STATE OF OREGON
BOARD OF CHIROPRACTIC EXAMINERS

BEFORE THE CHIROPRACTIC EXAMINERS OF THE STATE OF OREGON

In the Matter of the License of Kent J. Wilson, D.C.	) Agency Case No. DOJ 883 880 EA003 89)) Hearing No. 89-CEB-001)

FINAL ORDER

On March 29, 1990 the State Board of Chiropractic Examiners reviewed the Proposed Order promulgated by the Hearing Officer in the above referenced case, dated March 14, 1990.

The time for filing exceptions to the Proposed Order has expired.

As a result of the Board's review of the Hearing Officer's recommendations, the Board adopted as its Final Order the Proposed Order of the Hearing Officer and, pursuant to ORS 684.100(9), hereby revokes the license of Kent J. Wilson to practice chiropractic in this state.

Any person adversely affected or aggrieved by this Order or any party to this proceeding is entitled to judicial review of this Final Order as provided by ORS 183.482 through 183.500.

A copy of the Proposed Order of the Hearings Officer which was adopted in full by the Board is attached to this Final Order.

Dated this ______ day of April, 1990.

3/1/96

Steven Gardner, D.C.
Chair, Oregon Board of
Chiropractic Examiners

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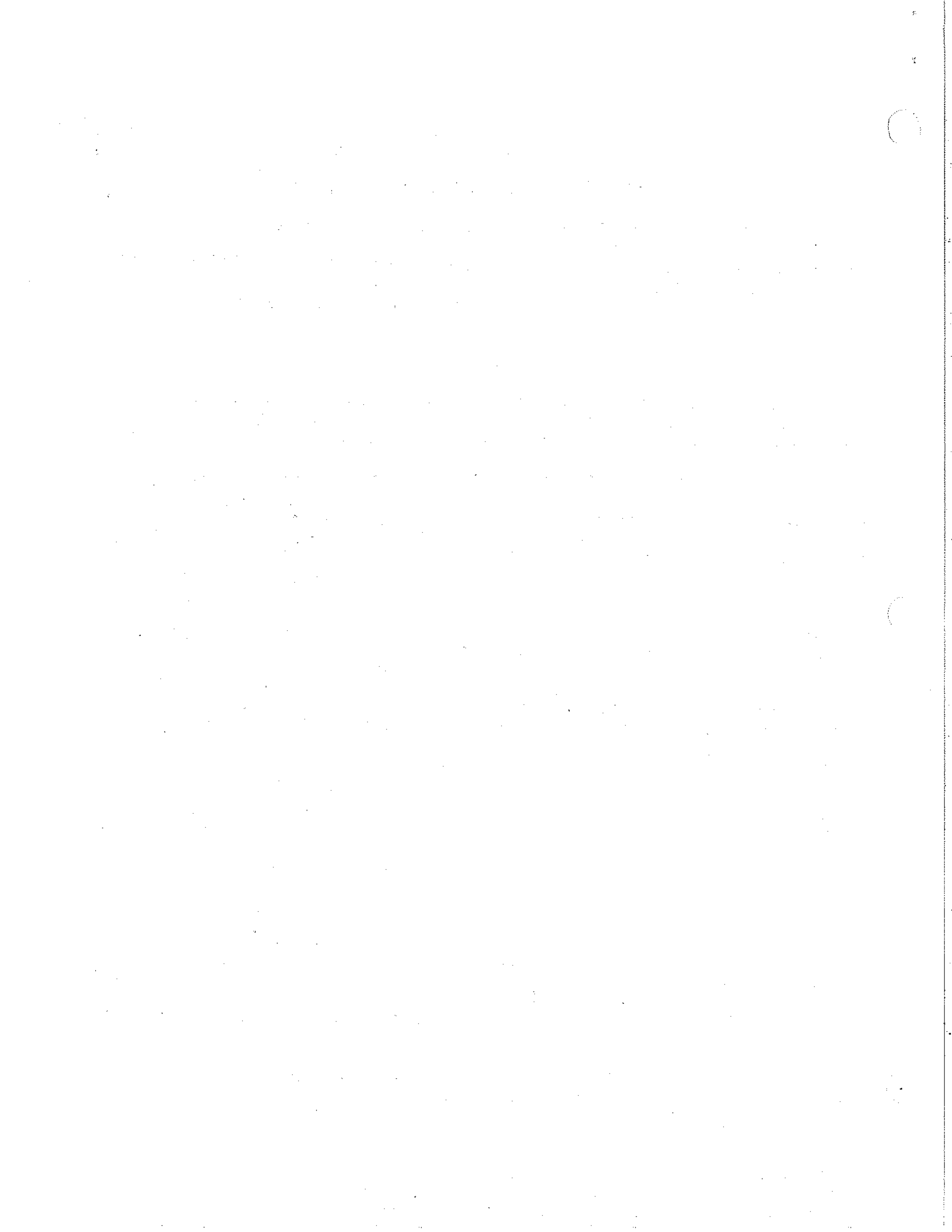

STATE OF OREGON
CHIROPRACTIC EXAMINERS BOARD

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BEFORE THE CHIROPRACTIC EXAMINERS OF THE STATE OF OREGON

In the matter of the license of Kent J. Wilson, D.C.	) ( ) (	Agency Case No. DOJ [illegible]-89 Hearings No. 89-CEB-001

PROPOSED ORDER

History of the Case: On March 17, 1989, a Notice of Proposed Revocation of License was issued to Kent J. Wilson, D. C. On March 27, 1989, the respondent, through his counsel, requested a hearing. A hearing was held on October 16 and 17, 1989, in Salem, Oregon. The record was left open until November 1, 1989, for the receipt of Exhibit 8, which was received at that time. A teleconference was held with counsel for both parties on November 17, 1989. The respondent appeared at the hearing and was represented by David Eves, Attorney at Law. Thomas Twist, Assistant Attorney General, represented the state.
appeared as witnesses. The record closed January 9, 1990, after the receipt of briefs and additional documents.

Legal Issue: Whether the respondent's chiropractic license shall be revoked because of a violation of ORS 684.100(1)(j).

Findings of Fact: (1) Respondent, Kent Wilson, is licensed to practice chiropractic in the State of Oregon. During the past several years his practice has been primarily in orthopedics, dealing with industrial injuries, automobile injuries and sports injuries.

(2) Respondent is the sole shareholder of Wilson Chiropractic Clinic; in 1986 the clinic had gross receipts of approximately $600,000. In 1987 the receipts were approximately $800,000. In 1988 the receipts, through April, 1988, approached $230,000.

(3) At least 60 per cent of the clients of the clinic were treated for industrial accidents.

(4) Oregon law requires that all patients, regardless of the type of insurance they carry, be billed at the same rate for the same services. However, Worker's Compensation carriers pay based on a standardized price list regardless of the amount billed. An administrative process is available to providers if they wish to challenge the amounts approved and paid by insurance carriers.

(5) Oregon law requires that an insurance company pay all Worker's Compensation medical bills within 60 days. If the bill is not paid within 60 days, there is an administrative process available to a provider to have a late penalty imposed.

(6) Respondent spent most of his time handling administrative problems. Less than half of his work time was spent treating patients. Respondent was involved in the financial aspects of the business.

(7) Prior to the fall of 1984, individual handwritten patient ledgers were kept. Each ledger reflected all services billed, and all credits and receipts to be applied to the account. If there were payments in excess of the balance due, a credit would appear on the patient ledger.

(8) In late 1984, the clinic acquired a computer for billing purposes. Patient ledgers continued to be maintained. The computer also carried all of the billing information and was used to generate a weekly bill to insurance carriers.

(9) Daily records were kept of all receipts. The computer generated a "day sheet", indicating how much had been received. The day sheet showed any discounts, and adjustments made to accounts. They also showed refunds. Copies of all day sheets were given to respondent. They also showed refunds.

(10) When a check was received from an insurance company, the patient records were pulled and reconciled. Payments were noted both on the hand ledger and on the computer. Adjustments were made on the ledgers to indicate portions of the bill which had been rejected or reduced by the insurance company. The check was deposited in the business account.

(11) Sometimes the check received would be for an amount greater than the reconciled balance owing. In those cases, only the amount of balance owing would be credited on the computer ledger. On some occasions, the insurance company would be contacted to reconcile the check with the patient account. The overpayment portion was put in a separate computer entry called OP. The OP entry always carried a zero balance, because each OP was debited at the same time it was credited. OP entries did not indicate the issuing insurance carrier, or the patient for whom the payment had been made. Day sheets recorded the amount of overpayments received each day.

(12) The hand ledger sometimes showed these overpayments. When it was recorded on the hand ledger, it was bracketed and written in pencil. These overpayment entries were erased if it was later determined that a subsequent billing was underpaid in an equal or greater amount. Oftentimes no notation was made on the hand ledger to reflect the overpayment.

(13) The state attorney general's office began investigating respondent's practice in the spring of 1988. A demand for financial records was made to respondent and his clinic.

(14) the respondent's wife and office manager, deleted all of the OP entries from the computer records prior to providing the information requested. The only other consistent record of overpayments were the day sheets.

(15) Day sheets for the period January 1, 1985, through May 11, 1988, were subpoenaed by the attorney general. Also subpoenaed were the patient ledgers. For the year 1985, 179 day sheets were not provided to the attorney general. All of the day sheets for 1986 and 1988 were provided. The day sheets for July through December, 1987, were not provided.

(16) The day sheets which were provided indicated 250 overpayments received for a total of in excess of $29,000. Sixty-two percent of overpayments found on the day sheets did not have corresponding entries on patient ledgers.

(17) Prior to the beginning of the investigation, no insurance companies were given refunds unless they made a request for a refund. Refunds given were reduced by late payment penalties, as calculated by respondent's office, costs of office visits which had previously been "written off" as "professional courtesy", as well as any amounts previously refused or reduced by the insurer. These reductions were made without using the administrative process as described in Finding of Fact (4).

(18) After the investigation began, respondent told one of his employes, , that he had known about overpayments. He explained that he considered the overpayments to be fair compensation for claims which had not been paid in full.

(19) Bills sent to insurance companies did not reflect credit balances when overpayments had been previously received. They only showed current charges.

(20) When insurance companies bills were not paid promptly, duplicate bills were mailed to the insurance company. Insurance companies were not notified of overpayments.

(21) Respondent, and the corporation were prosecuted for violations of RICO, in regard to his billing practices, and other matters. (See Exhibit 4). The Honorable Richard Barber, Judge for the Marion County Circuit Court, found the parties jointly and severally liable for $50,000 in civil penalties. Judge Barber also enjoined respondent from performing chiropractic services. (See Exhibit 5).

Credibility Discussion: Respondent would have the referee believe that he was unaware of the overpayments, and that the problem was at most a poor bookkeeping practice. He seems to be laying all of the blame for these practices on others.

However, in Circuit Court respondent testified to quite the contrary. He spent most of his time on administrative aspects of his practice. His employes consistently testified to his interest in the financial aspects. He received copies of all of the day sheets. Even his accountant explained that the doctor was very interested in his tax returns, and was aware of the details.

Respondent is not a man who was too busy providing medical care to his patients to concern himself with the business operation. Quite the opposite, respondent was intimately involved in the financial aspects. He knew that the overpayments were being held, instead of refunded, as he previously indicated to He received daily reports indicating overpayments had been received.

The respondent's attempts to have recant her previous testimony were ineffective and unpursuasive. at the trial stated that she had not felt pressure from the Department of Justice to testify. felt pressure because she had knowledge which might hurt her friends, the Wilsons.

Finally, respondent was married to the person who created the entire computer and bookkeeping system. They worked and lived together. They shared the bounty of his practice and therefore, unavoidably shared the knowledge of how it was obtained. It is difficult to believe that the couple never discussed the methods of billing, collecting or refunding to be used.

Conclusion and Reasons: The respondent violated ORS 684.100(1)(j), and his license should be revoked.

ORS 684.100(1) provides in part: (1) The board may * * * suspend or revoke a license, or impose a civil penalty not to exceed $1000 upon any of the following grounds:

> (j) the obtaining of any fee or payment from a private patient or a third party payor through fraud or misrepresentation.

The respondent contends that the accounting system used did not result in the "obtaining of any fees".

Respondent failed to disclose credits (overpayments) to the insurance companies. Presumably, if such a disclosure had been made he would have received reduced payments on subsequent billings. Respondent obtained the subsequent payments because of his failure to disclose. Additionally, the placing of designated overpayments into the general business account was an "obtaining" of fees. The money was commingled with the business account. At the time of deposit the overpayments were converted to the clinic's use. This is an obtaining of fees.

The respondent further contends that he had no personal knowledge of the accounting practice. As discussed in the credibility discussion, this contention has no merit. Respondent received reports which showed "OP" entries. He was intimately involved in the financial aspects of the business. Respondent had knowledge of the overpayments.

Finally, respondent argued that there was no fraud or misrepresentation.

Fraud is defined as:

> "An intentional perversion of truth for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him . . .; a false representation of a matter of fact, whether by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed, which deceives and is intended to deceive another so that he shall act upon it to his legal injury." "A generic term, embracing all multifarious means which human ingenuity can devise, and which are resorted to by one individual to get advantage over another by false suggestions or by suppression of truth . . .". "Bad faith" and "fraud" are synonymous." (Black's Law Dictionary, 5th Edition, 1979)

Respondent presented testimony about the acceptable percentage of error rate in accounting and argued that the doctor's office operated within the acceptable range. However, this argument is not on point. The respondent and his staff characterized the funds as overpayments. This was purposeful, not

accounting errors. Additionally, in order to arrive at an "acceptable percentage of error", the respondent made substantial adjustments of the overpayments received, including items which had been written off as professional courtesy, as late payment penalty, or as rejected by the insurance carriers. These were misleading adjustments.

Those items which had been marked as professional courtesy were not billed to the insurance carriers. Adjusting for unbilled items, in an attempt to reduce the overpayments to a more palatable amount, is absurd.

Equally, unpersuasive is the respondent's adjustment for amounts "improperly rejected" by the insurance company. There is an administrative process available to parties when there is a dispute. The respondent's ad hoc adjustments, without giving the insurance carrier an opportunity to present its case, cannot be used to reduce overpayments. This further demonstrates the respondent's attempt to disguise the amount of overpayment.

Finally, the evidence clearly indicates that the respondent considered it acceptable to offset overpayments against anticipated future underpayments. This strains the definition of offset well beyond reasonable limits. Offset is a legal right when the exact amounts of corresponding debts can be determined. Respondent "offset" the overpayments against speculative future underpayments. This is not a legitimate offset. There is no definite amount owed, either by the insurance carrier, generally, or in regard to each individual account.

The respondent had a pattern of concealment. His failure to disclose known overpayments to the insurance carriers resulted in monetary damage to these third-party payors.

The respondent's attempts to legitimize a clearly fraudulent practice are spurious. Respondent knowingly utilized an accounting system whereby he did not keep accurate records of overpayments on patient ledgers. Without reviewing the insurance company's checks, there was no way to determine if an overpayment existed on any given account. The overpayment records were kept on a separate computer entry, without reference to the insurance carrier or the patient.

The respondent never disclosed these overpayments to the insurance company. Instead, the monies were deposited in a general business account. The respondent obtained monies from insurance companies through fraudulent means.

PROPOSED ORDER

Kent Wilson's chiropractic license should be revoked under ORS 684.100(1)(j).

Original signature on file
at the OBCE office.

Dated this 14th day of March, 1990

W. B. Comstock
Referee

NOTICE: This is not the Final Order. Exceptions to this Proposed Order must be filed with the Board of Chiropractic Examiners, Room 112, State Office Building, Portland, Oregon 97201, not later than ten (10) days after the date of filing of this Proposed Order with the Board.

You are entitled to judicial review of the Final Order. Judicial review is by the Oregon Court of Appeals pursuant to the provisions of ORS 183.482. Judicial review may be obtained by filing a petition for review with the Office of State Court Administrator, Supreme Court Building, Salem, Oregon, 97310, within 60 days from the service of the Final Order.

In the event the final order is appealed to the Oregon Court of Appeals, a copy of the petition should be mailed to H. Scipio, Hearings Section, Employment Division, 875 Union St NE, Salem, Oregon, 97311 as a means of expediting the preparation of a transcript of the hearing.