BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON

In the Matter of	)	
	)	STIPULATED FINAL
William Thoens, D.C.	)	ORDER
	)	
	)	
Licensee.	)	Cases # 2004-1056; 2004-1041 and 2005-1004

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

Findings of Fact/Conclusions of Law

1.

Following initial review by the Oregon Board of Chiropractic Examiners, it was determined additional investigation was required. The Board requested the Peer Review Committee to review three separate complaints in regards to Licensee's patient files, billing practices, chart notes, and clinical decision making. Pursuant to OAR 811-010-0095 the Board accepts and agrees with the Peer Review Committee's findings.

Case No.: 2004-1041

2.

Licensee was interviewed by the Peer Review Committee on December 6, 2004 arising from a complaint filed by patient 1. Patient 1 complained that Licensee had not contacted him for an outstanding bill for a two year period and then turned him into collections. Patient 1 also complained that his records were released to his mother without his signed authorization, that his bills were excessive for the treatment performed, and that his charts did not document the charges that were billed.

In their review, the Peer Review committee was supplied with copies of patient charts and billings for patient 1, an IME report from Dr. Freedland, various correspondences from American Family Insurance and additional documents provided by Licensee. Records from Patient 2 were provided, chart notes from Dr. Sandmeier and other correspondence provided by Licensee and Patient 2. Records from Patient 3, patient account ledger information, billing information and correspondence provided by Licensee and Patient 3.

3.

After review of the information provided as stated in paragraph 2, the peer review found the following: Licensee initial exam of 2/27/02 for Patient 1 was inappropriately coded. The initial exam does not meet the criteria necessary for a 99204 code level of service. The key components required for a level 99204 consist of a comprehensive history, a comprehensive exam and clinical decision making of moderate complexity. The chart notes for 2/27/02 do not meet those components and should have been coded at a 99202. This is a violation of ORS 684.100(1)(A) (fraud or misrepresentation), OAR 811-015-0010 and 811-035-0015(5) (charging for services not rendered).

4.

There is no documentation that therapeutic exercises (97110) were administered on the two dates for which they were billed. Licensee told the PRC that he passively stretched some of Patient 1's muscles, and the charges for therapeutic exercises represent this therapy. The chart entries for April 11 and April 18, 2002 appear to support Licensee insofar as the entry in the Assessment section of the note for April 18 says "S/R Psoas Piriformis + Hamstrings" which could be interpreted as such. This entry is preceded by the abbreviation "TEX" which probably means therapeutic exercise. There is a similar entry on April 11 which is not preceded by "TEX." Nonetheless, passive stretching does not qualify as therapeutic exercise because therapeutic exercise consists of training the patient to perform the activity himself. Licensee's assertion in his letter of August 17, 2004 that "active stretching and release technique was provided" does not adequately fulfill the requirement for this code. This is a violation of ORS 684.100(1)(A) and OAR 811-015-0010 and 811-035-0015(5).

5.

Chart notes provided did not meet minimal competency. They are not complete and accurate insofar as the history was not adequately documented and the examination of the right shoulder was deficient. Furthermore, there was no treatment plan documented. The records are not sufficiently detailed and legible to the extent that another chiropractic physician could understand the nature of the case and be able to follow up with care. This is in violation of ORS 684.100(1)(A) and OAR 811-015-0005(1) and is unprofessional conduct in not keeping accurate records on all patients, including but not limited to legible notes, and updated treatment plans.

6.

The diagnosis of the AC joint sprain/strain is not justified. Treatment to the shoulders is not supported by documentation. The charges for the extra spinal CMT (98943) are not justified. Patient 1 did not complain of shoulder pain upon presentation. None of the notes refer to any shoulder pain. The exam form does not describe any exam on the shoulders and the findings in the objective portion of the chart entry do not appear to include any results pertaining to the shoulders. In his interview, Licensee told the committee that he may have diagnosed the AC Joint sprain/strain from an AP thoracic x-ray, however, the committee found in the thoracic film, the AC joints are not visible. Thus, Licensee's explanation lacks credibility. This is a violation of ORS 684.100 (1) (A) and (5), OAR 811-015-0010(3), 811-035-0015(2).

7.

Licensee's performance of multiple physical therapy modalities at each visit is excessive and in some cases redundant. Use of multiple modalities at each visit resulted in unnecessarily high fees. Licensee contends the intensity of treatment to Patient 1 was due to Patient 1 continuing to work despite Licensee's recommendation to take time off, which necessitated the unusually high number of modalities. However, Licensee declined to provide redacted records of other PIP patients for comparison and thus has not substantiated his claim. Subsequent review of Patient 3's records demonstrates the same pattern of multiple therapy modalities. This is a violation of ORS 684.100 (1) (A), OAR 811-035-0015 (2) and (5), OAR 811-015-0010(3).

Case No.: 2004-1056

8.

Patient 2 saw Licensee during the fall of 2004 for treatment for left shoulder soreness. Complaints surrounding the care of patient 2 involved failures to take x-rays of her left shoulder, continuing to treat patient 2 even when shoulder pain became worse and misdiagnosing the shoulder condition.

9.

Chart notes for Patient 2 were insufficient. The patient history and past medical history obtained by License was insufficient and did not meet minimal standards. Licensee failed to include information about a motor vehicle accident that occurred in 2001 and the resulting injuries and whether the patient sought treatment and the outcome of that treatment. Licensee failed to include how the previous accident related to the presenting complaints of Patient 2. There is no current diagnosis of this patient's condition in the notes. No clinical impression or assessment (other than assessment of a re-injury) appears in the chart. Although in the interview, Licensee said he treated Patient 2 for an AC joint separation, grade II, there is no notation in the chart notes. Further, Licensee fails to document a treatment plan. The chart notes are not sufficiently detailed and legible to allow another physician to take over care of this patient. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0010 (2) and OAR 811-015-0005(1) and (1)(a).

10.

Licensee's initial exam on Patient 2 did not meet minimal standards. When Patient 2 noted left arm/shoulder pain, Licensee's exam was more focused on the low back. Range of motion on the shoulder was not performed. No standard orthopedic tests were performed or reported. The muscles which tested weak were not compared to the same muscles in the right shoulder and other muscles of the left shoulder which may have been tested and found normal were not reported. In the interview, Licensee claimed that "he tested both sides," yet, it is not written in his chart. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0010 (2) and OAR 811-015-0005(1)(a).

11.

Licensee failed to meet the minimum standard of x-ray evaluation as he did not perform or order an x-ray exam of the patient's left shoulder. The chart notes do not mention whether Licensee considered taking an x-ray study of the shoulder and no reasoning was provided for choosing not to do an x-ray. Patient 2 also had some aggravations to the left shoulder injury, on October 2, 2002 and October 29, 2002. Yet, as treatment progressed without significant improvement, the decision not to x-ray the shoulder was not explained or discussed. Licensee's failure to recognize the worsening of pain and two aggravations would require an x-ray is below the minimal standard of care and is contrary to the clinical indications present. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0010 (1) and (2), and OAR 811-015-0005(1)(a).

12.

Licensee failed to make a diagnosis of this patient's condition. No diagnosis, clinical impression or assessment (other than the mention of "reinjury" on one occasion) appears in the chart. Licensee told the PRC that he treated Patient 2 for a "grade II AC joint separation." Although this may be his assessment of her condition ex post facto, he did not record it or any other diagnosis in the patient's chart. The Oregon Chiropractic Practice & Utilization Guidelines (OCPUG) state that an assessment or diagnosis need not be updated at each visit, but the results of periodic clinical reevaluations should be performed and the results included in the notes "with any alterations in the diagnosis." In this case, not only was the assessment never updated, there was no assessment to begin with. This is a violation of ORS 684.100 (1) (A), OAR 811-015-0005 (1), 811-015-0010 and OAR 811-010-0095(2)(b).

In addition, each page of Patient 2's chart notes does not identify the clinic by name, nor provide the address on the pages. No doctor or clinic identifying information appears on the exam form either. This is a violation of ORS 684.100(1)(A) and OAR 811-015-0005(1)(b).

13.

Licensee continued to treat Patient 2 with less than favorable response as indicated in the notes. No rationale was provided in the chart notes as to why treatment was continuing with the conditions noted by the patient and without any follow up x-ray studies. To continue treatment of this patient equates to treatment that exceeds beyond the recognized standards for which rationale cannot be established. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0010 (3).

Case No.: 2005-1004

14.

Licensee saw Patient 3 after he was rear ended in a motor vehicle accident in early 2002. Patient 3 treated with Licensee from February through April 2002. In early 2004 Patient 3 noticed his account with Licensee was referred to collections. Patient 3 discovered that when he applied for a loan and it appeared as an outstanding debt on his credit report. Patient 3 stated he did not have any prior knowledge that his bill had been sent to collections 2 years previously.

15.

Licensee did not request payment from Patient 3 for some time after he ceased treatment in 2002. It wasn't until 2004 when Patient 3 had applied for a loan that he learned the matter had been sent to collections. There is no billing for interest on any of the billing statements, yet Patient 3 is charged for that. The earliest evidence that Patient 3 was notified of his outstanding bill was an unsigned letter of April 17, 2003. The billing reports show charges of $10.28 dated 1/28/04 while the 7/23/04 report does not include that charge. At one point the ledger shows unpaid services totaling $1281.40 (for services from a prior episode of care) were written off in January 2004, yet on the same date Patient 3 is charged $10.96. Suddenly in April 5, 2005, the patient account ledger shows a $10.96 charge is replaced with a $427.93 charge. The billings do not make sense or track with any ongoing consistency. There is no evidence in the records that at any time Licensee fully explained the billing procedures, either orally or in writing, including interest charges to Patient 3. The referral to collections without any attempts to secure payment voluntarily by Patient 3 was misleading and constitutes unprofessional conduct. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0000 (1), (2) and (4) and 811-035-0015(7).

16.

Chart notes for Patient 3 are lacking sufficient patient history and past medical history by Licensee. They do not meet the minimal standards. This patient has been a patient since 2000 yet there is no mention of prior chiropractic treatment or any other previous accident history elicited. The initial exam of the shoulder of Patient 3 does not meet minimal standards. Rationale for therapeutic procedures to Patient 3 was not shown and Licensee fails to demonstrate the rationale for his treatment of this patient. Initial exam does not meet minimal standards with respect to the shoulder. The diagnosis of the AC joint sprain/strain is not supported by the examination. The exam does not include shoulder ranges of motion or commonly performed orthopedic tests for the shoulder. There is no treatment plan, prognosis, instructions to the patient or recommendation for follow up in the notes. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0010 (2) and 811-015-0005(1).

17.

Licensee failed to meet the minimum standards of x-ray evaluation. He did not perform or order an x-ray examination of the patient 3's shoulder. Licensee did not record the findings of the spinal x-ray studies in the patient chart. The decision not to obtain a left shoulder x-ray falls below the standard of care. If not at first, certainly by the time a deterioration of the shoulder problem was documented on April 1, 2002, Licensee should have ordered an x-ray of the left shoulder. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0010 (1).

Further review of Licensee's x-rays of Patient 3 reveals the following; each of the two oblique cervical views included most of the cranium. This was unnecessary exposure to radio-sensitive structures. This is a violation of OAR 811-030-0020(7) (All critical parts, ie, fetus, eyes, thyroid gland and gonads, beyond the area of primary examination shall be shielded), and OAR 811-030-0030(2)(b) (The radiographic field shall be restricted to the area of clinical interest.) Also, the

extension lateral film is underexposed. This is a violation of OAR 811-030-0020(2), (All radiographs shall be of diagnostic quality).

18.

Licensee's performance of multiple physical therapy modalities at each visit to Patient 3 is excessive and often redundant. Licensee's rationale for utilizing the multiple modalities (ie, eliminate pain prior to adjusting) is not one which the Peer Review Committee can support. Use of the multiple modalities at each visit resulted in unnecessarily high fees. Treatment was also excessive because Licensee continued treatment when the patient's less than favorable response indicated he should have ordered diagnostic imaging of the patient's shoulder. This is a violation of ORS 684.100 (1) (A) and OAR 811-015-0010 (3).

19.

The Peer Review Committee felt after review of these cases, that Licensee continually exhibited a pattern of chart notes below minimal competency and lack of clinical justification in the notes, past history, and examinations not meeting minimal competency, unprofessional conduct as to billing procedures, continuing treatment beyond the recognized standards, and lack of x-ray evaluation and diagnostic assessment within the minimal standard of care.

Stipulations

20.

Based on the above findings of fact and Conclusions of law, the Board and the Licensee stipulate and agree that this disciplinary action may be concluded by entry of this Stipulated Final Order upon the following terms:

1. Pursuant to ORS 183.415(5) the Board and Licensee agree to informally dispose of and settle this matter. Licensee agrees to the entering of this final order although no admission on behalf of the Licensee has occurred.
2. Licensee stipulates that he has been advised of his right to request a hearing in this matter pursuant to ORS 183.415(2)(a), and to be represented at hearing pursuant to ORS 183.415(3).
3. Licensee waives his right to a hearing in this matter.
4. Licensee agrees to be reprimanded for the above findings of fact and conclusions of law.
5. Licensee agrees to take 12 hours of continuing education in recordkeeping; this is in addition to the required amount to maintain licensure.
6. Licensee agrees to provide 5 files to the Board and PRC (one workers' compensation, one Medicare, two cash patients, and one PIP patient) within the next 60 days.

7. The Stipulated Final Order memorializes the entire agreement between Licensee and the Board and supersedes all prior offers, negotiations or settlement discussions.

I have read and I fully understand all of the above facts and agree to the above terms:

IT IS SO ORDERED this 3rd of ~~March~~ April 2006.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

Original signatures on file at the OBCE office.

By:
Dave McTeague
Executive Director

Original signatures on file at the OBCE office.

By:
William Thoens D.C.
Licensee