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Before the
State Of Wisconsin

In the Matter of the Application for Renewal of a Dentistry License, Bongmin An, Applicant

FINAL DECISION AND ORDER

Order No. 0005194

Division of Legal Services and Compliance Case No. 16 DEN 044

The State of Wisconsin, Dentistry Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, make the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Dentistry Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated at Madison, Wisconsin on the 1 day of March, 2017.

Member
Dentistry Examining Board

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Application for Renewal of a Dentistry License, Bongmin An, Applicant	DHA Case No. SPS-16-0043 DLSC Case No. 16 DEN 044

PROPOSED DECISION AND ORDER

The parties to this proceeding for purposes of Wis. Stat §§ 227.47(1) and 227.53 are:

Attorney Arthur K. Thexton
Thexton Law Offices
6229 W. Lloyd Street
Wauwatosa, WI 53213

Wisconsin Dentistry Examining Board
P.O. Box 8366
Madison, WI 53708-8366

Department of Safety and Professional Services, Division of Legal Services and Compliance, by

Attorney Amber L. Cardenas
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

PROCEDURAL HISTORY

On or about January 4, 2016, Applicant Bongmin An filed an application for renewal of his Wisconsin license to practice dentistry. The Wisconsin Dentistry Examining Board (Board or Wisconsin Board) issued a Notice of Denial, dated March 4, 2016, denying Dr. An's renewal application. Dr. An requested a hearing on this notice by letter dated March 14, 2016. On April 12, 2016, the Board issued a Notice of Corrected Denial, affirming its denial of Dr. An's renewal application and modifying the grounds for its denial. The grounds for denial were: (1) Dr. An engaged in unprofessional conduct under Wis. Stat. § 447.07(3)(a) and Wis. Admin. Code § DE 5.02(14) based on the facts and circumstances of prior discipline on his license to practice dentistry in the State of Oregon, and (2) denial of his renewal application was necessary to protect the public health, safety or welfare under Wis. Stat. § 440.08(4).

By letter dated April 19, 2016, Dr. An requested a hearing on the Notice of Corrected Denial. On May 23, 2016, the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division), served a Notice of Hearing on Dr. An, and the matter was assigned to the undersigned administrative law judge (ALJ).

Following a telephone prehearing conference held before the ALJ on June 29, 2016, the parties filed a Joint Stipulation of Facts and Joint Exhibit 1 on August 10, 2016. On August 15, 2016, Dr. An filed a "Motion for an Order determining the law applicable to this matter." In his motion, Dr. An argued that as a matter of law, he fulfilled all requirements for renewal of his license to practice dentistry and that he therefore must be issued his license renewal. He also argued that his application may not be denied based on actions taken by the dentistry Board in the State of Oregon because the term "suspension" in Wis. Admin. Code § DE 5.02(14) does not include a temporary suspension and a temporary suspension is not "disciplinary action" as contemplated by that provision. Following further submissions from the parties, the ALJ denied Dr. An's motion on September 8, 2016.

A hearing was held on September 20, 2016. Following the close of evidence, counsel for Dr. An provided an oral closing argument,[1] whereas the Division preferred to submit a written argument which was submitted on October 10, 2016. Counsel for Dr. An submitted a response on October 25, 2016, and the Division provided a reply on November 2, 2016.

FINDINGS OF FACT

1. On or about June 5, 2001, Dr. An was granted license number 5356-15 to practice as a dentist in the State of Wisconsin. (Joint Stipulation of Facts and Exhibits, ¶ 1)

2. Dr. An's license to practice dentistry in Wisconsin expired on or about September 30, 2003. (*Id.*, ¶ 2)

3. On or about January 5, 2016, Dr. An submitted an application to renew his license to practice dentistry in Wisconsin. (*Id.*, ¶ 3)

4. Dr. An's application for renewal was filled out on a form prescribed by the Department, and included payment. (*Id.*, ¶ 5)

5. Dr. An's application for renewal included a Certificate of Completion from the American Red Cross for Adult CPR/AED completed on December 22, 2015, which is valid for two years. (*Id.*, ¶ 6)

6. Dr. An's application for renewal included certificates of completion of continuing education courses. (*Id.*, ¶ 7)

[1] Dr. An's counsel provided a closing argument first, even though the parties agreed at hearing that the Department had the burden of proof in this matter.

7. On his renewal application, Dr. An answered yes to the question of whether he had ever surrendered, resigned, canceled or been denied a professional license or other credential in any other jurisdiction. He also answered yes to the question of whether any licensing or other credentialing agency had ever taken any disciplinary against him, including any warning, reprimand, suspension, probation, limitation or revocation. (Ex. 1, Tab A, p. 003; Hrg. Tr., pp. 26-27)

8. Included in Dr. An's January 5, 2016 application to renew his license to practice dentistry are two orders of the Oregon Board of Dentistry (Oregon Board) -- an Order of Immediate Emergency License Suspension (Emergency Suspension Order) dated March 12, 2012, and a Consent Order dated June 5, 2012. (Ex. 1, Tabs A and B)

9. The Emergency Suspension Order stated that the Oregon Board suspended Dr. An's license based on Dr. An failing to maintain accurate treatment notes for patients receiving treatment between August 2009 through January 2012, falsely billing treatment to dental insurance companies, altering dental records that were provided to the Oregon Board, and using and distributing marijuana. The Emergency Suspension Order found that Dr. An posed a serious danger to the public health and safety. (Ex. 1, Tab B, pp. 008-009)

10. The subsequent Consent Order states that Dr. An voluntarily resigned his license to practice dentistry in the State of Oregon and that he agreed not to seek future licensure from the Oregon Board. It contains no admission or finding of wrongdoing by Dr. An. (Ex. 1, Tab B; pp. 006-007)

Dr. An's explanation of events and his rehabilitative efforts

11. Dr. An was born in Seoul, Korea and came to the United States when he was 22 years old. He attended Marquette dental school in Wisconsin, graduating in 2001. He practiced for a short time in Madison, Wisconsin and subsequently moved to the State of Oregon, where he practiced from approximately December of 2001 through March of 2012, first with several group practices, and then in his own practice beginning in October of 2008. While in Oregon, he also got married and had two children. (Ex. 1, Tab B, p. 008, Tab N; Hrg. Tr., pp. 74-77)

12. Dr. An admits that his ethical lapses in Oregon were serious and that the conduct constituted unprofessional conduct. He admits that he accepted marijuana from a patient, that he kept the marijuana in his office, and that he offered it to two employees. He also admits to "lax" charting and that he falsely billed insurance companies. However, he provided further context for the violations, as set forth below. (Ex. 1, Tab C, pp. 012-014; Hrg. Tr., pp. 26-27, 37-39, 104-106; Applicant's post-hearing brief, p. 2).

13. Regarding his charting, Dr. An stated that he had used physical charts for many years but that in 2008, after starting his own practice, he switched to computerized recordkeeping. He did not obtain sufficient training on charting software. He was short-staffed and fell behind in finishing chart notes. Dr. An was too busy treating patients and having to perform office tasks such as sterilizing instruments himself, which would take him until approximately 7:00 or 8:00

p.m. He filled in his chart notes based on the x-rays, the treatment plan and billing statements. (Ex. 1, Tab C, pp. 13-14; Hrg. Tr., pp. 78-79, 82-83)

14. When the Oregon Board subsequently asked him for charts, some were not completed. Therefore, Dr. An completed the charts at a different time, trying to enter exactly what he did for the patients completely and accurately. He did not alter the records provided to the Board in any other way. Much of services he provided he considered to be routine procedures. He now recognizes that he should have kept contemporaneous records and that keeping records is a part of treatment and a duty to others providing care in the future. He also recognizes that he should have sent the charting to the Oregon Board as it existed and attached an additional explanation. (Ex. 1, Tab C, p. 014; Hrg. Tr., pp. 83-84)

15. Regarding the marijuana incident, Dr. An explained that in 2011, he had a patient who told him he was a licensed marijuana grower. At the time, Oregon allowed medical use of marijuana.[2] During the time that the patient was undergoing a partial denture, Dr. An and the patient had a light conversation about why Oregon approved marijuana growing and medical use of marijuana. At the end of the conversation, the patient stated that he may bring Dr. An some marijuana. Dr. An did not take it seriously, and thought the patient was joking. (Ex. 1, Tab C, p. 013; Hrg. Tr., pp. 80, 82)

16. One day after Dr. An had closed for the day, the patient brought him a bag of marijuana which Dr. An took and put in the refrigerator in his office. The marijuana was stored in the refrigerator for approximately six or seven months. Two of his staff had medical marijuana cards for chronic pain. At some point, Dr. An told them that they could save some money by taking some of the marijuana. He forgot the marijuana was in his office until he received the immediate suspension letter in 2012, whereupon he threw the marijuana away. (Ex. 1, Tab C, p. 13; Hrg. Tr., pp. 80-82)

17. Dr. An denied using the marijuana himself and stated he does not use marijuana or alcohol, or even over-the-counter pain medication. When he received the suspension order, he took a drug test at an occupational drug test center and faxed it to the Oregon Board. It was negative. He recognizes that he should have refused to accept the marijuana. (Ex. 1, Tab C, p. 013; Hrg. Tr., p. 81)

18. With respect to the conduct involving false insurance billing, Dr. An explained that he never billed for services which were not performed but that he sometimes entered the date of services as the following year so that the patient's insurance would cover the procedures. He stated that he did this in situations where a patient's yearly insurance allowance had maxed out but the patient needed treatment that year. Examples included fillings, root canal treatments and crowns. He stated that his only intention was to help the patient but that he recognizes his conduct was wrong. (Ex. 1, Tab C, p. 014; Hrg. Tr., pp. 84-85)

19. After receiving the letter of emergency suspension from the Oregon Board in March of 2012, Dr. An was shocked. He consulted with a physician for depression, experienced public

[2] *See* http://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx. Oregon also legalized small amounts of marijuana for adult recreational use in the fall of 2014. *Id.*

shame and could not leave his house. His wife asked him if the family could move to Texas. He sought employment in Texas so that he could support his family. Dr. An was first employed as a pet groomer but realized it was not for him. Both he and his wife then went to massage therapy school because it required only six months of training. At the time of the hearing, he had been working as a massage therapist for approximately four years. (Ex. 1, Tab C, p. 015; Hrg. Tr., pp. 86-87)

20. With his application, Dr. An submitted a number of continuing education certificates in ethics and dentistry. Dr. An completed over 100 hours of continuing education in the last two years. At his attorney's suggestion, he completed a 22-hour program in "Medical Ethics and Professionalism," which his attorney represented is a program the Wisconsin Medical Examining Board uses when one of its licensees exhibits an ethical lapse. It is a two-day course sponsored by the University of California, Irvine, School of Medicine, with the courses themselves lasting approximately eight hours per day and credit also given for course preparation and research. The course cost Dr. An between $1200-1300 and he had to travel to California to take it. The course includes requiring the attendees to name the violations engaged in and the danger the violations present, and to come up with a plan on how to prevent the ethical violations in the future. (Ex. 1, Tab C, p. 015, Tab O, p. 063; Hrg. Tr., pp. 89, 93-99, 120)

21. Dr. An's continuing education also included eight hours in "Dental Professional Liability Risk Management." This course, put on by a dental insurance company, covered the importance of taking accurate patient notes, as well as obtaining informed consent through PARQ (Procedures, Alternatives, Risks and Questions from patients). He also completed a two-hour course in "Maintaining Proper Dental Records" and a four-hour course in "Patient Records and Records Management." (Ex. 1, Tab C, p. 015, Tab O, pp. 063-064, 077-078; Hrg. Tr., pp. 89-92)

22. In further effort to keep his dentistry knowledge and skills current, Dr. An reads dental publications, has joined on-line educational groups on topics such as how to treat root canals, has followed YouTube lectures from a particular dentist, and has taken on-line continuing education. In addition, he has taken in-person courses, including one at the dental school in Texas on filling out broken front teeth. (Hrg. Tr., pp. 87-89)

23. Dr. An is willing to practice in an underserved area in Wisconsin, and has been in touch with a community clinic in Iron River. (Hrg. Tr., p. 101)

Testimony of Dr. Wendy Pietz

24. Dr. Wendy Pietz has been a licensed dentist practicing in Wisconsin since 2004 and has a specialty in oral and maxillofacial surgery. She has her own practice and has been a member of the Wisconsin Board since 2014. (Ex. 2; Hrg. Tr., p. 10)

25. On January 6, 2016, Dr. Pietz was appointed by the Chairperson of the Board to be the sole credentialing liaison for dentist applications. The Board delegated to her the authority to make all credentialing decisions on behalf of the Board, including denying applications and denying applications for renewal after five years. (Ex. 3; Hrg. Tr., pp. 12-13, 16, 20-21, 47)

26. In her capacity as a liaison reviewing applications, Dr. Pietz may either grant or deny a license or refer a case to the full Board for consideration. A license application only goes to the full Board for determination if Dr. Pietz cannot make a determination regarding the application. In the approximately nine months that Dr. Pietz had served as liaison, she had only referred a few cases back to the full Board. (Hrg. Tr., pp. 19-20, 48)

27. As an oral surgeon, professional dentist member of the Board, and credentialing liaison, she is familiar with licensure requirements, including those contained in Wis. Stat. ch. 447 and Wis. Admin. Code ch. DE 2, and the minimal standards of conduct for the practice of dentistry. (Hrg. Tr., pp. 21-22)

28. Dr. Pietz made the decision to deny Dr. An's renewal application. Although Dr. An's attorney asked if he and Dr. An could appear before the Board, the renewal application was not referred to the full Board. Dr. Pietz reviewed the application materials from Dr. An, including the letter from Dr. An and his attorney, and the documents from the Oregon Board. (Ex. 1, Tab C, p. 15; Hrg. Tr., pp. 26, 48)

29. Dr. Pietz was offered Dr. An's continuing education information but she neither requested nor reviewed any of the documents because she believed she had received sufficient information to make a determination regarding Dr. An's application. At the time of hearing, Dr. Pietz still had not reviewed the continuing education documentation. (Ex. 1, Tab F; Hrg. Tr., pp. 26, 48)

30. The denial of Dr. An's renewal application was based on two grounds. First, Dr. An's temporary suspension in the State of Oregon constituted unprofessional conduct under Wis. Stat. § 447.07(3)(a) and Wis. Admin. Code § DE 5.02(14), the latter of which defines unprofessional conduct to include "[h]aving a license, certificate, permit, or registration granted by another state to practice as a dentist or dental hygienist limited, suspended or revoked, or subject to any other disciplinary action." Second, based on the circumstances of the Oregon orders, denial of Dr. An's application for renewal was necessary to protect the public health, safety and welfare under Wis. Stat. § 440.08(4). (Hrg. Tr., pp. 44-46; Ex. 1, Tab J, pp. 054-055)

31. Dr. Pietz opined that a minimally competent dentist would not have engaged in any of the activities in which Dr. An engaged. (Hrg. Tr., pp. 30-34, 38-39, 104-106; Ex. 1, Tab B, pp. 008-009, Tab C, pp. 013-014)

32. With regard to record-keeping, Dr. Pietz stated that a minimally competent dentist keeps accurate and timely patient records, that keeping patient records is necessary to protect the public health, safety or welfare, and that failure to keep patient records is unprofessional conduct in Wisconsin and substantially departs from the standard of care ordinarily exercised by a dentist. She stated that patient records are relied upon by patients and other providers and allow other treating providers to be informed of the findings, what was done and what needs to be done. She stated that recordkeeping is a part of treatment and is a duty owed to the patient and other providers. She opined that for a dentist to understand what is going in a patient's mouth, it is insufficient to simply review x-ray films and treatment plans because they omit information

such as materials used, medications administered, prescriptions given, probing depths measured, and many other things. (Hrg. Tr., pp. 30-31, 37-38, 44)

33. Dr. Pietz admitted that there have been times when she herself has fallen behind in her charting but it was not by "three years."[3] She conceded that "in all of medicine," falling behind in charting is a more common problem than people realize and that when one falls behind, the first instinct is to catch up. (Hrg. Tr., pp. 56-57)

34. Dr. Pietz testified that if she were a case advisor in a disciplinary proceeding in which a dentist had fallen completely behind in charting and was under water, she would recommend discipline which included a mentor to watch closely the current practices of the provider and continuing education in charting and in ethics. (Hrg. Tr., p. 57)

35. Regarding falsely billing insurance companies, Dr. Pietz opined that a minimally competent dentist would accurately bill insurance companies for services on the actual date the services were rendered because that is what the law requires. She stated that she believed Dr. An's conduct with regard to billing insurance companies on incorrect dates constituted insurance fraud, which is unprofessional conduct in Wisconsin and a very serious violation. (Hrg. Tr., pp. 32-33, 39)

36. Although Dr. Pietz agreed that Dr. An falsely billed insurance companies in order to help patients obtain insurance, she further stated that it was also to benefit Dr. An. She opined that if a dentist was a Medicare provider and engaged in such conduct, the provider may be unable to treat patients under Medicare, may have to pay serious fines and could be imprisoned. She further opined if an insurance company did the investigation and discovered such violations, the violations would keep the provider from participating in its insurance network moving forward. (Hrg. Tr., pp. 58-60)

37. Regarding the marijuana incident, Dr. Pietz testified that a minimally competent dentist would not accept marijuana from a patient, would not keep marijuana in his or her dentistry office, and would not offer it to employees of the dental practice because it is an illegal substance. Dr. Pietz accepted Dr. An's version of events as true for purposes of her denial. She agreed that patients sometimes give small presents to dentists in appreciation of the services they received and that it was difficult to refuse a gift of small monetary value without risking offending the patient. She also did not dispute that at the time of the conduct, medical marijuana was legal in Oregon and that the patient was a licensed grower of marijuana in Oregon. (Hrg. Tr., pp. 33-34, 37, 44, 52, 80-81, 104-06)

38. Dr. Pietz opined that it was illegal for Dr. An to possess the marijuana and inappropriate to offer it to his staff even if the staff had medical marijuana cards. However, she further stated that she did not know the logistics of how someone obtains marijuana for medical purposes in a state where it is legal and does not know whether the person would need a prescription in that state. (Hrg. Tr., p. 54)

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[3] According to the Oregon Suspension Order, the actual length of time of inadequate charting was not three years, but a period of approximately two and a half years, between August 2009 and January 2012. (Ex. 1, Tab B, p. 008)

39. Dr. Pietz expressed safety concerns with marijuana in a dentist's office because it can alter one's cognitive abilities and pose a threat to public safety. (Hrg. Tr., pp. 33-34)

40. Dr. Pietz testified that she denied renewal because Dr. An's misconduct in Oregon was severe, Dr. An was suspended in Oregon and went on to resign his Oregon state license because of conduct occurring during a three-year period[4] relating to patient documentation, fraudulent billing and the marijuana incident. She stated that she found denial necessary to protect public health, safety and welfare and because he engaged in unprofessional conduct. (Hrg. Tr., p. 44)

41. Dr. Pietz relied on the Oregon Board's conclusion in its Emergency Suspension Order that Dr. An was an immediate danger to public health, safety, or welfare. Dr. Pietz testified that suspensions are rare and serious. Dr. Pietz explained that as the credentialing liaison, she gave serious consideration to the Oregon orders. The Oregon Board felt it was necessary to immediately suspend the Applicant's license to protect its citizens and she believes the citizens of Wisconsin are owed the same protection. (Hrg. Tr., pp. 28, 51, 67, 71).

42. Dr. Pietz agreed that there was nothing in the Oregon orders that implicated Dr. An's technical clinical skills. She agreed that all of the issues pertaining to the Oregon orders related to ethical lapses. She did not know whether a dentist could make a sincere effort to overcome ethical lapses and return to practice safely. If Dr. An's conduct in Oregon had occurred in Wisconsin, she did not know what disciplinary measures would be imposed by the Wisconsin Board. (Hrg. Tr., pp. 49-51)

43. Dr. Pietz had not heard of the two-day course, Medical Ethics and Professionalism, for which Dr. An had received 22 credits. She agreed that the amount of continuing education credits, and Dr. An's having to travel to California and pay the related expenses and tuition costs, showed a substantial commitment on his part. (Hrg. Tr., p. 61)

44. Regarding some of the other courses which Dr. An took on-line, such as the course in liability risk management and the course on patient records and records management, Dr. Pietz noted that the Board disfavored on-line courses. (Hrg. Tr., pp. 62-63, 78)

45. Dr. Pietz was asked whether the following four limitations on Dr. An's license would adequately protect the public: (1) Board pre-approval of Dr. An's practice setting and no solo practice; (2) a professional mentor approved by the Board to review Dr. An's charts weekly to ensure timeliness and completeness, and quarterly reports to the Board; (3) no involvement in billing other than to report the services Dr. An actually performed to staff involved in billing (who would not be supervised by him); (4) random urine drug screens at a frequency determined by the Board. Her answer was no. (Hrg. Tr., pp. 63-65)

46. Dr. Pietz was concerned about Dr. An's clinical abilities, given that he has been out of clinical practice of dentistry for four years. Additionally, Dr. Pietz opined that it is unrealistic to separate a dentist from the billing aspects of practice because staff is not often trained to the

[4] As stated above, the conduct actually occurred over a period of approximately two and a half years.

level in what procedures were done and the proper coding and billing for these procedures. (Hrg. Tr., pp. 63-66).

47. Dr. Pietz further explained, "[T]he licensee [is] ultimately responsible for the care of the patient, the documentation, the billing, and all of those ethical decisions. And I cannot say that a mentor can prevent fully these things from occurring again in the future ... I think these errors can and do occur even [] in the presence of a mentor." (Hrg. Tr., pp. 110-111).

48. Dr. Pietz also had concerns about why Dr. An resigned his license rather than allowing the Oregon Board to continue to issue whatever discipline it thought appropriate and Dr. An following through. She also did not believe that an applicant should make the determination about what he is lacking and fill in the blanks, and that the Oregon Board would have been in a better position to make that determination. (Hrg. Tr., pp. 66, 71, 109-110)

49. In response to Dr. An's hypothetical question as to what discipline Dr. Pietz would deem appropriate had this been a disciplinary case rather than an application for renewal, Dr. Pietz replied, "I think I would mirror the other state's actions. . . ." (Hrg. Tr., pp. 70-71)

50. Dr. Pietz could not think of any limitations or pathways back to licensure that would ensure protection of the public other than Dr. An having his license reinstated by the Oregon Board. Dr. Pietz testified that the "[Wisconsin] Board would welcome the Applicant renewing his license in the State of Oregon, facing the appropriate discipline imposed by Oregon, and demonstrating his competence and rehabilitation in Oregon." (Hrg. Tr., pp. 66, 68, 71, 109)

51. As part of the Oregon Consent Order, Dr. An "agree[d] not to seek future licensure from the Board." (Ex. 1, Tab B, p. 006)

52. Dr. Pietz believed that the Wisconsin Board typically either denied or granted an application for renewal, reinstatement or initial application. She was not aware of the Board issuing a license with limitations. (Hrg. Tr., pp. 68-69)

53. After hearing Dr. An's testimony regarding his continuing education and the circumstances surrounding the Oregon events at issue, Dr. Pietz stood by her decision to deny the renewal application. (Hrg. Tr., pp. 48, 111)

DISCUSSION

Burden of Proof

The Division states that it has the burden of proof in this matter involving denial of Dr. An's application for license renewal after five years. Consistent with this burden, the Division states that it must demonstrate by a preponderance of the evidence that: (1) Dr. An engaged in unprofessional conduct, in violation of Wis. Stat. § 447.07(3)(a) and Wis. Admin. Code § DE 5.02(14); and (2) denial of Dr. An's renewal application is necessary to protect the public health, safety or welfare. *See* Wis. Stat. § 440.08(4). However, the Division also advances two other distinct standards: (1) that the Board's denial is reviewed under an erroneous exercise of discretion standard, and (2) that the Board's denial must be affirmed if there was no mistake

of fact or law and was neither arbitrary nor capricious. (Division's Closing Argument, pp. 2-3; Notice of Corrected Denial; Hrg. Tr., pp. 121-122)

Dr. An agreed at hearing that the issue for review is whether the Board erroneously exercised its discretion in denying his renewal application. However, in his post-hearing brief, Dr. An states that upon further reflection, he is not sure there is a burden of proof in this matter. He also goes on to state that an applicant may have the initial burden of going forward because the applicant is seeking a change in the status quo, that this may be "really an *ab initio* review," and that the Division may have the burden to demonstrate unfitness or ineligibility. Ultimately, Dr. An argues that the burden of proof is not an important issue because under any reasonable view of the evidence and irrespective of who has what burden, Dr. An should be offered a renewal of his license, with limitations. (Applicant's Brief, p. 1)

The only authority cited by either party for their various proposed standards of review is a Final Decision and Order issued by the Accounting Examining Board cited by the Division, *In the Matter of the Application for Renewal of License to Practice as a Certified Public Accountant of Dennis L. Farr, Applicant*, Case No. LS9608281ACC (May 28, 1998). In *Farr*, the Accounting Examining Board determined that the Division bears the burden of proof in a license renewal denial proceeding, and that the level of proof is the same as that in a disciplinary proceeding – a preponderance of the evidence. However, the *Farr* decision does not state whether the preponderance of evidence standard applies to the finding that violations occurred or to the decision denying the renewal application, or both.

Based on the *Farr* decision and the Division's concession on this point, this decision assumes the Division has the burden in this case. Also, based on *Farr* and the apparent dearth of other relevant authority, this decision will also use the highest burden conceded by the Division – *i.e.*, that the Division must show by a preponderance of the evidence that (1) Dr. An engaged in unprofessional conduct, in violation of Wis. Stat. § 447.07(3)(a) and Wis. Admin. Code § DE 5.02(14); and (2) denial of Dr. An's renewal application is necessary to protect the public health, safety or welfare. Wis. Stat. § 440.08(4).

Unprofessional Conduct and Denial of License Renewal

As grounds asserted for the denial, the Board asserts that Dr. An engaged in unprofessional conduct pursuant to Wis. Stat. § 447.07(3)(a) and Wis. Admin. Code § DE 5.02(14); and that denial of Dr. An's renewal application is necessary to protect the public health, safety or welfare pursuant to Wis. Stat. § 440.08(4). Wisconsin Stat. § 447.07(3)(a) provides that the Board may deny, limit, suspend, or revoke the license of a dentist if it finds that the dentist has engaged in unprofessional conduct. Unprofessional conduct under Wis. Stat. § 447.07(3)(a) includes "[h]aving a license . . . granted by another state to practice as a dentist . . . limited, suspended or revoked, or subject to any other disciplinary action." Wis. Admin. Code § DE 5.02(14). In his prehearing motion, Dr. An argued that the temporary suspension and voluntary surrender in Oregon were not unprofessional conduct as defined in Wis. Admin. Code § DE 5.02(14) because the Oregon Board's immediate emergency suspension was not a suspension or discipline as contemplated by Wis. Admin. Code § 5.02(14). He

maintains this position in his post-hearing brief, noting that Dr. An surrendered his license with no finding of unprofessional conduct and that the Oregon Board's emergency suspension is not discipline because it was meant to be temporary and stems from a summary proceeding in which the burden of proof is likely probable cause, as it is for summary suspensions in Wisconsin.

This tribunal rejected Dr. An's arguments in its September 8, 2016 order denying his motion. Moreover, Dr. An now states that this issue is "moot" because he agrees that irrespective of whether he was disciplined or had his license suspended in Oregon as a matter of law under Wis. Admin. Code § 5.02(14), he did commit unprofessional conduct in that state in 2011. In light of the foregoing, the Division has proved by a preponderance of evidence that Dr. An engaged in unprofessional conduct.

The remaining issue therefore is whether the Division proved by a preponderance of the evidence that denial of Dr. An's license renewal application was "necessary to protect the public health, safety or welfare" pursuant to Wis. Stat. § 440.08(4)(a). Dr. An argues that his significant rehabilitative efforts, along with his proposed license limitations (and, presumably, others the Board may wish to impose) are sufficient to protect the public and ensure that he practices in a safe and ethical manner. Consequently, he asserts that denial of his application was unnecessary and a limited license should be issued. He states that if his unprofessional conduct in another state is grounds for an automatic denial, presumably forever, then the goal of public protection has been converted into one of punishment, similar to a "life-without-parole sentence," and that punishment is not a legitimate goal in proceedings before the Board. (Applicant's Brief, p. 1) Assuming the Board's denial is subject to an erroneous exercise of discretion standard, Dr. An further argues that it was an erroneous exercise of discretion for Dr. Pietz to fail to review Dr. An's continuing education materials prior to making her decision to deny Dr. An's renewal application.[5] Dr. An acknowledges Dr. Pietz's hearing testimony that she stood by her denial even after hearing Dr. An's testimony, including that related to his continuing education. However, Dr. An argues that what is relevant is the information Dr. Pietz took into account at the time she made her decision, not what occurred after that decision was made. (Applicant's Brief; Hrg. Tr., pp. 120-121)

Although it would have been preferable for Dr. Pietz to have considered the documentation related to Dr. An's rehabilitative efforts prior to denying his renewal application, I cannot conclude that the denial constituted an erroneous exercise of discretion or that the Division failed to show by a preponderance of the evidence that denial was warranted.

Dr. Pietz explained that she did not review the continuing education information because she had received enough information to make a determination. Dr. Pietz relied on the Oregon Board's conclusion in the Emergency Suspension Order that Dr. An was an immediate danger to public health, safety, or welfare. She testified that suspensions are rare and serious. She further explained that the Oregon Board felt it was necessary to immediately suspend Dr. An's license to

[5] In support of this assertion, Dr. An cites *In Interest of C.W.*, 142 Wis. 2d 763, 419 N.W.2d 327 (Ct. App. 1987). That case is inapplicable as it involved a circuit court's failure to consider criteria specifically required to be considered by statute.

protect its citizens and that she believed the citizens of Wisconsin are owed the same protection. Dr. Pietz evidently made the determination that the conduct resulting in immediate suspension in Oregon was sufficiently egregious that no amount of continuing education would satisfy her that Dr. An could safely practice in Wisconsin, particularly in light of the fact that at the time of the application denial, Dr. An had not practiced dentistry for approximately four years.[6]

Dr. Pietz suggested that Dr. An's only path to Wisconsin licensure is reinstatement in Oregon. This may appear to be a harsh result, particularly given that the Oregon Consent Order required that Dr. An agree "not to seek future licensure from the [Oregon] Board." However, the Oregon Board is in a much better position to know the aggravating and mitigating circumstances of Dr. An's conduct as well as what rehabilitative measures would best address his conduct and ensure safe and ethical practice. This is why Wisconsin credentialing boards often mirror the discipline imposed by other jurisdictions. As explained by the Wisconsin Medical Examining Board in *In the Matter of Disciplinary Proceedings Against William J. Alt, M.D., Respondent*, Case No. LS9210221Med (Feb. 23, 1994):

> Candidly stated, resort to the Michigan board's decision for disciplinary guidance is perhaps the best and only practical approach to ascertaining an appropriate determination in this case, short of requiring a hearing upon the actual facts alleged in the Michigan complaint.
>
> Accordingly, in my opinion, great weight should be given to the actual discipline imposed by the state of Michigan. The general basis for such an approach has at least two foundations. The first stems from notions of comity between states, which gives substantial weight to the discipline imposed by the sister-state board due to its proximity to the underlying facts leading to the initial disciplinary result. The second is more practical, in that the ability of the subsequent state to prove the underlying conduct is largely non-existent because its subpoena powers do not extend across the border.
>
> Such an approach is furthermore consistent with that taken in attorney disciplinary proceedings by the Wisconsin Supreme Court; that being to impose discipline identical to that of a sister state unless the misconduct justifies substantially different discipline in this state. SCR 22:25 (1992).

Although the proceedings in Oregon ultimately resulted in Dr. An resigning his Oregon license rather than being subject to discipline (beyond the immediate suspension initially imposed), the concerns expressed in the *Alt* case apply here.

Dr. An also suggested at hearing that Dr. Pietz's determination creates a situation whereby Dr. An may have fared better had he maintained his Wisconsin license and had his Oregon conduct come before the Board in the context of a disciplinary matter rather than through a renewal application. He suggested that had this been a disciplinary proceeding, there may have

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[6] Although not considered by Dr. Pietz in denying Dr. An's renewal application, I also note that at hearing, Dr. Pietz identified concerns with Dr. An's continuing education, such as the fact that many of the courses were on-line courses, which are disfavored by the Board.

been conditions imposed on his license, other than reinstatement in Oregon, which would have allowed a path back to Wisconsin licensure. This view was supported by Dr. Pietz's testimony regarding her understanding that license applications are either granted outright or denied, not granted with conditions. If it is true that the Board would consider limiting Dr. An's license had this been a disciplinary proceeding on an active Wisconsin license, then the Board is strongly urged to consider granting Dr. An's renewal application with limitations. However, this tribunal may not speculate as to what the Board would have done had Dr. An maintained Wisconsin licensure and been brought before the Board in a disciplinary proceeding based on his Oregon conduct.

Based on the record in this case, I conclude the Division has met its burden of establishing by a preponderance of the evidence that denial of Dr. An's renewal application was necessary to protect the public health, safety or welfare. The record establishes that a minimally competent dentist would not have engaged in any of the actions in which Dr. An engaged. It is undisputed that Dr. An did not keep adequate patient records; that a minimally competent dentist keeps accurate and timely patient records, that keeping patient records is necessary to protect the public health, safety or welfare; and that recordkeeping is part of treatment and a duty owed to the patient and other providers. It is undisputed that when the Oregon Board asked Dr. An for his patient records, he filled in patient information after the fact for an approximately two and a half-year period.

It is likewise undisputed that a minimally competent dentist would accurately bill insurance companies for services on the actual date the services were rendered and that Dr. An's conduct of falsely billing insurance companies constituted insurance fraud which could have subjected him to criminal sanctions and barred him from treating patients under Medicare or participating in certain insurance networks. It is also undisputed that a minimally competent dentist would not accept marijuana from a patient, would not keep marijuana in the dentist's office and would not offer it to employees. Also significant is the Oregon Board's finding that Dr. An posed enough of a danger to the public that emergency suspension of his license was required.

Moreover, I cannot conclude that Dr. An's rehabilitative efforts and the four licensing limitations he proposes would adequately protect the public in light of Dr. Pietz's testimony as to why they were insufficient, particularly her concern with respect to the fact that Dr. An has not practiced dentistry for approximately four years. Although there may be license limitations in addition to or in lieu of those Dr. An proposes which would adequately ensure public safety, the Board, with its specialized expertise, is in the best position to fashion any such limitations.

CONCLUSIONS OF LAW

1. The Division established by a preponderance of the evidence that Dr. An engaged in unprofessional conduct in violation of Wis. Stat. § 447.07(3)(a) and Wis. Admin. Code § DE 5.02(14).

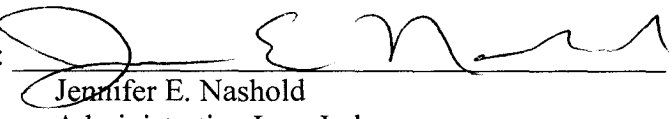
2. The Division established by a preponderance of the evidence that denial of Dr. An's license was necessary to protect the public health, safety or welfare pursuant to Wis. Stat. § 440.08(4).

ORDER

For the reasons set forth above, the Board's denial of Dr. An's renewal application is affirmed.

Dated at Madison, Wisconsin on November 22, 2016.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: 
Jennifer E. Nashold
Administrative Law Judge