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**BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON**

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In the Matter of)	
)	FINAL ORDER BY DEFAULT
Jonathan Preiss, D.C.)	
)	
)	
Licensee.)	Case # 2004-2002

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

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Findings of Fact

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In response to a complaint, the Oregon Board of Chiropractic Examiners directed the Peer Review Committee to review the complaint in regards to Licensee's patient files, insufficient medical justification for duration of treatment, record keeping, use of excessive modalities per visit and lack of clinical rationale for x-rays.

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Due to a complaint being filed by an insurance carrier, in response, Licensee's file and the complaint were reviewed by the Peer Review Committee during the Spring 2005. The complaint stated that Licensee did not provide sufficient medical justification for the duration or treatment; did not have records that supported the frequency of treatment, had an excessive number of modalities per visit with inadequate records to explain/support their medical necessity; and had no clinical rationale for the amount of radiation exposure to the patient. In their review, the Peer Review committee was supplied with copies of patient charts and billings for patient 1 from the Licensee, x-rays included with the file, and responses of Licensee provided. Licensee treated patient from September 20, 2004 through January 19, 2005.

Peer Review Committee also noted that Licensee has had similar discipline in the past as in 1998 when he received a civil penalty for billing issues. (Case number 1998-1002)

3.

After review of the information provided as stated in paragraph 2, the peer review found the following: Daily chart notes of Licensee were not legible. The tracking of subjective complaints throughout the months of treatment is very difficult and often impossible. It is difficult to support the necessity for treatment of the patient without ability to understand daily SOAP notes.

1 It is not possible to correlate the daily chart note with a 9896 CMT code and the treatment absent
2 legible complete and explanatory documentation that is lacking in the file. There is no ongoing
3 case management plan indicated and no treatment plan in the notes. There did not appear to be
4 an original treatment plan and there was no explanation provided for the treatment used or
5 discussion of reasoning for the treatment plan that was delivered. The subjective complaints
6 noted in the chart notes did not meet minimal standards. This is in violation of ORS
7 684.100(1)(A) and OAR 811-015-0010(1) and OAR 811-015-0005(1). The chart notes do not
8 identify the patient by name nor the clinic by name or address as is required in OAR 811-015-
9 0005(1)(b).

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11 4.

12 After the investigation began and the chart notes were received by the Board, Licensee's office
13 provided typed chart notes that were provided to the insurance carrier in regards to questions for
14 billing purposes. In comparing the handwritten contemporaneous chart notes to the typed chart
15 notes, the content difference between them were stark. There was no apparent correlation
16 between the original notes and the typed notes provided in March 2005. The typed notes lacked
17 veracity and were not considered by the Peer Review Committee as part of the clinical record on
18 review. The typed notes were received by the insurance carrier on March 31, 2005, long after the
19 office visits from which the contemporaneous chart notes were derived. The Peer Review
20 Committee felt the typed notes were created simply to expedite payment of the billed charges and
21 were not a verbatim typed version of the original handwritten notes.

22
23 For example, a contemporaneous handwritten note for 9/23/04 visit stated as follows:

24
25 *"(Sif or clinic?) mobil imp w/ (increased) HA-STM neck-ctrac- Cont w/ posture*
26 *exercises - wobble chair. "3SWTX".*

27
28 The typed version was as follows:

29
30 *Subjective: Ms. Agee has a chief complaint of pain and soreness of the upper back, mid*
31 *back and neck. The symptoms are described as moderate and constant. The condition*
32 *has been present for about a day or so. Patient also complains of headaches. The*
33 *symptoms are described as moderate and constant.*

34 *Objective: My findings indicate subluxation of the C1, C2, C4 and C5 segments; T3, T4*
35 *and T5 segments. Palpation examination indicates spasm and tenderness of th*
36 *suboccipital muscles bilaterally; spasm and tenderness of the paracervical muscles*
37 *bilaterally; spasm and tenderness of the Paradorsal muscles bilaterally.*

38 *Assessment: The condition is virtually unchanged at this time.*

39 *Plan: Treatment performed today consisted of spinal manipulation (3-4 regions)*
40 *myofascial therapy, rehabilitative postural exercises, neuromuscular re-education and*
41 *cervical traction. Patient will stay on regularly scheduled plan for return visits.*
42

1 It is unclear at how Licensee arrives at his findings in the typed notes, as review of the
2 handwritten vs. typed versions did not find correlation. The handwritten chart notes are
3 inadequate in painting a picture of how the patient is responding to care. There is no ongoing
4 case management plan, nor a treatment plan. The typed notes purporting to be a reflection of
5 services are not a verifiable account of the doctor/patient encounter and is in violation of
6 ORS 684.100(1)(A) and OAR 811-035-0015(7) and (12).

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8 5.

9 Review of a single lateral cervical spine x-ray dated 9/20/04 was billed to the carrier for two
10 views. On 9/22/04 there was a single view AP cervicothoracic spine x-ray; yet the carrier was
11 billed for two views. There was no x-ray report for these thoracic films.

12
13 On 12/16/04 two views of the cervical were taken and a single view of the lumbopelvic. No
14 pregnancy waiver was found in the file. A single view of the spinal area does not provide
15 adequate visualization and is not sufficient for diagnostic purposes. Female patients of
16 childbearing age should be screened for pregnancy prior to taking the films. There is no clinical
17 justification found in the patient records for the 12/16/04 films. This is in violation of ORS
18 684.100(1)(A) and OAR 811-015-0010, 811-030-0030(2)(d) and 811-030-0020(1)(2)(6).

19
20 6.

21 The frequency of treatment was high and lacked sufficient supporting documentation from
22 September through December 2004. The number of modalities used at each office visit and the
23 frequency of visits is not supported from the initial patient complaint of minimal upper back
24 pain. No rationale was found to explain the treatment intensity in association with this injury.
25 The patient was treated four days in a row initially, five days the second week, three days the
26 third through fifth weeks and four days again the sixth week. There is no rationale offered by
27 Licensee in the charts for the number and frequency of treatments. The frequency of treatment
28 exceeds the OCPUG recommendations and there is no supporting documentation to detail the
29 necessity for such treatment outside the guidelines. The intensity and number of modalities
30 performed were not provided any rationale for their use in relation to the injury. Thus, frequency
31 of treatment does not meet minimal standards. This is in violation of ORS 684.100(1)(A) and
32 OAR 811-015-0010(1), (2) and (4) and is unprofessional conduct in not keeping accurate records
33 on all patients, including but not limited to legible notes, and updated treatment plans.

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35 7.

36 Licensee provides two fee schedules which list different prices for similar procedures. For
37 example, neuromuscular re-education (code 97112) is \$27 on one fee schedule and \$50 on
38 another. Licensee has billed the insurance carrier the \$50 charge for one unit each time he bills a
39 code 97112-52. This is in violation of OAR 811-015-0000(3).

8.

On September 28, 2005, a Notice of Proposed Discipline was issued to Licensee. On October 27, 2005, Licensee indicated in writing to the Board that he was not requesting a formal contested case hearing, and wrote a letter that Licensee requested become part of the record. In the Notice of Proposed Discipline issued on September 28, 2005, the Board included language stating that if Licensee failed to request a hearing the matter would be issued by final order by default and the sanctions would be imposed. In addition, the notice stated that the record would be used as a prima facie case for purposes of default.

Conclusions of Law

9.

The Licensee has violated 684.100(1)(A) and OAR 811-015-0010(1), (2) and (4) and OAR 811-015-0005(1), and (1)(b), OAR 811-015-0015(7) and (12), OAR 811-030-0030(1), (2)(d) and (6), OAR 811-015-0000(3).

The Peer Review Committee felt after review of this case, that Licensee continually exhibited a pattern of substandard chart notes, lack of clinical justification in the notes, no treatment planning, lack of clinical justification for x-rays, unprofessional conduct in typing up chart notes that do not correlate with the original chart notes, and treatment modalities unsupported by chart notes. Due to the repeat patterns the Board and Peer Review Committee have concerns about the ability of Licensee to effectively practice and order the following:

Order

10.

The Board orders Licensee receive a letter of reprimand and a \$1000 civil penalty pursuant to ORS 684.100(9)(f). The civil penalty is due and payable within 30 days of the date of this final order.

Ordered this 5th day of December 2005.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

By: I
Original signatures on file
at the OBCE office.

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State of Oregon) Case # 2004-2002
County of Marion) Jonathan Preiss, D.C.

I, Dave McTeague, being first duly sworn, state that I am the Executive Director of the Oregon Board of Chiropractic Examiners, and as such, am authorized to verify pleadings in this case: and that the foregoing Final Order by Default is true to the best of my knowledge as I verily believe.

Original signatures on file at the OBCE office.

Dave McTeague, Executive Director
Oregon Board of Chiropractic Examiners

SUBSCRIBED AND SWORN to before me

this 5th day of December, ~~2003~~ ²⁰⁰⁵

Original signatures on file at the OBCE office.

NOTARY PUBLIC FOR OREGON
My Commission Expires: 10/7/2007



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Certificate of Service

I, Dave McTeague, certify that on December 5, 2005, I served the foregoing Final Order by Default upon the party hereto by mailing, certified mail, postage prepaid, a true, exact and full copy thereof to:

Jonathan Preiss, DC
7412 Beaverton Hills Highway, Suite 109
Portland, Oregon 97221

By Regular mail to:

Karen O’Kasey
Hoffman, Hart & Wagner
1000 SW Broadway Twentieth Floor
Portland, Oregon 97205

Original signatures on file
at the OBCE office.

Dave McTeague
Executive Director
Oregon Board of Chiropractic Examiners

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**BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON**

6 In the Matter of)
7)
8 Jonathan Preiss, D.C.) NOTICE OF PROPOSED
9) DISCIPLINARY ACTION
10)
11 Licensee.) Case # 2004-2002
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14 The Board of Chiropractic Examiners (Board) is the state agency responsible for licensing,
15 regulating and disciplining chiropractic physicians in the State of Oregon. Jonathan Preiss, D.C.
16 (Licensee), is licensed by the Board to practice as a chiropractic physician in the State of Oregon.
17 The Board proposes to discipline Licensee for the following reasons.
18

19 1.

20 In response to a complaint, the Oregon Board of Chiropractic Examiners directed the Peer
21 Review Committee to review the complaint in regards to Licensee's patient files, insufficient
22 medical justification for duration of treatment, record keeping, use of excessive modalities per
23 visit and lack of clinical rational for x- rays.
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25 2.

26 Due to a complaint being filed by an insurance carrier, in response, Licensee's file and the
27 complaint were reviewed by the Peer Review Committee during the Spring 2005. The complaint
28 stated that Licensee did not provide sufficient medical justification for the duration or treatment;
29 did not have records that supported the frequency of treatment, had an excessive number of
30 modalities per visit with inadequate records to explain/support their medical necessity; and had
31 no clinical rationale for the amount of radiation exposure to the patient. In their review, the Peer
32 Review committee was supplied with copies of patient charts and billings for patient 1 from the
33 Licensee, x-rays included with the file, and responses of Licensee provided. Licensee treated
34 patient from September 20, 2004 through January 19, 2005.
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36 Peer Review Committee also noted that Licensee has had similar discipline in the past as in 1998
37 when he received a civil penalty for billing issues. (Case number 1998-1002)
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39 3.

40 After review of the information provided as stated in paragraph 2, the peer review found the
41 following: Daily chart notes of Licensee were not legible. The tracking of subjective complaints
42 throughout the months of treatment is very difficult and often impossible to understand. It is

1 difficult to support the necessity for treatment of the patient without ability to understand daily
2 SOAP notes. It is not possible to correlate the daily chart note with a 9894x CMT code and the
3 treatment absent legible complete and explanatory documentation that is lacking in the file.
4 There is no ongoing case management plan indicated and no treatment plan in the notes. There
5 did not appear to be an original treatment plan and there was no explanation provided for the
6 treatment used or discussion of reasoning for the treatment plan that was delivered. The
7 subjective complaints noted in the chart notes did not meet minimal standards. This is in
8 violation of ORS 684.100(1)(A) and OAR 811-015-0010(1) and OAR 811-015-0005(1). The
9 chart notes do not identify the patient by name nor the clinic by name or address as is required in
10 OAR 811-015-0005(1)(b).

11
12 4.

13 After the investigation began and the chart notes were received by the Board, Licensee's office
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15 billing purposes. In comparing the handwritten contemporaneous chart notes to the typed chart
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17 between the original notes and the typed notes provided in March 2005. The typed notes lacked
18 veracity and were not considered by the Peer Review Committee as part of the clinical record on
19 review. The typed notes were received by the insurance carrier on March 31, 2005, long after the
20 office visits from which the contemporaneous chart notes were derived. The Peer Review
21 Committee felt the typed notes were created simply to expedite payment of the billed charges and
22 were not a verbatim typed version of the original handwritten notes.

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24 For example, a contemporaneous handwritten note for 9/23/04 visit stated as follows:

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34 *symptoms are described as moderate and constant.*

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36 *and T5 segments. Palpation examination indicates spasm and tenderness of th*
37 *suboccipital muscles bilaterally; spasm and tenderness of the paracervical muscles*
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3 inadequate in painting a picture of how the patient is responding to care. There is no ongoing
4 case management plan, nor a treatment plan. The typed notes purporting to be a reflection of
5 services are not a verifiable account of the doctor/patient encounter and is in violation of
6 ORS 684.100(1)(A) and OAR 811-035-0015(7) and (12).
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9 Review of a single lateral cervical spine x-ray dated 9/20/04 was billed to the carrier for two
10 views. On 9/22/04 there was a single view AP cervicothoracic spine x-ray; yet the carrier was
11 billed for two views. There was no x-ray report for these thoracic films.
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13 On 12/16/04 two views of the cervical were taken and a single view of the lumbopelvic. No
14 pregnancy waiver was found in the file as patient 1 was pregnant. A single view of the spinal
15 area does not provide adequate visualization and is not sufficient for diagnostic purposes.
16 Female patients of childbearing age should be screened for pregnancy prior to taking the films.
17 There is no clinical justification found in the patient records for the 12/16/04 films. This is in
18 violation of ORS 684.100(1)(A) and OAR 811-015-0010, 811-030-0030(2)(d) and 811-030-
19 0020(1)(2)(6).
20

21 6.

22 The frequency of treatment was high and lacked sufficient supporting documentation from
23 September through December 2004. The number of modalities used at each office visit and the
24 frequency of visits is not supported from the initial patient complaint of minimal upper back
25 pain. No rationale was found to explain the treatment intensity in association with this injury.
26 The patient was treated four days in a row initially, five days the second week, three days the
27 third through fifth weeks and four days again the sixth week. There is no rationale offered by
28 Licensee in the charts for the number and frequency of treatments. The frequency of treatment
29 exceeds the OCPUG recommendations and there is no supporting documentation to detail the
30 necessity for such treatment outside the guidelines. The intensity and number of modalities
31 performed were not supported by any rationale for their use in relation to the injury. Thus,
32 frequency of treatment does not meet minimal standards. This is in violation of ORS
33 684.100(1)(A) and OAR 811-015-0010(1), (2) and (4) and is unprofessional conduct in not
34 keeping accurate records on all patients, including but not limited to legible notes, and updated
35 treatment plans.
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37 7.

38 Licensee provides two fee schedules which list different prices for similar procedures. For
39 example, neuromuscular re-education (code 97112) is \$27 on one fee schedule and \$50 on
40 another. Licensee has billed the insurance carrier the \$50 charge for one unit each time he bills a
41 code 97112-52. This is in violation of OAR 811-015-0000(3).
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2 8.

3 The Peer Review Committee felt after review of this case, that Licensee continually exhibited a
4 pattern of substandard chart notes, lack of clinical justification in the notes, no treatment
5 planning, lack of clinical justification for x-rays, unprofessional conduct in typing up chart notes
6 that do not correlate with the original chart notes, and treatment modalities unsupported by chart
7 notes. Due to the repeat patterns the Board and Peer Review Committee have concerns about the
8 ability of Licensee to effectively practice and propose the following:
9

10 Due to the aforementioned violations, the OBCE proposes the Licensee receive a letter of
11 reprimand and a \$1000 civil penalty pursuant to ORS 684.100(9)(f).
12

13 9.

14 Licensee shall pay costs of this disciplinary proceeding, including investigative costs and
15 attorney fees pursuant to ORS 684.100(9)(g).
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18 10.

19 Licensee has the right, if Licensee requests, to have a formal contested case hearing
20 before the OBCE or its hearings officer to contest the matter set out above. At the hearing,
21 Licensee may be represented by an attorney and subpoena and cross examine witnesses. That
22 request for hearing must be made in writing to the OBCE, must be received by the OBCE within
23 30 days from the mailing of this notice (or if not mailed, the date of personal service), and must
24 be accompanied by a written answer to the charges contained in this notice.
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27 11.

28 The answer shall be made in writing to the OBCE and shall include an admission or
29 denial of each factual matter alleged in this notice, and a short plain statement of each relevant
30 affirmative defense Licensee may have. Except for good cause, factual matters alleged in this
31 notice and not denied in the answer will be considered a waiver of such defense; new matters
32 alleged in this answer (affirmative defenses) shall be presumed to be denied by the agency and
33 evidence shall not be taken on any issue not raised in the notice and answer.
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36 12.

37 If Licensee requests a hearing, before commencement of that hearing, Licensee will be
38 given information on the procedures, rights of representation and other rights of the parties
39 relating to the conduct of the hearing as required under ORS 183.413-415.
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4 If Licensee fails to request a hearing within 30 days, or fails to appear as scheduled at the
5 hearing, the OBCE may issue a final order by default and impose the above sanctions against
6 Licensee. Upon default order of the Board or failure to appear, the contents of the Board's file
7 regarding the subject of this automatically become part of the evidentiary record of this
8 disciplinary action upon default for the purpose of proving a prima facie case.
9

10 DATED this 28th day of September, 2005.
11

12 BOARD OF CHIROPRACTIC EXAMINERS
13 State of Oregon
14

15 Original signatures on file
16 at the OBCE office.
17 By: E _____, Executive Director
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State of Oregon) Case # 2004-2002
County of Marion) Jonathan Preiss, D.C.

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

Original signatures on file
at the OBCE office.

Dave McTeague, Executive Director
Oregon Board of Chiropractic Examiners

September 28, 2005

Original signatures on file at
the OBCE office.

*My commission expires
Oct 7, 2007*



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Certificate of Service

I, Dave McTeague, certify that on September 28, 2005, I served the foregoing Notice of Proposed Disciplinary Action upon the party hereto by mailing, certified mail, postage prepaid, a true, exact and full copy thereof to:

Jonathan Preiss, DC
7412 Beaverton Hills Highway, Suite 109
Portland, Oregon 97221

Original signatures on file at
the OBCE office.

Dave McTeague
Executive Director
Oregon Board of Chiropractic Examiners