for a consult for what the Respondent documented as, "rectal bleeding/hemorrhoids/polyp." Patient 6 did not document on her intake form a reason for the visit to the Respondent.

23. On April 1, 2016, the Respondent documented that he conducted an EGD,[7] a colonoscopy, a rectal prolapse repair, a hemorrhoidectomy and an anal fissurectomy.

24. The standard of quality care for anal fissures and hemorrhoids begins with medical and/ or office-based management. The Respondent failed to document any medical and/or office-based management had been attempted for Patient 6.

[7] EGD stands for esophagogastroduodenoscopy which is a test to examine the lining of the esophagus, stomach and duodenum.

25. The Respondent did not document the characteristics or severity of Patient 6's symptoms.

26. The standard of quality care requires that the entire pathological tissue be excised when performing a hemorrhoidectomy, fissurectomy and resection of rectal prolapse. The pathology documents do not support that the Respondent submitted the tissue in its entirety for any of these procedures.

27. The Respondent failed to adequately document the anatomic and pathological details for the rectal prolapse, anal fissure and hemorrhoid.

28. The Respondent's billing submission to the insurance company was duplicative as he billed for two colonoscopies and two EGDs, when he had only performed one of each procedure.

29. The Respondent's actions and inactions as outlined in pertinent part above constitute evidence of a failure to meet the standard of quality medical and surgical care in violation of Health Occ. § 14-404(a)(22), inadequate documentation in violation of Health Occ. § 14-404(a)(40), unprofessional conduct in the practice of medicine in violation of Health Occ. § 14-404(a)(3)(ii) and gross overutilization of health care services in violation of Health Occ. § 14-404(a)(19).

INADEQUATE DOCUMENTATION

30. The peer reviewers concurred that in the remainder of the patient records reviewed, the Respondent failed keep adequate medical records (Patients 2, 3, 4, 5, 7, 8, 9, 10).

31. The peer reviewers concurred the Respondent's operative notes are inadequately descriptive. Specifics include but are not limited to that the Respondent failed to:

- document adequate consultation notes;
- include the anatomical and pathological details necessary to understand the location, the size, the degree of the prolapse, and whether it was full thickness or only mucosal;
- describe appearance and/or location of anal fissures; and
- describe appearance and/or location of hemorrhoids.

32. The Respondent's record-keeping constitutes evidence of inadequate documentation in violation of Health Occ. § 14-404(a)(40).

DUPLICATIVE BILLING

33. The peer reviewers concurred that in the remainder of the patient records reviewed, the Respondent engaged in duplicative billing (Patients 2, 3, 4, 5, 7, 8, 9, 10). Specifically:[8]

- Patient 2 - The Respondent billed for two colonoscopies on the same date when only one was performed;
- Patient 3 - The Respondent billed for two colonoscopies on the same date when only one was performed;
- Patient 4 - The Respondent billed for two colonoscopies on the same date when only one was performed;
- Patient 5 - The Respondent billed for two colonoscopies and two EGD's on the same date when only one of each procedure was performed;
- Patient 7 - The Respondent billed for two colonoscopies on the same date when only one was performed;
- Patient 8 - The Respondent billed for two colonoscopies on the same date when only one was performed;
- Patient 9 - The Respondent billed for two colonoscopies and two EGD's on the same date when only one of each procedure was performed; and
- Patient 10 - The Respondent billed for The Respondent billed for two colonoscopies and two EGD's on the same date when only one of each procedure was performed.[9]

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[8] The Respondent claims that the apparent duplicative billing pattern can be explained by the performance of two distinct surgical procedures, a polyp snare and a biopsy, performed during the course of a single colonoscopy.

[9] The patient's responsibility was $10,775.00.

34. The Respondent's duplicative billing as outlined in pertinent part above constitutes evidence of unprofessional conduct in the practice of medicine in violation of Health Occ. § 14-404(a)(3)(ii) and gross overutilization of health care services in violation of Health Occ. § (19).

II. CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel B concludes as a matter of law that the Respondent's conduct constitutes violations of Health Occ. II § 14-404(a)(3)(ii), (19), (22) and (40).

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by Disciplinary Panel B, hereby:

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS.**[10] During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

1. Within **SIX (6) months**, the Respondent shall successfully complete a comprehensive Board disciplinary panel-approved course in ethics. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education ("CME") credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

2. Within **SIX (6) months**, the Respondent shall successfully complete a comprehensive Board disciplinary panel-approved course in Current Procedural Terminology ("CPT") coding. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the CME credits required for

[10] If the Respondent's license expires while the Respondent is on probation, the probationary period and any probationary conditions will be tolled.

license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

3. Within **TWO (2) YEARS**, the Respondent shall pay a civil fine in the amount of $25,000.00 by money order or bank certified check made payable to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297; 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 before an Administrative Law Judge of the Office of Administrative Hearings. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or Panel B; and it is further

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

ORDERED that the Respondent shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen Prov. §§ 4-101-4-601 (2014 & 2016 Supp.).

02/06/2018
Date

Christine A. Farrelly
Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

CONSENT

I, Dong Hwang, M.D., License No. D46354, by affixing my signature hereto, acknowledge that:

I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

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 provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

1/23/2018
Date

Signature on File
Dong Hwang, M.D.

STATE/ DISTRICT OF Maryland

CITY/COUNTY OF:

I HEREBY CERTIFY that on this 23rd day of January, 2018, before me, a Notary Public of the State/District and County aforesaid, personally appeared Dong Hwang, M.D., 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.

Rhonda Mason
Notary Public

My commission expires:

RHONDA MASON
Notary Public-Maryland
Montgomery County
My Commission Expires
May 15, 2019