

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
CHIROPRACTIC QUALITY ASSURANCE COMMISSION**

In the Matter of

EDWARD L. WEST
Credential No. CHIR.CH.00001640

Respondent

No. M2011-1183

**STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND
AGREED ORDER**

The Chiropractic Quality Assurance Commission (Commission), through Kyle Karinen, Department of Health Staff Attorney, and Respondent, represented by counsel, Patrick C. Sheldon, stipulate and agree to the following:

1. PROCEDURAL STIPULATIONS

1.1 On June 22, 2012, the Commission issued a Statement of Charges against Respondent.

1.2 Respondent understands that the Commission is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.3 Respondent understands that if the allegations are proven at a hearing, the Commission has the authority to impose sanctions pursuant to RCW 18.130.160.

1.4 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.5 Respondent waives the opportunity for a hearing on the Statement of Charges provided that the Commission accepts this Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order).

1.6 The parties agree to resolve this matter by means of this Agreed Order.

1.7 Respondent understands that this Agreed Order is not binding unless and until it is signed and accepted by the Commission.

1.8 If the Commission accepts this Agreed Order, it will be reported to the Health Integrity and Protection Databank (45 CFR Part 61), the National Practitioner Databank (45 CFR Part 60) and elsewhere as required by law. It is a public document and will be placed on the Department of Health's website and otherwise disseminated as required by

the Public Records Act (Chap. 42.56 RCW) and the Uniform Disciplinary Act (RCW 18.130.110).

1.9 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

2. FINDINGS OF FACT

Respondent and the Commission stipulate to the following facts:

2.1 On March 12, 1981, the state of Washington issued Respondent a credential to practice as a chiropractor. Respondent's credential is currently active.

Patients A and B

2.2 Respondent had a long-time personal and professional relationship with Patients A and B who are wife and husband. Patients A and B were involved in a motor vehicle accident on or about August 17, 2009. During the time period that followed through December 5, 2009, Respondent billed their insurance carrier for performing services using Current Procedure Terminology (CPT) codes promulgated by the American Medical Association.

2.3 On or about August 17, 2009, Respondent billed Patient A's insurance carrier for an examination falling under CPT code 99204 (examination, new patient, forty-five (45) minutes). This examination record did not include record of vital signs, reflex testing or family history and the health history was inadequate. Additionally, the examination record did not contain a complete plan of treatment.

2.4 Patient A was re-examined on October 10, 2009, and the re-examination record did not contain a complete plan of treatment.

2.5 Patient A was re-examined again on November 30, 2009, and orthopedic tests performed at that time indicated symptoms consistent with radicular pain, but nothing in the re-examination record or previous chart notes explain why Patient A would show radicular pain symptoms at that point without having presented with them previously.

2.6 On multiple dates between August 17, 2009 and December 5, 2009, Respondent billed Patient A's insurance carrier for treatment falling under CPT code 98942 (chiropractic manipulative treatment, five (5) regions).

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2.7 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.6 above, or any other patient treatment records for Patient A do not document the performance of adjustments in five (5) spinal regions.

2.8 On or about August 17, 2009, Respondent billed Patient B's insurance carrier for an examination falling under CPT code 99204 (examination, new patient, forty-five (45) minutes). This examination record did not include record of vital signs, reflex testing or family history and the health history was inadequate. Additionally, the examination record did not contain a complete plan of treatment.

2.9 Patient B was re-examined on September 26, 2009, and the re-examination record did not contain a complete plan of treatment.

2.10 Patient B was re-examined on October 20, 2009, and the re-examination record did not contain a complete plan of treatment.

2.11 On multiple dates between August 17, 2009 and December 5, 2009, Respondent billed Patient B's insurance carrier for treatment falling under CPT code 98942.

2.12 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.11 above, or any other patient treatment records for Patient B do not document the performance of adjustments in five (5) spinal regions.

2.13 On multiple dates between August 17, 2009 and December 5, 2009, Respondent billed Patient B's insurance carrier for treatment falling under CPT code 97124 (therapeutic procedure, one (1) or more areas, each fifteen (15) minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)). This treatment was described by Respondent as "HydroMassage."

2.14 The treatment described in Paragraph 2.13 should have been billed using the applicable CPT code for mechanical traction.

2.15 Between August 17, 2009 and November 30, 2009, Respondent billed Patient A's insurance carrier for treatment on fifty (50) separate dates.

2.16 Between August 17, 2009 and November 30, 2009, Respondent billed Patient B's insurance carrier for treatment on fifty (50) separate dates.

2.17 For the treatment described in Paragraphs 2.15 and 2.16, Respondent was questioned by the insurance carrier's employee as to which dates treatment was received.

Respondent subsequently asked Patient A and B to come to his home office and sign backdated attendance sheets that stated they received treatment from him on the dates in question.

Patient C

2.18 On or about August 14, 2010, Respondent started providing chiropractic treatment to Patient C. Respondent continued to treat Patient C to at least March 25, 2011. During that time period, Respondent billed Patient C's insurance carrier for performing services using CPT codes.

2.19 Patient C's initial examination record did not contain a complete plan of treatment.

2.20 Patient C was re-examined on December 13, 2010, and the re-examination record did not contain a complete plan of treatment.

2.21 On multiple dates between August 14, 2010 and March 25, 2011, Respondent billed Patient C's insurance carrier for treatment falling under CPT code 98942.

2.22 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.21 above, or any other patient treatment records for Patient C do not document the performance of adjustments in five (5) spinal regions.

2.23 On August 16, 2010, Respondent took multiple radiographs for Patient C. Neither the lateral cervical flexion view nor the lateral lumbar view was of diagnostic quality. Additionally, there was no collimation on the lateral cervical flexion view.

Patient D

2.24 On or about January 21, 2011, Respondent started providing chiropractic treatment to Patient D. Respondent continued to treat Patient D to at least June 17, 2011. During that time period, Respondent billed Patient D's insurance carrier for performing services using CPT codes.

2.25 Patient D's initial examination record did not contain a complete plan of treatment.

2.26 Patient D was re-examined on April 25, 2011, and the re-examination record did not contain a complete plan of treatment.

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2.27 Patient D was re-examined on May 11, 2011, and the re-examination record did not contain a complete plan of treatment.

2.28 On multiple dates between January 21, 2011 and June 17, 2011, Respondent billed Patient D's insurance carrier for treatment falling under CPT code 98942.

2.29 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.28 above, or any other patient treatment records for Patient D do not document the performance of adjustments in five (5) spinal regions.

Patient E

2.30 On or about December 24, 2010, Respondent started providing chiropractic treatment to Patient E. Respondent continued to treat Patient E to at least June 15, 2011. During that time period, Respondent billed Patient E's insurance carrier for performing services using CPT codes.

2.31 Patient E's initial examination record did not contain a complete plan of treatment. Additionally, Respondent noted a positive Soto-Hall test, but did not note which vertebrae were affected.

2.32 On May 11, 2011, Respondent billed Patient E's insurance carrier for treatment falling under CPT code 99213 (examination, established patient, fifteen (15) minutes). Respondent did not adequately document this re-examination.

2.33 On multiple dates between December 24, 2010 and June 15, 2011, Respondent billed Patient E's insurance carrier for treatment falling under CPT code 98942.

2.34 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.33 above, or any other patient treatment records for Patient E do not document the performance of adjustments in five (5) spinal regions.

2.35 On February 7, 2011, Respondent performed a re-examination of Patient E. In the chart notes for the re-examination, Respondent noted: "MRI reveals severe degerative [sic] changes along with disc involvement." On January 12, 2011, Respondent had previously noted: "MRI shows severe degerative [sic] changes with disc problems at multiple levels." Respondent did not quantify any of the changes noted or specifically

identify the vertebrae that were affected, so it is not possible to determine the progression of the degeneration in Patient E's cervical discs.

Patient F

2.36 On or about March 23, 2011, Respondent started providing chiropractic treatment to Patient F. Respondent continued to treat Patient F to at least June 24, 2011. During that time period, Respondent billed Patient F's insurance carrier for performing services using CPT codes.

2.37 Patient F's initial examination record did not contain a complete plan of treatment.

2.38 On multiple dates between March 23, 2011 and June 24, 2011, Respondent billed Patient F's insurance carrier for treatment falling under CPT code 98942.

2.39 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.38 above, or any other patient treatment records for Patient F do not document the performance of adjustments in five (5) spinal regions.

2.40 On March 23, 2011, Respondent took multiple radiographs for Patient F. The full spine lumbar view was not diagnostic quality. All cervical views contained artifacts and were inadequately collimated.

Patient G

2.41 On or about April 28, 2010, Respondent started providing chiropractic treatment to Patient G. Respondent continued to treat Patient G to at least October 4, 2010. During that time period, Respondent billed Patient G's insurance carrier for performing services using CPT codes.

2.42 Patient G's initial examination record did not contain a complete plan of treatment.

2.43 Patient G was re-examined on June 23, 2010, and the re-examination record did not contain a complete plan of treatment.

2.44 On multiple dates between April 28, 2010 and October 4, 2010, Respondent billed Patient G's insurance carrier for treatment falling under CPT code 98942.

2.45 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.44 above, or any other patient treatment records for Patient G do not document the performance of adjustments in five (5) spinal regions.

2.46 On April 28, 2010 and August 30, 2010, Respondent took radiographs for Patient G. On both dates, the AP full spine lumbar views contained artifacts. Additionally, the April 28, 2010 AP full spine view was inadequately collimated and resulted in Patient G's upper arm being unnecessarily included in the view. The August 30, 2010 AP cervical view was underexposed.

Patient H

2.47 On or about April 19, 2011, Respondent started providing chiropractic treatment to Patient H. Respondent continued to treat Patient H to at least June 20, 2011. During that time period, Respondent billed Patient H's insurance carrier for performing services using CPT codes.

2.48 Patient H's initial examination record did not contain a complete plan of treatment. Additionally, Respondent noted a positive Soto-Hall test, but did not note which vertebrae were affected.

2.49 On multiple dates between April 19, 2011 and June 20, 2011, Respondent billed Patient H's insurance carrier for treatment falling under CPT code 98942.

2.50 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.49 above, or any other patient treatment records for Patient H do not document the performance of adjustments in five (5) spinal regions.

2.51 On April 20, 2011, Respondent took multiple radiographs for Patient H. The cervical and thoracic views were not of diagnostic quality due to underpenetration.

Patient I

2.52 On or about March 23, 2011, Respondent started providing chiropractic treatment to Patient I. Respondent continued to treat Patient I to at least June 24, 2011. During that time period, Respondent billed Patient I's insurance carrier for performing services using CPT codes.

2.53 Patient I's initial examination record did not contain a complete plan of treatment. Additionally, Respondent noted a positive Soto-Hall test, but did not note which vertebrae were affected.

2.54 On multiple dates between March 23, 2011 and June 24, 2011, Respondent billed Patient I's insurance carrier for treatment falling under CPT code 98942.

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2.55 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.54 above or any other patient treatment records for Patient I do not document the performance of adjustments in five (5) spinal regions.

2.56 On March 23, 2011, Respondent took multiple radiographs for Patient I. The AP full spine view was not diagnostic quality from approximately the T9 vertebrae down due to underexposure. One (1) of the cervical views contained an earring artifact that obscured the area of interest. There were multiple other views that had inadequate collimation and/or were underexposed.

2.57 Respondent's chart notes for Patient I's March 25, 2011 visit, state that Patient I may have an "injury to the brain stem." Respondent's chart notes do not reflect a subsequent referral for neurological testing or MRI.

Patient J

2.58 On or about July 24, 2010, Respondent started providing chiropractic treatment to Patient J. Respondent continued to treat Patient J to at least June 25, 2011. During that time period, Respondent billed Patient J's insurance carrier for performing services using CPT codes.

2.59 Patient J's initial examination record did not contain a complete plan of treatment.

2.60 On multiple dates between June 24, 2010 and June 25, 2011, Respondent billed Patient J's insurance carrier for treatment falling under CPT code 98942.

2.61 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.60 above, or any other patient treatment records for Patient J do not document the performance of adjustments in five (5) spinal regions.

2.62 On July 24, 2010, Respondent took multiple radiographs for Patient J. The lateral neutral cervical view, the lateral cervical flexion view and AP full spine lumbar view were not diagnostic quality. Additionally, only five (5) vertebrae were included in the AP cervical view, the lateral lumbar view had no collimation and the lumbar-sacral view was underpenetrated.

2.63 Respondent's chart notes for Patient J's July 26, 2010 visit, state that Patient J may have an "injury to the brain stem." Respondent's chart notes do not reflect a subsequent referral for neurological testing or MRI.

Patient K

2.64 On or about January 9, 2010, Respondent started providing chiropractic treatment to Patient K. Respondent continued to treat Patient K to at least June 4, 2010. During that time period, Respondent billed Patient K's insurance carrier for performing services using CPT codes.

2.65 Patient K's initial examination record did not contain a complete plan of treatment. Additionally, Respondent noted a positive Soto-Hall test, but did not note which vertebrae were affected.

2.66 On March 31, 2010, Respondent billed Patient K's insurance carrier for treatment falling under CPT code 99213. Respondent did not adequately document this re-examination.

2.67 On multiple dates between January 9, 2010 and June 4, 2010, Respondent billed Patient K's insurance carrier for treatment falling under CPT code 98942.

2.68 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.67 above or any other patient treatment records for Patient K do not document the performance of adjustments in five (5) spinal regions.

2.69 On January 9, 2010, Respondent took multiple radiographs for Patient K. The lateral cervical views and the AP cervical view were not diagnostic quality. Additionally, both the lateral lumbar view and lateral cervical views were not adequately collimated and underexposed.

Patient L

2.70 On or about January 22, 2011, Respondent started providing chiropractic treatment to Patient L. Respondent continued to treat Patient L to at least June 15, 2011. During that time period, Respondent billed Patient L's insurance carrier for performing services using CPT codes.

2.71 Patient L's initial examination record did not contain a complete plan of treatment.

2.72 On multiple dates between January 9, 2010 and June 4, 2010, Respondent billed Patient L's insurance carrier for treatment falling under CPT code 98942.

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2.73 Respondent's corresponding daily chart notes for the dates referenced in Paragraph 2.72 above, or any other patient treatment records for Patient L do not document the performance of adjustments in five (5) spinal regions.

3. CONCLUSIONS OF LAW

The Commission and Respondent agree to the entry of the following Conclusions of Law:

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180.180(1), (4) and (7) based on WAC 246-808-540, WAC 246-808-560 and WAC 246-808-565.

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

4. COMPLIANCE WITH SANCTION RULES

4.1 The disciplining authority applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. WAC 246-16-800(2)(c) requires the disciplining authority to impose terms based on a specific sanction schedule unless "the schedule does not adequately address the facts in a case."

4.2 Respondent's alleged conduct falls in Tier A of the "Practice Below Standard of Care" schedule, WAC 246-16-810. The sanction range associated with that tier does adequately address the alleged facts of this case. The disciplining authority has identified an aggravating factor that – even in light of Respondent's lack of disciplinary history – justifies a sanction that falls at the high end of the range of the above identified tier.

4.3 The disciplining authority considered the following aggravating factors:

A. Number or frequency of the acts of unprofessional conduct.

4.4 The disciplining authority considered the following mitigating factors:

A. No previous disciplinary history.

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5. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, the Commission and Respondent agree to entry of the following Agreed Order:

5.1 Respondent's credential to practice as a chiropractor in the state of Washington shall be **MONITORED** for at least three (3) years commencing on the effective date of this Agreed Order. Additionally, Respondent shall comply with all of the following terms and conditions.

5.2 Respondent shall not perform any radiographic studies of patients.

5.3 Respondent shall pay a fine to the Commission in the amount of five thousand dollars (\$5,000.00), which must be received by the Commission within three (3) years of the effective date of this Agreed Order. The fine shall be paid by certified or cashier's check or money order, made payable to the Department of Health and mailed to the Department of Health, Chiropractic Quality Assurance Commission, at PO Box 1099, Olympia, WA 98507-1099. Credit or Debit cards can also be used for payment at the front counter of the Department of Health building at 111 Israel Road SE, Tumwater, WA 98501, during regular business hours.

5.4 In addition to any other inspections that the Commission may make, Respondent shall permit a Department of Health investigator, on an unannounced basis, to audit at least ten (10) patient records to compare chart notes and billing records. The audit and review will take place at the licensee's place of employment or practice and may occur two (2) to three (3) times a year for the duration of the probation period, beginning with the effective date of this Agreed Order. If Respondent fails to comply with the audit or the investigator finds any violations during the audit it will be considered a violation of this Agreed Order and the disciplinary authority may take further action against Respondent's credential.

5.5 In addition to mandatory continuing education, within one (1) year of the effective date of this Agreed Order, Respondent shall complete twenty-four (24) hours of continuing education, pre-approved by the Commission or its designee, as follows:

- A. Twelve (12) hours of continuing education in the area of Records Keeping;
and
- B. Twelve (12) hours of continuing education in the area of Coding.

Respondent shall provide the Commission with proof of completion of such course-work within thirty (30) days of such completion. Failure to complete the required minimum hours of pre-approved continuing education in the specified areas within the specified time(s) shall constitute violation of this Agreed Order.

5.6 Respondent shall take and pass the Commission's jurisprudence examination within six (6) months of the effective date of this Agreed Order.

5.7 Any documents required by this Agreed Order shall be sent to the Department of Health, Compliance Unit at PO Box 47873, Olympia, WA 98504-7873.

5.8 Respondent is responsible for all costs of complying with this Agreed Order.

5.9 Respondent shall inform the Department of Health, Office of Customer Service, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change. The mailing address for the Office of Customer Service is PO Box 47865, Olympia, WA 98504-7865.

5.10 The effective date of this Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Agreed Order.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the credential after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the credential should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

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7. ACCEPTANCE

I, EDWARD L. WEST, have read, understand and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.

Edward L. West Jr
EDWARD L. WEST
RESPONDENT

2-1-13
DATE

Patrick C. Sheldon
PATRICK C. SHELDON, WSBA #11398
ATTORNEY FOR RESPONDENT

February 1, 2013
DATE

8. ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

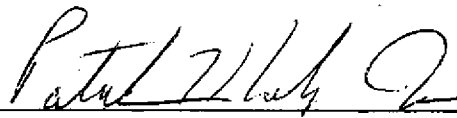
DATED: 2/14/ 2013

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
CHIROPRACTIC QUALITY ASSURANCE
COMMISSION



PANEL CHAIR

PRESENTED BY:

 #28924
for KYLE S. KARINEN, WSBA #34910
DEPARTMENT OF HEALTH STAFF ATTORNEY
February 14, 2013
DATE