BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON

In the Matter of	)	
	)	FINAL STIPULATED
Nick Toyas, D.C.	)	ORDER
	)	
	)	
Licensee.	)	Case # 2005-3011

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

Findings of Fact

Following initial review by the Board, this case was referred to the Peer Review Committee which conducted an interview with Licensee on February 14, 2006. In addition to Patient JV, Licensee subsequently provided three additional Patient files for the Board's review (Patient's 1-3). The Board also reviewed Patient 4's patient file which became available through receipt of another complaint.

1.

On June 15, 2005, the Board received a complaint regarding Licensee's treatment of Patient JV. The complaint alleged that Licensee saw Patient JV 34 times over a period of three months "with virtually no improvement in his condition" and no evidence in the chart notes of a change in care or of any diagnostic workup. Each of the chart entries appeared "almost identical" to all the others. An IME review of Licensee's notes found ".. no standard examination findings, orthopedic or neurological tests," that daily chart entries listed only "reduced joint play" in the assessment portion. "At which segment the reduced joint play was and what areas were treated were not indicated. ..." There were no outcomes assessments in the notes. The IME review also found "significant peripheral abnormalities warranting an MRI." These included a decreased right patellar reflex, a weak right quadriceps muscle, and altered sensation to light touch and pinprick. The IME review also noted that Licensee was apparently utilizing "a machine purportedly developed by NASA" which the reviewer thought to be a type of thermogram. The reviewer also thought Licensee might be relying on this machine for his diagnosis. The complaint is summarized as follows:

- The daily chart entries did not reflect the patient's current status and response to treatment but continued to identify only "reduced joint play."

- Licensee did not document significant neurological findings which were present at the time of the IME review and which would have justified to the payer Licensee's referral of the patient for an MRI, had they been documented.
- Licensee employed an unknown device and/or technique (FRAS assessment) upon which he may have based his diagnostic and/or treatment decisions instead of utilizing standard examination procedures.

2.

Licensee made an attempt to refer Patient JV for an MRI, but the insurance company refused authorization because there were no objective findings to support such imaging.

3.

The Peer Review Committee made specific findings in their report regarding the history of presenting problems falling below the minimal acceptable standards, the past history did not meet minimal standards, the subjective complaints documented in the initial visits in all patients did not meet minimal standards, the examination did not meet minimal standards, the re-examinations did not meet minimal standards, Licensee did not order or perform x-rays for one patient, the diagnosis did not meet minimal standards, the chart notes did not meet minimal standards, the treatment plan did not meet minimal standards, the use of E and M codes was below minimal standards, and the frequency and duration of car was below minimal standards. The Peer Review Committee made specific findings as to treatment of Patient JV that were similar to the areas listed above.

Conclusions of Law

4.

The Board finds the following violations:

a. 811-015-0005 (1). Licensee did not keep "complete and accurate records" of his patients. The records are deficient in the areas of case history, examination, therapeutic services, and treatment plan.

b. 811-015-0005 (1)(a). The records are not "sufficiently detailed" to allow another chiropractor "to understand the nature of that patient's case" and "follow up with the care of that patient. ..." The deficiencies in the chart records noted in this report would not allow another chiropractor to have an accurate picture of the patient's current status and response to treatment. Furthermore, the lack of a treatment plan would further inhibit the assumption of care by another chiropractor.

c. 811-015-0010 (1). Licensee did not demonstrate clinical rationale for his opinions and the therapeutic procedures rendered.

d. 811-015-0010 (3). The requirement of performing a functional chiropractic analysis or PARTS exam was not met. The FRAS procedure is not a substitute for a functional chiropractic analysis. At most, it may satisfy only one component of the exam, determination of "decrease or loss of specific movements. ..."

e. 811-015-0010 (4). Licensee did not demonstrate the necessity of treatment frequency and duration by use of evidence based outcomes management or by any other means. Furthermore, the treatment of Patient 1's condition falls outside of the Oregon Practices and Utilization Guidelines - NMS Volume I, Chapter 5. Licensee did not offer proof that the treatment was justified and is thus contrary to accepted standards.

f. 811-035-0005 (2). Informed consent was not documented and therefore presumed not to have been obtained.

g. 811-035-0015 (5). Charging a higher E&M level of service than documented constitutes charging a patient for services not rendered. Licensee also charged for treatment procedures he did not document on at least three occasions.

Stipulations

5.

Therefore, pursuant to ORS 183.415(5) and ORS 684.100(9)(e) the OBCE orders:

1. The parties have agreed to enter this stipulated final order. Licensee agrees to the entering of this final order. Licensee agrees that he is aware of her 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 parties wish to settle and resolve the above matter without further proceedings.
2. Licensee agrees to the following actions for purposes of rehabilitation with the goal of ensuring his competency to practice.
3. Licensee will attend a Board-approved class in clinical record keeping, minimum of six hours. This is above and beyond the required 20 annual hours. Licensee will provide proof of attendance to the Board.
4. Licensee will attend a Board-approved class in chiropractic examination procedures, minimum of six hours. This is above and beyond the required 20 annual hours. Licensee will provide proof of attendance to the Board.
5. Licensee will participate in and successfully complete a mentoring plan with a board approved Mentor for a period of at least one year from the date this order is signed. The Mentor will be a licensed Oregon chiropractic physician chosen by the OBCE who will sign a personal services contract with the OBCE for the provision of this service. The mentoring plan will have a focus on development of acceptable examination, clinical justification, charting and billing practices to ensure compliance with statutes and rules and addressing all issues identified in this order. The Mentor will be responsible to

review charts and report any findings to the Board that are appropriate. At any time that Licensee ceases active practice, his license lapses or he changes to inactive status, this will not count towards completion of the Mentoring plan period The Mentor will perform file reviews of records and billings of Licensee's case work and report to the board on his progress at meeting minimum standards of chiropractic health care. Licensee must allow the Mentoring Doctor to enter Licensee's business premises to examine, and review Licensee's patient or other records to determine compliance with the terms of this order, for the duration of this Mentoring plan. If the Mentor requests and with the patient's agreement, Licensee will allow the Mentor to observe a patient encounter. The Mentor will make periodic reports to the OBCE regarding Licensee's progress in meeting minimum standards of chiropractic health care. As part of this report, the Mentor may pull one or two of the patient files reviewed with identifiers redacted for the Board's review. The financial compensation for the Mentoring Doctor will be at Licensee's expense which will be due and payable to the OBCE. The Mentor will provide OBCE with periodic billings for services and in turn the OBCE will bill the Licensee. The hourly rate will be determined by the Mentoring Doctor in agreement with the OBCE plus mileage at the state rate. Successful completion of the mentoring plan also requires that this financial obligation be met; however the OBCE will be reasonable in setting up a payment plan if Licensee makes this request. Failure of Licensee to fully cooperate with the Mentor and the mentoring plan will be grounds for future disciplinary action.

Licensee has arranged to be mentored by Dr. Kim Christensen at PeaceHealth St. John Medical Center, 16154 Delaware, Longview, Washington, 98632. Should the designated mentor not be able to complete his duties as the mentor, the Board will select another appropriate Board-approved mentor under the same requirements listed above.

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

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

IT IS SO ORDERED DATED this th day of July 2006.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

By: Original signatures on file at the OBCE office.

Dave McTeague, Executive Director

By: Original signatures on file at the OBCE office.

Nick Toyas D.C.

State of Oregon) Case # 2005-3011
County of Marion) Nick Toyas DC

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 Stipulated Order 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 12th day of September 2006

Original signatures on file
at the OBCE office.

NOTARY PUBLIC FOR OREGON
My Commission Expires: 10/7/07

OFFICIAL SEAL
KELLY J BIRD
NOTARY PUBLIC - OREGON
COMMISSION NO. 373440
MY COMMISSION EXPIRES OCT. 7, 2007

BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON

In the Matter of	)	
	)	NOTICE OF PROPOSED
Nick Toyas, D.C.	)	DISCIPLINARY ACTION
	)	
	)	
Licensee.	)	Case # 2005-3011

The Board of Chiropractic Examiners (Board) is the state agency responsible for licensing, regulating and disciplining chiropractic physicians in the State of Oregon. Nick Toyas, 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.

Following initial review by the Board, this case was referred to the Peer Review Committee which conducted an interview with Licensee on February 14, 2006. In addition to Patient JV, Licensee subsequently provided three additional Patient files for the Board's review (Patient's 1-3). The Board also reviewed Patient 4's patient file which became available through receipt of another complaint.

1.

On June 15, 2005, the Board received a complaint regarding Licensee's treatment of Patient JV. The complaint alleged that Licensee saw Patient JV 34 times over a period of three months "with virtually no improvement in his condition" and no evidence in the chart notes of a change in care or of any diagnostic workup. Each of the chart entries appeared "almost identical" to all the others. An IME review of Licensee's notes found ".. no standard examination findings, orthopedic or neurological tests," that daily chart entries listed only "reduced joint play" in the assessment portion. "At which segment the reduced joint play was and what areas were treated were not indicated. ..." There were no outcomes assessments in the notes. The IME review also found "significant peripheral abnormalities warranting an MRI." These included a decreased right patellar reflex, a weak right quadriceps muscle, and altered sensation to light touch and pinprick. The IME review also noted that Licensee was apparently utilizing "a machine purportedly developed by NASA" which the reviewer thought to be a type of thermogram. The reviewer also thought Licensee might be relying on this machine for his diagnosis. The complaint is summarized as follows:

- The daily chart entries did not reflect the patient's current status and response to treatment but continued to identify only "reduced joint play."

- Licensee did not document significant neurological findings which were present at the time of the IME review and which would have justified to the payer Licensee's referral of the patient for an MRI, had they been documented.
- Licensee employed an unknown device and/or technique (FRAS assessment) upon which he may have based his diagnostic and/or treatment decisions instead of utilizing standard examination procedures.

2.

Licensee made an attempt to refer Patient JV for an MRI, but the insurance company refused authorization because there were no objective findings to support such imaging.

3.

The Peer Review Committee made the following report which the Board accepted at their May 18, 2006 meeting:

History: History of presenting problem falls below minimal acceptable standards. The handwritten chart note for March 18, 2005, the first time Patient JV saw Licensee for his MVA-related back injury, contains brief information about the accident (indicating that Licensee was aware the patient had been in an accident, contrary to his statement to the PRC that he was unaware of the accident when he first saw him for the back injury). Licensee also noted that "MD tried PT and meds - no help." The history in the typed notes is similar.

The history of the presenting problem in the files of the three unidentified patients provides brief information regarding the nature of the injuries (two MVAs and one on-the-job injury). In one case there is mention of prior treatment for the injury from another provider before presentation to Licensee. The handwritten and typed notes are consistent in each case.

In the chart notes for Patient #4 there is no patient history whatsoever. The note begins by listing the patient's presenting symptoms. There is no mention of the mechanism of onset, and the duration of the symptoms is not stated. Furthermore, prior treatment for the presenting complaints is not noted, although it is apparent from other records in the file that the patient had received chiropractic care previously.

Past History: Past history does not meet minimal standards. Licensee made no mention of Patient JV's past medical history. The patient's past history is significant, not only because of a prior back injury or two, but because he had been a patient of Licensee in the past. Licensee did not state that he was familiar with this patient from previous encounters, and he did not report an interim history since he had last seen the patient. In his October 15, 2005 letter to the Board in response to the complaint, Licensee stated he had treated Patient JV twice in the past, once for

shoulder pain and a second time for low back pain. Each time the patient had responded well, and each problem was "quickly and totally resolved."

In the three additional files, a past history is briefly mentioned in two cases and only with respect to past accidents and injuries of the spine. For Patient #3, Licensee noted, "She says that she has not had any previous accidents or injuries to her back; nor has she had any type of spinal problems." And in the case of Patient #2, "He states that prior to the accident, he felt fine and was not having any problems whatsoever with his back." Past medical history is not reported for Patient #4.

Subjective Complaints: The subjective complaints documented at the initial visits in all the patient files reviewed does not meet minimal standards The descriptions of patients' symptoms lack necessary details concerning location, quality, aggravating and palliating factors, and temporal factors. For example, in the first note for Patient JV on March 18, 2005, Licensee's description of the subjective complaints consists of the following: "... he has had serious low back pain and pain and weakness in his legs since the accident. ... he has not been able to work since the accident." The subjective complaint documentation in the other four patient files is similar. For Patient #4, no information was documented concerning the nature of the patient's headache. Licensee obtained no information from the patient to allow him to differentiate between cervicogenic, muscle tension, migrainous, and intracranial mass etiologies.

Examination Findings: Examination does not meet minimal standards. In the case of Patient JV, the examination findings described in the March 18, 2005 typed note consists entirely of the following: "Examination of the patient reveals that there is decreased joint play." The handwritten note for that date contains no information about joint play or any other examination finding. There is no examination form in the records. The finding of decreased joint play was presumably obtained from the FRAS data.

In the October 15, 2005 letter to the Board, Licensee stated that he normally performs standard examination procedures when a patient presents with a new problem. He further stated that Patient JV presented as a walk-in on March 18, 2005, that there was no time available, but he was worked into the schedule because he was in pain. Presumably, then, Licensee had no time to perform any type of examination that day. Nonetheless, "after spending quite a bit of time consulting with him I was virtually convinced that he had one or more significantly damaged discs in his lower back." Licensee also performed a FRAS assessment and treatment on March 18, 2005.

The files of the three unidentified patients (Patient's 1-3) contain examination findings in both the typed and handwritten formats which are within acceptable standards. If FRAS analysis and treatment were performed in any of these cases, there is no documentation of it.

Patient #4's examination is acceptable with respect to her complaint of low back pain. Examination findings are not sufficient for evaluation of her headache. Cervical ranges of motion

and joint play were assessed, but a palpatory examination of the neck and provocative testing were not performed.

Reexaminations: Reexaminations do not meet minimal standards. No reexaminations are documented in Patient JV's notes over the course of 15 weeks.

Reexaminations appear to have been performed routinely in the other three cases. Some reassessment of positive findings was performed at most visits, and more detailed reexaminations were performed regularly.

X-ray: Licensee did not order or perform x-rays of Patient JV. His decision to order a lumbar MRI cannot be supported. Medical necessity for the study was not demonstrated in the absence of examination findings. Apparently this was the reason Mr. Naylor at Allied Insurance would not authorize the imaging study.

Diagnosis: Diagnosis does not meet minimal standards. Licensee diagnosed a moderate to severe lumbar sprain/strain for Patient JV. It is not possible to support the validity of the diagnosis in the absence of examination findings. No diagnosis appears in the notes for Patient #4.

Chart Notes: The chart notes do not meet minimal standards. Patient JV's file contains both handwritten and typed chart entries. The handwritten entries briefly describe the patient's subjective status; for example, "less pain and stiffness" (3/25/05) and "started back to work; LB really bad." (3/28/05) Some entries are longer but still pertain only to the patient's subjective status, e.g., "Needs letter for waiter job. Doesn't want to lose seniority, makes quite a bit of money there." (4/18/05) The note for June 14, 2005 has no information written in it, only check marks indicating the treatment procedures. The typed notes appear to be contemporaneous with the written notes (with the exception of the June 14 note which does contain subjective information). The handwritten notes contain no objective findings, but the typed notes consistently refer to "decreased spinal joint play." Apparently this finding is derived from the printouts of the FRAS evaluations. The handwritten notes do not show an assessment while the typed notes reflect Licensee' assessment at each visit. The handwritten notes indicate by check marks which therapies were performed, and there is also a check mark for "CMT." On some entries there are no check marks for any of the treatment procedures including CMT, but there is a charge for CMT at each visit, and there is a FRAS report for each visit. On three of the entries where there is no indication that treatment procedures were performed, the CMS-1500 forms list charges for CMT (98940), electric stimulation (97014), and mechanical traction (97012). The typed notes do not document treatment procedures except for statements such as "continue spinal adjustments and adjunctive therapies as previously outlined in treatment program" or, as seen in one entry, "Treat this patient according to the recommendations of the medical doctor in charge of this case." (3/22/05)

The printouts of the FRAS procedures are apparently intended to document the spinal evaluation and adjustments at each visit.

The handwritten notes for the three unidentified patients contain objective findings on many but not all of the entries. The typed notes are fairly consistent with the handwritten ones in this respect. The handwritten notes do not contain assessments. As with the typed notes for Mr. Velazquez, treatment procedures are not documented. Statements such as those noted in Patient JV's typed chart notes are seen in these notes as well. Most of the handwritten notes indicate "CMT" and therapies, but a few do not. Specific vertebral levels, listings, or even areas of the spine adjusted are not noted. Four of the entries for Patient #1 omit any indication of treatment.

The two handwritten chart entries for Patient #4 are similar to the notes for the other patients. As in all the files, the patient is identified by name, but there is no clinic name or address. The provider of the service and author of the record are not identified.

Aside from Patient JV, none of the patient charts contain FRAS reports. If this procedure was utilized in any of these cases, there is no documentation of it.

Treatment Plan: The treatment plan does not meet minimal standards. The initial treatment plan for Patient JV called for gentle spinal manipulation, hot packs, interferential current, flexion-distraction, and ultrasound. Treatment frequency was to be daily for one week, then three times per week for three weeks after which a reevaluation would be performed. However, the treatments did not follow this plan insofar as they were routinely administered four times a week on most weeks. Some of the chart entries also state that "the patient should be seen on an as needed basis." This is in addition to the previously noted statement regarding continuation of the treatment program. The initial treatment plan was never reviewed and updated.

The treatment plans in two of the three unidentified patient files are also rather ill-defined. For Patient #1, treatment was to be "3 times per week for 4 weeks and evaluate progress." However, at the next office visit, Licensee noted that "he has to remain at work, as the crew depends on him to do his job." He therefore concluded, "Patient will need to be seen on a daily basis if there is to be any hope of keeping him at work as a construction laborer." The near daily frequency continued for several weeks after the patient appears to have improved significantly. The treatment plan was finally revised on January 19, 2006 to three times per week for one week, then once a week for six to eight weeks at which time he was to be evaluated and released from active care.

The treatment plan for Patient #2, seen for an on-the-job injury, stated, "See daily to get patient out of pain as quickly as possible and keep him at work while his low back is beginning to recover and stabilize." He was seen daily, except for weekends and over the Christmas and New Year holidays, for a total of 12 visits. On January 3, 2006, the twelfth visit, the plan was to "continue treatment of this patient utilizing the procedures previously outlined for today's visit. The patient will now be under the care of his medical doctor." The patient returned to Licensee

on January 12, 2006 with a prescription for twice weekly chiropractic treatments. Thereafter, the treatment plan stated, "Treat this patient according to the recommendations of the medical doctor in charge of this case," or some variation thereof.

In the case of Patient #3, Licensee listed treatment goals in the initial visit note of January 12, 2006. He stated he would see her three times per week for four weeks and then reevaluate. By the time of the fifth visit on January 19, 2006, the patient was improved to the extent that Licensee decreased the treatment frequency to once a week.

No treatment plan is apparent for Patient #4, but there is a notation above the chart note for the first visit that says "for 5 visits cash w/p [*sic*]." The first five chart note spaces on the pages are numbered one through five, in handwriting, although only the first two contain notes.

Evaluation and Management Codes: Use of E&M codes is below minimal standards. Appropriately, no E&M codes were used to bill for Patient JV's care. However, E&M codes for Patients #1 and #3 were not appropriate. The initial E&M code used for both Patient #1 and Patient #3 was 99203. This level of service is appropriate for a new patient presenting with a problem of moderate severity. It requires a detailed history, detailed examination, and a low level of clinical decision making. All three key components must be met or exceeded. Licensee documented a history that was focused, at best. Therefore, the appropriate E&M code is 99201. There are no additional E&M codes in these patients' ledgers.

No E&M codes appear on the ledger for Patient #2.

For Patient #4, the Patient Account Ledger indicates that she paid $100 on February 16, 2006 "for 5 visits." There is no E&M code on the ledger.

Frequency/Duration of Care: Frequency and duration of care is below minimal standards. Patient JV was treated 59 times over approximately 15 weeks. During that time the treatment frequency remained essentially unchanged. A reexamination was never performed, so it was not possible for Licensee to assess the patient's response to treatment (or to compare to the patient's condition at the outset of care as no examination was performed at that time). The FRAS procedure may or may not be a valid method of evaluating and treating vertebral subluxations, but it is not appropriate for measuring treatment outcomes in the absence of other commonly used methods. Licensee claimed that he was treating the patient according to the prescription from the referring medical doctor and, furthermore, that his goal was only to relieve Patient JV's back pain so he could continue to work while awaiting authorization for an MRI. However, the prescription from Patient JV's medical doctor did not recommend any specific treatment plan. These reasons do not excuse Licensee from his responsibility as a chiropractic physician to document the necessity of treatment on an ongoing basis.

Patient #1 received 33 treatments from December 9, 2005 through February 20, 2006. There is no indication that the patient was discharged on February 20. The frequency was four or five times

per week for the first six weeks, three times in the following week, then once weekly through the last date documented. As was noted above under Treatment Plan, Licensee treated the patient on essentially a daily basis so that he would be able to remain at work, but the near daily frequency continued for several weeks after the patient improved significantly. The treatment plan was finally revised on January 19, 2006 to three times per week for one week, then once a week for six to eight weeks at which time he was to be evaluated and released from active care. The frequency of treatment beyond the first week appears to have been greater than necessary. It may have been more appropriate to authorize a short period of temporary total disability. Duration of care is not questionable for the period of time under consideration except to note that treatment was ongoing.

Patient #2 received 22 treatments from December 15, 2005 through February 23, 2006. The patient was treated under a workers' compensation claim. The first 12 treatments were accomplished in under three weeks. After that time treatment continued on referral from a medical doctor at a frequency of about once a week through February 2, 2006. Then the frequency increased to twice a week for no apparent reason. Given the 12 visit/30 day constraint under which chiropractors are attending physicians in workers' compensation claims, the initial treatment frequency seems rather contrived and disingenuous.

4.

The following findings are made in regards to Licensee's treatment of Patient JV:

- *The history was insufficient and does not meet minimum standards for chiropractic physicians in Oregon.*

- *The past medical history was insufficient and does not meet minimum standards for chiropractic physicians in Oregon.*

- *The initial examination does not meet minimum standards. Licensee did not document any examination findings but relied solely upon the FRAS procedure to evaluate the patient. Licensee' failure to examine Patient JV and document the examination findings, especially neurological findings which were noted by the IME reviewer, probably prevented the patient from obtaining timely authorization for diagnostic imaging and specialist referral.*

- *The daily chart entries do not reflect the patient's current status and response to treatment. Licensee did not meet minimum standards with respect to reexaminations, assessments, and chart notes. Furthermore, the typed notes do not document the treatment procedures rendered at each visit. The handwritten notes omit documentation of some or all treatment procedures on several occasions, yet the Patient Account Ledger reflects charges for those services, and the CMS-1500 forms include charges on three dates for which treatment was not documented.*

- *The treatment plan does not meet minimal standards. A treatment plan was initially documented but not followed or revised.*

- *Diagnosis does not meet minimal standards.*

- *Frequency and duration of care does not meet minimal standards.*

The following pertains to the review of the additional patient files for patients 1-4:

- *History of the presenting problem does not meet minimal standards.*

- *Past medical history does not meet minimum standards.*

- *Subjective complaints do not meet minimal standards.*

- *Use of radiographic examinations does not meet minimal standards insofar as no AP open mouth views were obtained with the cervical studies.*

- *Chart notes do not meet minimal standards.*

- *Treatment plans do not meet minimal standards. As noted previously, a chiropractic physician cannot abdicate the responsibility of determining a treatment plan appropriate for the patient's condition to a referring medical doctor.*

- *Evaluation and management codes were inappropriate.*

- *Frequency and duration of care does not meet minimal standards.*

5.

The Board finds the following violations:

a. 811-015-0005 (1). Licensee did not keep "complete and accurate records" of his patients. The records are deficient in the areas of case history, examination, therapeutic services, and treatment plan.

b. 811-015-0005 (1)(a). The records are not "sufficiently detailed" to allow another chiropractor "to understand the nature of that patient's case" and "follow up with the care of that patient. ..." The deficiencies in the chart records noted in this report would not allow another chiropractor to have an accurate picture of the patient's current status and response to treatment. Furthermore, the lack of a treatment plan would further inhibit the assumption of care by another chiropractor.

c. 811-015-0010 (1). Licensee did not demonstrate clinical rationale for his opinions and the therapeutic procedures rendered.

d. 811-015-0010 (3). The requirement of performing a functional chiropractic analysis or PARTS exam was not met. The FRAS procedure is not a substitute for a functional chiropractic analysis. At most, it may satisfy only one component of the exam, determination of "decrease or loss of specific movements. ..."

e. 811-015-0010 (4). Licensee did not demonstrate the necessity of treatment frequency and duration by use of evidence based outcomes management or by any other means. Furthermore, the treatment of Patient 1's condition falls outside of the Oregon Practices and Utilization Guidelines - NMS Volume I, Chapter 5. Licensee did not offer proof that the treatment was justified and is thus contrary to accepted standards.

f. 811-035-0005 (2). Informed consent was not documented and therefore presumed not to have been obtained.

g. 811-035-0015 (5). Charging a higher E&M level of service than documented constitutes charging a patient for services not rendered. Licensee also charged for treatment procedures he did not document on at least three occasions.

6.

Due to the aforementioned violations, the OBCE proposes the following actions for the purpose of rehabilitation and the goal of ensuring competent practice by Licensee:

a. Attendance of a Board-approved class in clinical record keeping, minimum of six hours. This is above and beyond the required 20 annual hours.

b. Attendance of a Board-approved class in chiropractic examination procedures, minimum of six hours. This is above and beyond the required 20 annual hours.

c. Licensee must participate in and successfully complete a mentoring plan with a board approved Mentor for a period of at least one year. The Mentor will be a licensed Oregon chiropractic physician chosen by the OBCE who will sign a personal services contract with the OBCE for the provision of this service. The mentoring plan will have a focus on development of acceptable examination, clinical justification, charting and billing practices to ensure compliance with statutes and rules and addressing all issues identified in this order. The Mentor will be responsible to review charts and report any findings to the Board that are appropriate. At any time that Licensee ceases active practice, his license lapses or he changes to inactive status, this will not count towards completion of the Mentoring plan

period The Mentor will perform file reviews of records and billings of Licensee's case work and report to the board on his progress at meeting minimum standards of chiropractic health care. Licensee must allow the Mentoring Doctor to enter Licensee's business premises to examine, and review Licensee's patient or other records to determine compliance with the terms of this order, for the duration of this Mentoring plan. If the Mentor requests and with the patient's agreement, Licensee will allow the Mentor to observe a patient encounter. The Mentor will make periodic reports to the OBCE regarding Licensee's progress in meeting minimum standards of chiropractic health care. As part of this report, the Mentor may pull one or two of the patient files reviewed with identifiers redacted for the Board's review. The financial compensation for the Mentoring Doctor will be at Licensee's expense which will be due and payable to the OBCE. The Mentor will provide OBCE with periodic billings for services and in turn the OBCE will bill the Licensee. The hourly rate will be determined by the Mentoring Doctor in agreement with the OBCE plus mileage at the state rate. Since the Mentor may be from out of Licensee's immediate area, if the Mentor requests, Licensee must make travel for any meeting as requested by the Mentor. Successful completion of the mentoring plan also requires that this financial obligation be met; however the OBCE will be reasonable in setting up a payment plan if Licensee makes this request. Failure of Licensee to fully cooperate with the Mentor and the mentoring plan will be grounds for future disciplinary action.

7.

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

8.

Licensee has the right, if Licensee requests, to have a formal contested case hearing before the Office of Administrative Hearings 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.

9.

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

10.

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.

11.

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.

DATED this 25th day of May 2006.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

Original signatures on file at the OBCE office.

By:
Dave McTeague, Executive Director

State of Oregon) Case # 2005-3011
County of Marion) Nick Toyas DC

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 signature on file at the OBCE office.

Dave McTeague, Executive Director
Oregon Board of Chiropractic Examiners

SUBSCRIBED AND SWORN to before me

this 25th day of May, 2006

Original signatures on file at the OBCE office.

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

OFFICIAL SEAL
KELLY J BIRD
NOTARY PUBLIC - OREGON
COMMISSION NO. 373440
MY COMMISSION EXPIRES OCT. 7, 2007

Certificate of Service

I, Dave McTeague, certify that on May 25, 2006, 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:

Nick Toyas, DC
Toyas Chiropractic Center
1011 4th Street
Seaside, Oregon 97138

Original signatures on file at the OBCE office.

Dave McTeague
Executive Director
Oregon Board of Chiropractic Examiners