

ORIGINAL

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NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE SUSPENSION)
OR REVOCATION OF THE LICENSE OF)

JOSEPH DOYLE, D.C.)

TO PRACTICE CHIROPRACTIC IN)
THE STATE OF NEW JERSEY)

Administrative Action

FINAL ORDER

This matter was opened to the New Jersey State Board of Medical Examiners upon the filing of a complaint by the Attorney General by Joan D. Gelber, Deputy Attorney General. The complaint alleged that respondent, Joseph Doyle, D.C., treated a patient, Audrey Frazier, and/or billed for office visits which were in fact grossly excessive and unnecessary, prepared a patient record which was inadequate and at substantial variance with accepted standards of chiropractic practice, submitted a fabricated patient record to the Board during an inquiry held March 26, 1986, materially misrepresented in the fabricated records the patient's status and presented her condition as more seriously impaired than as originally recorded and listed dates of services for visits never made and for dates different than those on which services were actually rendered and took and billed for radiographs which were below the standard of acceptable quality. On

July 8, 1986 respondent filed an answer to the complaint denying the allegations and requested a hearing on the charges.

The hearing was held before the Board on December 10, 1986. Deputy Attorney General Joan Gelber appeared on behalf of the Attorney General. Respondent appeared and was represented by Robert P. Glickman, Esq.

The State offered as its first witness, Diana Stewart, a nurse who had been employed as an auditor for Associated Rehabilitation Consultants (ARC). Ms. Stewart testified that in August 1985 she went to respondent's office on behalf of Allstate Insurance Company to review his records of Audrey Frazier in connection with insurance claims that had been submitted for services allegedly rendered by respondent to Ms. Frazier. Ms. Stewart obtained from respondent photocopies of his medical record for Audrey Frazier.

Ms. Stewart testified that she discussed with Dr. Doyle his lack of documentation of patient visits for which he billed. She testified that respondent told her that he did in fact perform the services for which claims were submitted but did not always record the visits on the patient's medical record. Ms. Stewart testified that she found Dr. Doyle to be cooperative and confirmed that her report to Allstate states her belief that the treatment claimed was actually rendered to patient Frazier. However, she admitted that she did not interview the patient nor did she check respondent's appointment book to corroborate his story.

The State then called Thomas P. Fasulo, D.C. as an expert witness. Dr. Fasulo testified that the medical records

maintained by respondent for patient Frazier did not meet accepted standards of practice in that they did not include, for example, history of the patient, subjective complaints or objective findings. Dr. Fasulo further testified comparing the original medical records supplied to Ms. Stewart and the medical record supplied to the Board at an investigative hearing held in March 1985. Dr. Fasulo pointed to a number of discrepancies between the two records. For example, the original record shows a negative result on the Foraminal Compression Test, but the record presented to the Board shows a positive result. The original medical record shows a measure of 45 degrees for patient flexion, but the record provided to the Board shows a measurement of 32 degrees. The original medical record shows a 40 degree measurement of extension, but the record submitted to the Board shows a 28 degree extension. The findings recorded in the records given to the Board, he testified, generally made the patient's condition appear to be more serious than it appears to be in the original records.

Dr. Fasulo also testified regarding the quality of the X-rays taken by respondent. While Dr. Fasullo did not believe the X-rays were of a particularly good quality, he found them generally to be marginally acceptable. However, he did note that the radiographs were improperly identified by use of a taped label instead of a "flash card" image on the X-ray itself. He testified that in his opinion respondent unnecessarily took a second lumbar X-ray of the patient. It was his opinion that there was no chiropractic basis for the patient's complaint of lower back pain which would have justified a second radiograph.

It was Dr. Fasulo's further opinion that respondent rendered excessive treatment to Ms. Frazier. Dr. Fasulo had examined the patient on behalf of Allstate as part of the company's review of respondent's claims. Dr. Fasulo testified that it was his opinion that the patient had no chiropractic basis for her complaints of pain when he saw her. He testified that he would have considered 30 to 40 visits sufficient for treatment of Ms. Frazier.

Dr. Doyle testified on his own behalf. He admitted to not having included items in Ms. Frazier's medical record that should have been there. He also admitted to having fabricated the medical record which was presented to the Board at the investigative inquiry held in March 1986. He admitted that the night before the hearing, he sat down with a number of different pens and wrote a record to present before the Board. He admitted that he presented this record at the inquiry as his original medical record. He stated that the reason he did this was because he had lost the original record for the patient, but he stated he had no intent to defraud the insurance company nor to misrepresent his treatment to the Board. He stated that his fabrication of the record was a panicked reaction. He stated that in fabricating the record presented to the Board, he relied upon his appointment book for the dates of services. However, he did not bring the appointment book to the hearing to corroborate his story.

Respondent testified that Ms. Frazier was a difficult patient who came to his office without appointment almost every

day demanding treatment. He testified that when she came to his office, his receptionist would record her visit in the appointment book and that he would render treatment to her. He testified that he did not keep medical records or progress notes for each visit because Ms. Frazier's symptoms did not change and the treatment he rendered did not change.

In regard to the poor quality of his X-rays, respondent testified that he had recently opened a practice and had purchased a new machine. He testified that he had the company to his office many times in an effort to correct the problems. Ultimately, he testified, it was determined that the "grid" had not been put in the machine. In addition, he stated that the problems he had in properly identifying the X-rays were a result of a problem in the "flash card" cassette provided to him by the company.

Testifying in mitigation of penalty were Dennis Doyle, D.D.S., respondent's father and Leslie Metsky, C.P.A., the family accountant. Both men stated that respondent had an excellent reputation in the community.

Admitted into evidence were the following exhibits:

- P-1 Photocopies of Andrea Frazier's medical record provided by respondent to Diana Stewart.
- P-2 Subpoena issued by Deputy Attorney General Gelber to Dr. Doyle dated March 27, 1986.
- P-4 Patient record fabricated by respondent and presented at the investigative inquiry.
- P-5(a) Series of radiographs taken by respondent of Audrey Frazier dated December 28, 1984.
- P-5(b) Series of radiographs taken by respondent of Audrey Frazier dated May 20, 1985.

- P-6 Transcript of Investigative inquiry held March 26, 1986.
- J-1 Letter dated August 15, 1985 from Diana Stewart to Allstate with audit report attached.
- J-2 Letter dated April 25, 1986 from Diana Stewart to Deputy Attorney General Joan Gelber regarding the audit conducted by Ms. Stewart of respondent's bill for services rendered to Audrey Frazier.

FINDINGS OF FACT

The Board finds that:

1. On or about December 28, 1984 and continuing thereafter respondent undertook to provide chiropractic treatment for Audrey Frazier.
2. The medical record prepared by respondent for Ms. Frazier failed to include adequate patient history, subjective complaints, objective findings, progress notes and in many instances failed to document in any way that the patient had received treatment on a particular date.
3. Respondent treated the patient more than the 25 times shown on his original medical record; however, the Board is not persuaded that respondent in fact performed services on each of the dates submitted to the insurance company. Respondent failed to include any documentation to support his contention that services were performed on each of the 90 days claimed. The Board notes that even the fabricated record made by respondent records fewer than 90 visits.
4. Respondent rendered excessive and unnecessary treatment to the patient. It appears to the Board, based largely upon

testimony of Dr. Doyle, that decisions regarding treatment were made by the patient and that Dr. Doyle willingly rendered treatment to her, although he would not have recommended himself that she come for chiropractic treatment on those dates. In this regard, the Board notes that by respondent's own testimony he was new in practice and his patient load was relatively small. Thus, there was an economic motivation on the part of respondent to have rendered the excessive treatment, particularly where such treatment may have been aggressively sought by the patient.

5. Respondent fabricated a patient record for Audrey Frazier and submitted it to the Board representing the record to be an original.

6. This fabricated record was created with the intention to deceive the Board not only in regard to respondent's recordkeeping, but also in regard to the patient's condition and number of visits to respondent.

7. The fabricated record contained alterations from the original record which presented Ms. Frazier's condition as more seriously impaired than originally recorded.

8. The X-rays taken by respondent were within acceptable standards. The Board accepts respondent's testimony regarding the difficulty he had with his X-ray machinery which, at the time the films were taken, made it difficult for him to obtain good quality X-rays properly identified. The original medical records prepared by respondent constitute a substantial deviation from accepted standards of chiropractic practice in violation of

N.J.A.C. 13:35-6.5, N.J.A.C. 13:35-7.1 and N.J.S.A. 45:1-21(d) and (h).

2. The intentional creation of a fabricated patient record misrepresenting the patient's status and presenting her condition to be more seriously impaired than originally recorded and including dates of treatment on days services were not rendered with an intent to justify prolonged and frequent chiropractic treatment and with the intent to deceive both the insurance company and this Board and particularly respondent's intent to deceive this Board by representing the record to be an original medical record both in his sworn testimony at an investigative inquiry and by his use of various different pens in fabricating the record constitutes violation of N.J.S.A. 45:1-21(b), (d) and (e), N.J.S.A. 45:9-41.5, N.J.A.C. 13:35-6.5 and N.J.A.C. 13:35-7.1.

3. Count VI alleging violation of N.J.S.A. 45:1-21(d) and (e) in regard to the X-rays taken by respondent is dismissed.

THEREFORE, IT IS ON THIS *3rd* DAY OF *January*, 1987,
HEREBY ORDERED that:

1. Respondent, Joseph Doyle, D.C., is hereby suspended for a period of three years commencing January 15, 1987. The first four months of this suspension shall be active, the remainder of the suspension shall be stayed and shall be served as a period of probation by respondent. Respondent shall physically submit his certificate of registration to the Board office on January 15, 1987.

2. Respondent shall complete 300 hours of community service which shall be approved by the Board before such service is commenced. The community service shall not be as a chiropractor.

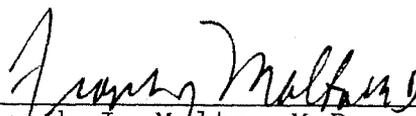
3. Respondent is hereby assessed a civil penalty of \$2,500.

4. Respondent shall reimburse to Allstate Insurance Company the sum of \$1,025 for claims paid for its fees charged to patient, Audrey Frazier.

5. Respondent is hereby assessed costs in this action including costs of investigation, witnesses and all trial expenses including transcripts. A certification of costs shall be provided to respondent by the Executive Secretary of the Board who shall establish a schedule for payment of the civil penalty, costs and reimbursement with respondent.

6. Respondent shall hire, at his own expense, a New Jersey licensed chiropractor acceptable to the Board who shall, during the term of respondent's probation, conduct quarterly audits of respondent's financial and patient records and who shall submit a report in writing to the Board regarding his or her findings following each audit. The first report shall cover the period from May 16 to August 15, 1987 and shall be delivered to the Board office on or before September 1, 1987. Reports shall be due at three month intervals thereafter for the entire period of respondent's probation. In the event that a report is not submitted as required or the report reveals information which

would constitute a violation of statutes or regulations administered by this Board, respondent's probation shall on notice to respondent and opportunity to be heard be converted to an active suspension pending a hearing on the matter.



Frank J. Malta, M.D.
Vice-President
State Board of Medical Examiners