BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON

In the Matter of	)	STIPULATED FINAL
	)	ORDER
John Platt, D.C.,	)	
	)	
Licensee.	)	Cases # 2011-2003, 2011-3017, 2012-1013,
	)	2013-2007, 2013-2016, 2013-2023, 2014-2001

The Board of Chiropractic Examiners (Board) is the state agency responsible for licensing, regulating and disciplining chiropractic physicians in the State of Oregon. John Platt, D.C. (Licensee), is licensed by the Board to practice as a chiropractic physician in the State of Oregon.

1.

The Board received complaints against Licensee and his business partner, Dr. Kimberly Privitera. The majorities of Licensee's patients are Latino and are receiving treatment due to motor vehicle accidents and using their PIP coverage. The Board investigated and attempted to interview Licensee, but he declined. The Board's investigation included other interviews, gathering of data and evidence and review of 31 patient files. On September 11, 2014, the Board issued a First Amended Notice of Proposed Disciplinary Action against Licensee. Licensee timely requested a hearing. The Board alleged in the Proposed Notice that Licensee's supervision and control of the clinic and treatment practices and policies constituted unprofessional conduct and gross negligence toward the patients. The Board hereby incorporates by reference the First Amended Proposed Notice of Discipline.

2.

Findings of Fact

If this matter were to proceed to hearing, the Board is of the opinion that the outcome would confirm evidence of violations of ORS 684.100(1)(f)(A) and (B)(q) and (4); danger to patient, gross negligence; ORS 684.150; OAR 811-035-0005(1) and (2)(a)-(b); welfare of patient is first priority; and OAR 811-035-0015: unprofessional conduct, providing unnecessary care; and OAR 811-015-0010(1) and (2): clinical justification; OAR 811-035-0015 (2): willful disregard or careless disregard for patient safety and charging fees for unnecessary services; OAR 811-030-0030(2)(a): x-ray violations; OAR 811-035-0015 (5), (7), and (12): charging for unnecessary services, billing for services not rendered, threatening/dishonest fee collection, perpetrating fraud on third party payors; OAR 811-035-0005(2)(a)-(b) and (A)-(C): informed

consent; and OAR 811-015-0005(1)(a)-(b): records. Licensee denies any wrongdoing and disagrees with the Board's opinion as set forth above, but is nevertheless willing to enter into the stipulation set forth herein.

Stipulations

3.

Therefore, pursuant to ORS 183.415(5) and ORS 684.100(9)(e) the parties have agreed to the following:

1. The parties have agreed to enter this stipulated final order. Licensee does not agree to the Board's findings of fact, however agrees to the entering of this final order. Licensee agrees that he is aware of his right to a hearing with his attorney present to contest the charges and hereby waives that right and agrees to entry of this order. The signature of this order also waives any right to appeal. The parties wish to settle and resolve the above matter without further proceedings.

2. Licensee agrees to immediately change his chiropractic license status to INACTIVE. Licensee will no longer be able to practice chiropractic treatment, provide supervision and/or consult with other chiropractors, or author patient charts in Licensee's name in the State of Oregon. Licensee will be able to maintain any ownership interest he has in his three clinics as part of his inactive license status. However, if at any time, Licensee's INACTIVE license lapses, this no longer applies. Licensee agrees as owner in name only, he will not provide any chiropractic treatment or manage any of the clinics as a supervising chiropractor in any way. Licensee must meet the rules of ownership under OAR 811-010-0120.

3. Licensee agrees he will not attempt to ever apply for active license status in the State of Oregon.

4. Licensee agrees through his interest as an owner, to cooperate with the compliance review by Affiliated Monitors.

5. Licensee agrees to file a dismissal of Multnomah County Circuit Court Case number 1401-00824 with prejudice, including a waiver for any costs or fees awarded to either party.

6. Failure to complete this final stipulated order with the terms so stated, may result in further discipline, up to and including, revocation.

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IT IS SO STIPULATED AND AGREED TO:

DATED this 5th day of May, 2015.

Original signatures are on file in the OBCE office.

By: _____
John Platt, DC

DATED this 6th day of May, 2015.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

Original signatures are on file in the OBCE office.

By: _____
Cassandra C. Skinner, J.D.
Executive Director

BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON

In the Matter of	)	FIRST AMENDED
	)	NOTICE OF PROPOSED
John Platt, D.C.,	)	DISCIPLINARY ACTION
	)	(REVOCATION)
	)	
Licensee.	)	Cases # 2011-2003, 2011-3017, 2013-1013,
	)	2013-2016, 2013-2023, 2014-2001

The Board of Chiropractic Examiners (Board) is the state agency responsible for licensing, regulating and disciplining chiropractic physicians in the State of Oregon. John Platt, D.C. (Licensee), is licensed by the Board to practice as a chiropractic physician in the State of Oregon. The Board proposes to discipline Licensee for the following reasons.

1.

The Board received complaints against Licensee and his managing doctor, Dr. Kimberly Privitera. The majority of Licensee's patients are Latino and are receiving treatment due to motor vehicle accidents and using their PIP coverage. The Board investigated and attempted to interview Licensee, but he declined. The Board's investigation included other interviews, gathering of data and evidence and review of 31 patient files. The Board found the following:

2.

Introduction

Licensee specifically dictated and directed clinic protocols and all aspects of patient medical management, billing, and the hiring and firing and training of all associate doctors, staff, and personnel. These associate doctors were employees who would defer to Licensee even if something unprofessional was being requested for fear of losing their job. Although Licensee generally did not provide medical care to the patients reviewed in the investigation directly, he was listed as the attending physician for nearly all, his NPI was used for billing, all checks from insurance were paid to him, and the medical care provided was directed by him.

Licensee's supervision and control of the clinic and treatment practices and policies, in tandem with Dr. Privitera, resulted in his putting revenue ahead of patient safety and welfare, constituting unprofessional conduct and gross negligence towards his patients.

The practices and protocols instituted and controlled by Licensee created an environment of negligence that compromised patient safety and wellbeing by providing medically unnecessary and unwarranted treatment. This included taking of unnecessary X-rays and failing to refer

patients for a second opinion or for ancillary care. Licensee often failed to provide the patients with sufficient information for them to make informed consent following the PARQ format.

Patient files show evidence of overbilling, billing for services not rendered, lack of clinical justification for the treatment provided, and/or gross negligence that put patients at risk of harm, and a failure of Licensee to meet minimal competency standards of care for an Oregon chiropractor. Licensee controlled treatment in a way that did not provide clinical rationale for the level of care provided or the number of modalities/visits used with patients, and promoted a pattern of overtreatment.

Patient X-ray data and patient files provided evidence of over-utilization and billing for services not provided over a period of several years. Specifically, this involved billing for X-rays that were never taken of specific patients.

Licensee served the Latino community and put generate revenue ahead of patient safety and welfare, at the expense of his patients and the PIP system, constituting unprofessional conduct and gross negligence. Some Latino patients would continue to come to the clinic for as long as they were asked to, and according to associates these were the patients that saw the most visits.

The Board reviewed the files of two undercover patients, Patients 8 and 9, who presented at the clinic for treatment for fictitious motor vehicle accidents. Each healthy undercover patient went through at least two months of care without proper documentation of pain, proper diagnosis, credible findings, or rationale for the frequency or duration of treatment or the modalities administered. Exam findings, patient subjective complaints, and pain levels were exaggerated or fabricated. These patients were repeatedly prompted and coerced to provide a pain level, which, when not provided, was fabricated. Neither undercover patient had subjective or objective findings from Licensee to justify their care.

Licensee's associate doctors failed to properly inform patients to obtain appropriate informed consent for the treatment they received. In most cases, the patient merely signed a form attesting that they had been properly informed without any input from the treating doctor as required, and in most cases did not understand what they were signing. Parents were not informed of potential negative consequences for treatment and submitting to X-rays for their children. Licensee would override associates' attempts to delay an X-ray for a minor when the parents were not available. Associates who spent extra time explaining proper contraindications and report of findings were told by Licensee "don't waste time telling them about anything but the loss of lordosis, the loss of curvature of the spine. They won't understand anything you told them anyway."

Licensee failed to cooperate with the Board by refusing to appear for a Board interview. Licensee further failed to cooperate by providing either a partial response, or no response at all, to complaint notices and Board requests for information, and by generally and repeatedly

challenging the Board's authority to conduct investigations and provide oversight to the profession.

3.

Findings of Fact

The Board found violations of ORS 684.100(1)(f)(A) and (B)(q): danger to patient, gross negligence; OAR 811-035-0015(7): engaging in misleading fee collection; OAR 811-035-0005(1): welfare of patient is first priority; and OAR 811-035-0015: unprofessional conduct, as follows: As evidenced by the chart notes, his sworn testimony, prior interviews, and data collected, Licensee was listed as the attending physician for nearly all patients reviewed, his NPI was used for billing, all checks from insurance were paid to him, and the care provided was implicitly or explicitly directed by him. Licensee is directly responsible for how the clinic was operated, how patients were treated, how services were billed, and the actions of the associates under his and Dr. Privitera's direction.

Associate doctors were required to provide daily updates to Dr. Platt, usually via internal (Woodstock) email accounts, providing a list of patients seen, and some general findings about the patients. Usually associates provided a percentage of improvement overall or specific regions, which, for example, a 90% rating would be 10% short of full recovery.

4.

The Board found violations of ORS 684.100(1)(f)(A) and (B): unprofessional conduct, providing unnecessary care, and OAR 811-015-0010(1) and (2): clinical justification, as follows:. The Board's review of patient records and interviews of two undercover patients indicated unnecessary treatment was provided to healthy individuals. This unnecessary treatment constituted incompetence and negligence as well as exposing the patients to unnecessary risk. The undercover patients were not provided wellness or maintenance treatment but were provided acute injury care for injuries that did not exist. Neither undercover patient presented with subjective findings, or had objective findings that were valid, reasonable, or worthy of medical treatment.

Overall, there seems to be little or no alteration of treatment plans (between patients, and in patient's individual plan) despite changes in patient subjective complaints (better or worse). Plans follow a standard 5 times in week one, followed by 4-6weeks of care at 3-times/week, followed by 4-6 weeks of care at 2-times/week.

Licensee does not provide clinical rationale for the level of care provided or the number of modalities used with patients. Several of these patients were children whose files were reviewed. For example, Patient 1, a 3.5 year old, was treated 29 times in 11 weeks. Patient 2, a 2 week old infant was treated 22 times over 10 weeks, and Patient 3, a 6 year old received 36 visits over 16 weeks. All three children received manipulation and 1 unit of massage each visit. Patient 1's treatment plan called for care at a frequency of 2-3 times per week for 2-3 weeks, yet her chart notes indicate she was treated 29 times with manipulation and massage over 11 weeks.

The chart notes do not provide any reason for additional care. This child received two levels of spinal manipulation and one unit of massage at each of the 29 visits. The Board found this level of treatment excessive given the children's ages and the documented findings. There was insufficient clinical justification for the amount of massage prescribed to these children in the charts.

Another example of a minor patient whose treatments lacked justification is Patient 4, a 4 month old, who was treated 11 times in 6 weeks. Spinal palpation indicated subluxation levels but the patient was pain free. Despite this finding, she was prescribed treatment 2-3 times per week for 2-3 weeks followed by treatment 1-2 times per week for 1-2 weeks. Chart notes document she received soft tissue massage. Based on chart notes and the patient's age, the Board found this was excessive massage and adjustment frequency without documented need.

Patient 5, a 7 year old, was in a minor rear end collision and was treated 24 times over the course of 17 weeks, despite the fact that by appointment on July 15, 2013, she reported no pain and ranges of motion were normal, yet treatment continued for eight additional visits, each visit including soft tissue massage and manipulation.

Other adult patients were also treated excessively. Specifically, as evidenced by the following:

Patient 6 received extremity manipulation to his knees 21 times over the course of six weeks for mild soft tissue strain and subluxation, without evidence of a basic knee regional examination to rule in or out competing diagnosis. This constitutes excessive treatment without sufficient clinical justification to warrant the amount and duration of treatment.

Patient 7 was treated 39 times in 13 weeks at which time the insurer ordered an independent medical examination (IME). The IME doctor stated that care should have concluded after four weeks. Patient 7 received protracted, high density treatment with poorly documented clinical outcomes. There were no circumstances documented for his slow recovery as should have been done, nor any referral for a second opinion noted in the file.

Doctors of Chiropractic who worked for Licensee indicated that treatment schedules were based on Croft Guidelines and severity grades. However, the records provided no rationale for treatment frequency such as complicating factors, prior injuries, advanced age, prior surgery, or degenerative disc disease as recommended by Dr. Croft. There was no indication of what regions, left versus right side, time spent, or other information about the modalities given. In fact, while massage and electrical stimulation were used with almost every patient, there was no indication within the notes of the duration or number of units provided or who provided the therapy. Licensee inflated treatment frequency by considering most of the MVA patients to be severely injured, even though patient records were more indicative of injuries that were mild to moderate. According to Dr. Croft's severity grades for whiplash injuries, patient records indicate that most patients were less severely injured than their diagnoses and treatment plans indicated.

Of the 31 files reviewed only four had diagnoses of moderate/severe or severe, three as moderate, and 24 or 77% as mild/moderate strains/sprains. There were no diagnoses indicating neurological involvement or neuropathy, which are the criteria for Grade III. The injury severity recorded in patient files more closely corresponded with Dr. Croft's Grade I or Grade II. A comparison of treatment recommendations with actual number of treatments recorded demonstrates a high frequency of treatment provided by Licensee's clinic.

5.

The Board found violations of ORS 684.100(1)(f)(A),(B) and (q): unprofessional conduct, providing unnecessary care); OAR 811-035-0015 (2): willful disregard or careless disregard for patient safety and charging fees for unnecessary services; and OAR 811-035-0005(1): the health and welfare of the patient shall be the first priority, as follows: Under the direct supervision of Licensee, clinicians compromised the health and welfare of patients by providing unnecessary and unreasonable medical treatment. Treating doctors who work or who worked for Licensee stated they did not always have access to the most recent chart notes. It was common practice that the most recent treatment notes might not be available for the treating doctor, including the most recent examination, until after the patient visit. These doctors indicated that this practice compromised patient safety because they didn't know full patient histories, contraindications or current concerns regarding patients when they provided treatment, nor did they know what was being billed for their treatments, and typically were not consulted about their chart notes or any confusion about treatment. The doctors stated that at times they did not have enough information on a patient to treat the patients appropriately or safely and further stated that they were typically "going in blind." One doctor noted it would be very difficult to take up care of a patient without prior knowledge based on just the chart notes.

The associate doctors also noted that when the volume dropped in the clinics, treatment for some patients jumped from two treatments per week to three, without an increase in pain or symptoms. Licensee monitored staff through cameras mounted in the clinic with internet access.

The doctors also stated that there was a lack of continuity of care for the patients. Doctors were not given their own assigned patients; patients would see a different doctor on different dates. The doctors would often not know which of the three clinics they would be going to that day until they got a text message that morning from the Licensee. This prevented them from monitoring or fulfilling the patient's course of medical treatment, providing consistent care, establishing a doctor-patient relationship, determining their recommendations for ending care, referring to a specialist, reducing care, or providing specialized treatment. The doctors agreed that the continuity and efficacy of care was directly compromised and that this negatively affected the patient's well-being and faith in the care being provided. The doctors stated that there was no formal method for passing information between doctors regarding patient issues and concerns. Important changes in patient status, recommended tests, regional examinations and re-examinations, and referrals were either missed or not communicated, to the detriment of patient care and safety.

Associate doctors providing medical treatment attempting to decrease or recommending a decrease in care or patient visits only found that more visits had been added to the schedule on the computer, resulting in patients receiving additional and unnecessary care. The associate doctors understood that they had no control over the treatment plans of the patient(s) they were treating, to the point where they could not tell the patient when their next appointment was when they asked, referring that patient to the front desk. This control over the associate doctors' treatment of patients led to unnecessary and unreasonable medical care based on inaccurate objective and subjective findings, and subjected the patients to unnecessary risk of injury, used up limited PIP benefits that could have been used for legitimately beneficial treatment, violated the patient's trust to act in a legal and ethical manner, and failed to effectively treat legitimate injuries. The Board found this was negligence and below the standard of care for an Oregon chiropractor.

One of the doctors who worked for Licensee said that doctors had "discretion but didn't have authority" over patients' medical care. Licensee did not explain his clinical decision-making to the associate doctors. They were told the clinic belonged to the Licensee, and his managing doctors were the employee physicians. There was no latitude for differing opinions regarding injury severity and treatment. Licensee would typically control the final approval to end care. Releasing a patient was difficult for an associate doctor to do. Doctors stated that their decision to end care was over ridden by Licensee on numerous occasions. When the associate doctors would ask for Licensee to assist with ending their care, Licensee would not respond for up to two weeks or more.

Patients 8 and 9, the two undercover patients, experienced substandard and grossly negligent care in the two clinics they were treated in. They were under the care of 10 different chiropractors receiving 22 and 21 treatments, respectively. These patients represented the typical blue-collar Latino patients seen at Licensee's clinic. For Patients 8 and 9, the Board found that Patient 9 was billed seven times for services not rendered. This patient reported not being adjusted on several occasions, only being provided massage/soft tissue work, yet according to the chart and billing, he was adjusted and billed for the adjustments. Dates of service ranged from August 25, 2011, to October 17, 2011. The undercover patients stated that there were deficient, errant, or a lack of communications with them in the clinic, by treating chiropractors, Chiropractic Assistants, and other staff, putting them at potential risk for injury and not properly informed about their care. For example, there were instances of failure to accommodate the patient's language ability in the informed consent portion of treatment. There were instances of CA staff who administered e-stimulation modality treatments without any substantive communication with the patient. Both Patient 8 and 9 indicated that the placement of the pads seemed to be random to them, changing position at times on visits for no apparent reason. There was also a lack of supervision of the CA staff. On several visits with Patients 8 and 9, the CA did not return to check on the patient until the time bell rang 10 minutes later during e-stimulation sessions.

Patient 10 presented with several constitutional symptoms which were suggestive of a concussion or trauma to the brain or brain stem. This patient's file lacked documentation of any examination to address these symptoms, any reference to concern about the symptoms, or referral for additional oversight.

Billing records for Patient 11 demonstrate use of 5 region manipulation (CPT code 98942), plus electrical stimulation (97014) and massage therapy (97124) on every one of this patient's visits. The pain diagram, from the intake denotes only a lower lumbar region of chief complaint. The Board felt that this treatment and billing for treatment was excessive and unnecessary. Based on the lack of physical examination findings, there does not appear to be sufficient justification to warrant 5 regions of manipulation, massage therapy and electrical stimulus.

For Patient 7, one treatment was billed as CPT code 98942 for 4 regions. In this case, the thoracic, lumbar, lumbosacral and SI joints are considered separate regions. This is inappropriate as the 2013 Chiro Code Desk Book spinal regions are cervical, thoracic, lumbar, sacral and SI joint. The lumbosacral joint is part of the lumbar spine and is not considered a separate joint. This charting error was repeated on several other patients.

With Patient 8, when he received treatment and provided responses in Spanish, information was incorrectly interpreted to the doctor that he had low back pain when he said he had none. On two occasions in September 2011, Patient 8 told the doctors that he felt 95-100% recovered, however this statement was not charted in the notes and did not make it into any charts until a later date. Even with a report of that recovery, Patient 8 was treated for several additional visits. Patient 9 was put at risk by clinicians and staff who treated him without seeing any of his records. On one occasion, on 8/23/11, he was treated in the Hillsboro clinic when his records had not been received. He was asked to give some information about his accident and someone interpreted for him. Without asking where his pain was, staff put four electrical patches on his back region. Since there were no records, the staff had no information about the appropriate region for treatment and subjected this patient to risk of injury. Patient 9 received care on 10/17/11 and came limping into the office stating that he had had another accident. He was told by all staff that he would not be able to be treated for that unless he opened up another claim. His low back was not examined and he was only treated for his neck. He was not offered any other options for the low back pain. The chart notes for this date of service did not mention any new accident or new pain. This patient should have been examined and assessed prior to receiving care. To treat this patient knowing another injury occurred is grossly negligent and outside of the standard of care of an Oregon chiropractor.

Patients 8 and 9 experienced treatment with non-Spanish speaking doctors without an interpreter in the room on multiple occasions. The doctor conversed in English as if the patient understood when these patients clearly presented that they did not understand English. On some occasions when the doctor asked questions and did not get an answer, they called out for a CA interpreter to come in. This happened with several doctors.

The minors referred to in paragraph 4 were treated on several occasions that were not medically necessary and lacked clinical justification in the chart notes. Associate doctors acknowledged to the Board that treatment for these children was more than it should have been. One doctor recalled trying to release a patient and Licensee told him "he's not good until I say he's good."

These are examples of how Licensee places his maximizing-revenue-generation business model ahead of the welfare and safety of his patients, constituting unprofessional conduct. Licensee discouraged individualized treatment by his clinicians. The above conduct places patients at risk in that they are getting care that is medically unnecessary and unreasonable and being subjected to care that can cause further risk of serious injury, in violation of ORS 684.100(1)(f)(A) and (B), OAR 811-035-0015, and OAR 811-035-0005(1).

6.

The Board finds violations of ORS 684.100(1)(f)(A) and (B): unprofessional conduct, providing unnecessary treatment; OAR 811-030-0030(2)(a): x-ray; and OAR 811-035-0015(2): charging fees for unnecessary services, where Licensee acted in an unprofessional manner, as follows:

Licensee compromised patient safety by his policies and practices that were to take a full spine X-ray series on all new patients who had been in a motor vehicle accident. Licensee specifically directed to his doctor associates on 9/11/09 that "he wanted 3-2-3 files done on all PI [personal injury] patients except infants. Do not hesitate. Trauma is all that is needed. I don't want them postponed or ordered piecemeal or when you believe they are indicated. Get them done." Further, Licensee told one associate to "light them up" referring to patients being X-rayed. The Board finds that this constitutes over-exposure of patients to harmful X-rays. The Board relies on the University of Western States Diagnostic Imaging Guidelines for Musculoskeletal Complaints which found that absent pain, normal range of motion and absent of neurological deficits, physical examination is reliable in this region (i.e. no need for X-rays). When the patient is alert and asymptomatic, injury risk is low and radiographs provide no clinical utility. Licensee's directive to "light up" the patients is inappropriate and exposes patients unnecessarily to radiation. Research indicates that even low doses of radiation can be harmful and increase the risk of cancer.

Patients were referred for X-rays at the clinic when there were very limited or no objective findings to support the need. Patient 5, a juvenile, was sent for further X-rays on 6/21/13 without clear explanation of need, and despite recently having had X-rays done at the ER for the same incident. Patient 9's cervical region was X-rayed even though he only complained of a mild headache which had resolved by the time he presented for care. Moreover, he did not report neck pain so cervical X-rays were not indicated. Patient 13 reported no cervical pain in his pain drawings at the initial intake. In fact, his treatment plan specifically indicated that no cervical manipulation should be performed on this patient due to a recent prior cervical surgery.

However, an associate and Licensee still ordered and performed three cervical views on this patient without indication of pain and knowing that this region would not be addressed in treatment. Furthermore, the radiography order calls for "AP, Lateral, PA spot—lumbar spine." The films show there was no collimation to visualize only the lumbar spine and no gonadal shielding was provided for the patient.

Evidence was accumulated from over 200 claims from patients treated in Licensee's clinic which showed that billing patterns involved performing the same set of X-ray studies using the CPT billing codes of 72050, 72070 and 72110 on most patients who had received treatment. In terms of X-rays, each patient was charged for 4 views with codes 72050 and 72110. The X-rays were reviewed by a DACBR reviewer and his reports showed that he reviewed only 2-3 views not 4, which reveals that the correct codes should have been 72040 and 72100, respectively. In information provided by Licensee, he admitted to errors in X-ray billing, but stated that to identify those specific patients and amounts in issue would be too costly and he was owed money for other unpaid claims. The Board's review of billing for X-rays showed a pattern of billing for services not rendered over a 7 year period, amounting to many hundreds of claims. An identical pattern of billing for services not rendered was found in 332 claims paid from another source. The clinic was billing for 4 views (code 72050) and charging $75 while the reviewer was interpreting 2-3 views (code 72040) and charging $35.

7.

The Board finds violations of ORS 684.100(1)(f)(A): unprofessional conduct/danger to patient and OAR 811-035-0015(2), (5), (7), and (12): charging for unnecessary services, billing for services not rendered, threatening/dishonest fee collection, perpetrating fraud on 3rd party payors, as follows:

At the direction of Licensee, associate doctors were directed to treat patients unnecessarily and take unnecessary X-rays. (Paragraph 6). When associate doctors would attempt to decrease the care to a level they felt more appropriate, they would find more visits added to the schedule.

Two undercover patients, Patients 8 and 9, were treated in excess of 20 times before they were released from care. These patients had no true injury or pain and were healthy prior to presenting at the clinic. Patient 9 stated that he was not adjusted on 8/25/2011, 8/30/2011, 9/7/2011, 9/9/2011, 10/10/2011, 10/12/201, and 10/17/2011, but records show billing for adjustments on those dates.

For DOS 12/14/11, records for Patient 8 included a no-show bill for $450 for a consultation with Dr. Tim Borman DO, orthopedic surgeon. The chart notes do not mention this referral, nor was the patient informed of this appointment. There is no clinical justification for this referral.

Both undercover patients noted that the soft tissue therapy provided by the chiropractors and billed as 97124 in most cases fell short of the required time component of at least eight minutes, in most cases being closer to five minutes, which does not meet required billing standards for timed modality codes (see ChiroCode Deskbook 2011 for details).

8.

The Board finds violations of ORS 684.100(1)(f)(A): danger to patient, and OAR 811-035-0005(2)(a)-(b) and (A)-(C): informed consent. Licensee failed to get appropriate informed consent from the patients for the treatment they received.

Licensee was not provided adequate consent to further treat Patients 8 and 9, the undercover patients. The patients acted as if they only spoke Spanish and asked for assistance on many intake forms that they filled out. While bilingual staff attempted to explain the forms, the patients indicated that staff rushed through the forms and did not adequately explain them to them. The associates did not explain about the treatment or contraindications. Had these patients been solely Spanish speaking, they would not have been provided adequate information to be able to provide consent for treatment. The patient files of patients 8 and 9 did not have any informed consent to treat forms in the files, and files submitted for patients 10 and 6, both minors, did not include the informed consent forms. Associates indicated that Licensee had instructed staff to X-ray all children, asserting that X-rays were a part of a routine exam and can be done without consent.

9.

The Board finds violations of ORS 684.100(1)(f)(A): danger to patients, and OAR 811-015-0005(1)(a)-(b): records. Records did not meet minimal standards in the 31 charts reviewed.

The new patient exam form left inadequate space to record patient specific information. There is inadequate space for the patient range of motion in degrees, or important information as to where the pain is located or the quality of the pain. This minimal charting supports the statements of associates that the volume of the clinic and the direction of Licensee drove the doctors to emphasize speed over any other concern or motivation. For example, on the ROM section there is space for the patient's ROM in degrees and then the clinician can circle a number 0 to 3, to indicate whether there is pain, and a 'C/T/L' which indicates the region where the pain is felt (cervical, thoracic, lumbar region). Again, there is no space for important information such as *pain in the right lower cervical with left lateral flexion* or the quality of the pain provoked by ROM. There simply is nowhere for the clinician to note any of this type of information—only the most basic findings can be noted. The Assessment section is also lacking. There are abbreviations referring to body regions which can be circled and categorized as mild, moderate, marked, improved, flare-up. If the clinician has any impressions whatsoever about the patient's condition, progress, or lack thereof, there is no place to record them.

The areas where the clinician can inscribe circles regarding tests performed and clinical findings was very difficult to read as it was illegible when a clinician did write. This is important

as different doctors saw the patient day-to-day and week-to-week, so legibility and clarity was important for continuity of and efficacious care. In some parts of the form, there were small areas where the clinician could accompany the circle with commentary, but this was done rarely; when it was done it was nearly always illegible.

The subjective portion of the chart notes rarely records the patient's own words. They consist only of circles around abbreviations referring to body region. Patients 8 and 9 confirm that they did not fill out this form, or they were instructed what to circle. The subjective sections of daily notes (i.e. the "Daily Soap Note") consist only of circles around abbreviations referring to a body region, or around "All Sx," to indicate either "Same, Mildly improved, Improved, Much improved, or Flare-up." This conveys no subtlety and, in cases where many areas are injured—as is the case in most auto crashes—there is no way for the reader to really know specifics for any one area. There is evidence that the CAs or staff fill out and embellish pain complaints, leading patients to admit to areas or levels of pain they do not have, or intentionally misinterpreting what a patient says in Spanish to the clinician.

File reviews indicated two separate chart notes for Patient 9, dated 10/25/11, with different doctors treating, with billing for one treatment on 10/25/11. This also occurred for another patient reviewed on 03/05/13 where two associates both appear to have treated the patient. This is either an example of very poor record keeping or poor continuity of care, if the patient is inadvertently seen twice in one day.

Subjective records for Patient 10 were largely insufficient or deficient in describing the patient's status, or in following key symptoms (enuresis, concentration pain level etc.), particularly those not included on the clinic forms for "circling.

Recorded neurological symptoms are devoid of any real information pertinent to or revealing of the patient's true medical condition. The chart only notes if the patient has numbness tingling or weakness, and there is no room for recording precise locations and nature of the pain, therefore, no basis for a differential diagnosis.

The objective portion of the chart contains only spinal levels that are circled and does not include a space for the clinician to comment on radiological findings.

The assessment section is lacking in that there are abbreviations referring to the body regions, but if the clinician has any impressions about the condition, there is no room to write those.

The Plan portion or treatment rendered notation areas that are circled but do not leave the clinician free to write any distinctive plan attributes for care.

Most notes that have a Home Exercise Program (HEP) circled but there are no notes as to what exercises or home instruction was given. Evidence obtained by Patients 8 and 9 indicate

that patients are just given a document describing exercises, usually in English, without explanation or doctor input. The patients were also not properly monitored for safe or effective application or progress obtained through the home exercise program.

There is little alteration of each patient's treatment plans despite changes in patient subjective complaints. Plans follow a standard 5 week program, followed by many weeks of care 3 times a week with many unspecified modalities. This looks like a "one size fits all" approach which does not adequately consider the needs, health and well-being of the patients.

The signatures of the treating doctor are circled and not signed, so it is not clear who made the circles or if the chart was modified in some way.

Accuracy of records is at least questionable given admissions by several clinicians that they typically saw 35 or more patients a day, and that it was so busy they had to complete the chart notes at the end of the day. One associate stated that in "no way" could he ethically or accurately do 35 chart notes at the end of the day.

Licensee signs forms authorizing time loss on most patients and assess apportionment, yet the files do not include documentation to indicate they were ever examined or treated.

The daily SOAP notes do not provide another clinician with any sense of the patient's condition, limitations, or progress. The nature of the examination and treatment forms, with circles and pre-written statements, do not create a credible record. Since there is very little handwriting, mostly circled items, or illegible writing, it is impossible to tell if another party added findings, subjective symptoms or treatment information after the fact. Treatment plans do not provide sufficient detail for another clinician to take over care of the patients.

Follow up exams are devoid of any treatment plan detail beyond treatment frequency and duration of care until the follow up exam. For example, Patient 12 diagnosed with acute severe strains to cervical, thoracic, lumbar, and sacrum and left shoulder received a treatment plan for daily care for the first week, 3 times per week for the next 4-6 weeks with care expected to last 14-20 weeks. There is no indication of what areas received what treatment modalities, nor are there any treatment goals for the various injuries.

10.

The Board finds violations of OAR 811-035-0015 (19), OAR 811-035-0015 (20): failure to cooperate, ORS 684.150: power of board, ORS 684.100 (4): refusing an interview, and OAR 811-015-0006(3)(a) and (b): disclosure of records, as follows. On November 18, 2013, a letter was sent to Licensee and Dr. Privitera, his managing doctor, requesting their appearance for an interview with the Board on January 9, 2014, in relation to these complaints and open cases. The Board voted to issue a Notice of Proposed Disciplinary Action and issued it on February 27, 2014. The Board hereby incorporates by reference that Proposed Notice of Discipline issued on that date and attached herein to this notice. Over a period of over 22 months starting in March 2012, Licensee also failed to cooperate by failing to respond to complaint letters, failing to

respond to requests for information, partially responding to complaints, repeatedly challenging the grounds for investigation and complaint, failing to provide certification of patient records, and repeatedly missing deadlines for production of responses and documents.

11.

Conclusions of Law

The Board finds violations of ORS 684.100(1)(f)(A) and (B),(q), ORS 684.150, ORS 684.100 (4), OAR 811-010-0095, 811-015-0010(1) and (2), 811-015-0005(1)(a)-(b), OAR 811-015-0006(3)(a) and (b), 811-015-0010(1) and (2), 811-035-0005(2)(a)-(b) and (A)-(C), and OAR 811-035-0015 (2). (5), (7), (12), (19), (20) as follows:

For the above reasons as stated in paragraphs 1-10, the Board finds that Licensee has operated below the standard of care of an Oregon chiropractor in that he has put his maximizing-revenue-generation business model ahead of his patients' safety and well-being. He has directed a clinic enterprise that provided care to patients without clinical justification, he has been unprofessional and grossly negligent in care of the patients as noted in the allegations, has subjected patients to unnecessary risk, both overall and in over-exposure to X-ray radiation without clinical justification, has billed for X-rays not taken of patients, has billed for services not rendered, has failed to provide patients a continuity of care as required, has inadequate records for the patients he has overseen treatment of, and has failed to cooperate during the investigation of these matters.

12.

The Board determined that the egregiousness of unprofessional conduct and gross negligence, as noted above, and the significant risk to patients, as depicted within paragraphs 1-11 above, warrants the sanction of Revocation. The allegations as noted above are serious issues and have represented conduct over the span of years, and as evidenced in the 31 files reviewed by the Board and the statements of associates. The care is below the standard of care in Oregon of a chiropractic physician. Licensee, as the attending physician on all the patients' files, and as director and supervisor of the clinic, is responsible to deliver ethical and appropriate care to these patients and has not done so.

13.

Licensee shall pay costs of this disciplinary proceeding, including investigative costs and attorney fees pursuant to ORS 684.100(9)(g). Pursuant to ORS 293.241 the Board will refer amounts owed to collection if it has received no payment on the account for more than 90 days. Thereafter, the Board will consider assignment to the Oregon Department of Revenue or a private collection agency for collection. Final fees may include additional percentages for any increase in the amount you owe due to the accrual of interest on the unpaid principal amount.

14.

Licensee has the right, if Licensee requests, to have a formal contested case hearing before the OBCE or the Administrative Law Judge to contest the matter set out above. At the

hearing, Licensee may be represented by an attorney and subpoena and cross examine witnesses. That request for hearing must be made in writing to the OBCE, must be received by the OBCE within 30 days from the mailing of this notice (or if not mailed, the date of personal service), and must be accompanied by a written answer to the charges contained in this notice.

15.

If Licensee requests a hearing, before commencement of that hearing, Licensee will be given information on the procedures, rights of representation and other rights of the parties relating to the conduct of the hearing as required under ORS 183.413-415.

16.

If Licensee fails to request a hearing within 30 days, or fails to appear as scheduled at the hearing, the OBCE may issue a final order by default and impose the above sanctions against Licensee. Upon default order of the Board or failure to appear, the contents of the Board's file regarding the subject of this automatically become part of the evidentiary record of this disciplinary action upon default for the purpose of proving a prima facie case.

17.

NOTICE TO ACTIVE DUTY SERVICEMEMBERS:

Active duty service members have a right to stay these proceedings under the federal Service members Civil Relief Act. For more information contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 800-452-7500 or the nearest United States Armed Forces Legal Assistance Office through http://legalassistance.law.af.mil.

DATED this 11th day of September 2014.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

Original signatures are available in OBCE office.

By:
Cassandra C. Skinner, J.D.,
Executive Director

County of Marion) Case # 2011-2003 et al.,

I, Cassandra C. Skinner, being first duly sworn, state that I am the Executive Director of the Board of Chiropractic Examiners of the State of Oregon, and as such, am authorized to verify pleadings in this case: and that the foregoing Notice is true to the best of my knowledge as I verily believe.

Original signatures are available in OBCE office.

Cassandra C. Skinner, J.D.
EXECUTIVE DIRECTOR
OREGON BOARD OF CHIROPRACTIC EXAMINERS

SUBSCRIBED AND SWORN to before me

this 11th day of September, 2014.

Original signatures are available in OBCE office.

NOTARY PUBLIC FOR OREGON
My Commission Expires: Dec 5, 2015

OFFICIAL SEAL
SHARI K BARRETT
NOTARY PUBLIC - OREGON
COMMISSION NO. 464041
MY COMMISSION EXPIRES DECEMBER 05, 2015

CERTIFICATE OF SERVICE

I, Lori H. Lindley, hereby certify that on October 30, 2014, I served the foregoing First Amended Notice of Proposed Disciplinary Action (Revocation) dated September 11, 2014, served upon the party or parties hereto by having a full, true and correct copy thereof, sent by email and regular mail, postage prepaid, to:

Andrew T. Reilly
Black, Helterline LLP
801 SW Broadway, Suite 1900
Portland, OR 97205

Cassandra C. Skinner, J. D.
Executive Director
Oregon Board of Chiropractic Examiners
3218 Pringle Rd., SE, Suite 150
Salem, OR 97302

Original signatures are available in OBCE office.

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