

IN THE MATTER OF  
ANDREW JOYCE, D.C.

Respondent

License Number: 02160

BEFORE THE STATE BOARD

OF CHIROPRACTIC

EXAMINERS

Case No. 05-32C

\* \* \* \* \*

**FINAL CONSENT ORDER**

Based on information received and a subsequent investigation by the State Board of Chiropractic Examiners (the "Board"), and subject to Md. Health Occ. Ann. § 3-101, et seq., (2005 Repl. Vol. and 2007 Supp.) (the "Act"), the Board charged Andrew Joyce, D.C., (the "Respondent"), with violations of the Act. Specifically, the Board charged the Respondent with violation of the following provisions of § 3-313:

Subject to the hearing provisions of § 3-315 of this subtitle, the Board may deny a license to any applicant, reprimand any licensee, place any licensee on probation, with or without conditions, or suspend or revoke a license, or any combination thereof, if the applicant or licensee:

- (2) Fraudulently or deceptively uses a license;
- (8) Is unethical in the conduct of the practice of chiropractic;
- (9) Is professionally incompetent;
- (12) Makes or files a false report or record in the practice of chiropractic;
- (16) Overutilizes health care services;
- (19) Violates any rule or regulation adopted by the Board;
- (22) Grossly overutilizes health care services;
- (25) Submits false statements to collect fees for which services were not provided;
- (26) Misrepresents qualifications, education, training, or clinical experience;  
or
- (28) Violates any provision of this title.

The Board also charges the Respondent with the violation of the following

provisions of the Act:

§ 3-301.

- (a) The Board may issue, as appropriate:
  - (1) A license to practice chiropractic; or
  - (2) A license to practice chiropractic with the right to practice physical therapy.
- (c) A chiropractor who holds a license to practice chiropractic with the right to practice physical therapy may practice chiropractic and physical therapy in this State.

§3-306.

- (b) The Board shall include on each license that it issues:
  - (2) Designations that clearly distinguish between those licensees who may practice chiropractic and those who may practice chiropractic with the right to practice physical therapy.

The Board further charges the Respondent with a violation of the following regulations, Code Md. Regs. tit. 10. § 43.14 (Code of Ethics) (1/9/00):  
.03 Standards of Practice.

A. A chiropractor...shall concern [themselves] primarily with the welfare of the patient.

C. A chiropractor...shall:

- (1) Use professional discretion and integrity in relationships with a member of the health care community;
- (2) Be professional in conduct, with honesty, integrity, self-respect, and fairness;
- (3) Remain free from conflict of interest while fulfilling the objectives and maintaining the integrity of the chiropractic profession;
- (4) Provide accurate fee information to the patient, the individual responsible for payment for treatment, and the insurer;
- (6) Practice chiropractic only as defined in the scope of practice set forth in Health Occupations Article, §3-101(f) and (g), Annotated Code of Maryland;

(8) Cooperate with any lawful investigation conducted by the Board, including:

(a) Furnishing information requested;

(b) Complying with a subpoena;

(c) Responding to a complaint at the request of the Board;  
and

(d) Providing meaningful and timely access to relevant patient records; and

D. A chiropractor...may not:

(1) Misrepresent credentials, qualifications, or affiliations and shall attempt to correct others who misrepresent the chiropractor's or the chiropractic assistant's credentials, qualifications, or affiliations;

(2) Knowingly engage in or condone behavior that is fraudulent, dishonest, or deceitful, or involves moral turpitude;

#### .04 Relationship with Patient.

A. A chiropractor shall:

(4) Maintain a written record of treatment of the patient under the chiropractor's care for at least:

(a) 5 years after the termination of treatment; and

(11) Ensure clear and concise professional communications with patients regarding:

(a) Nature and duration of treatment;

(b) Diagnoses;

(c) Costs;

(d) Billing; and

(e) Insurance; and

(12) Administer fair and equitable fees to patients regardless of status or insurance.

B. A chiropractor may not:

(4) Exploit the professional relationship by:

(b) Charging for a service:

(i) Not provided; or

(ii) Different from those actually provided.

.06 Records, Confidentiality, and Informed Consent.

A chiropractor shall:

B. Disclose the patient's records or information about the patient only with the patient's consent or as required by law;

D. Provide sufficient information to a patient to allow the patient to make an informed decision regarding treatment, including:

(1) The purpose and nature of an evaluation or treatment regimen;

(2) Alternatives to treatment;

(3) Side effects and benefits of a treatment regimen proposed and alternatives to that treatment;

(4) The estimated cost of treatment and alternatives to treatment;  
and

G. Promptly and efficiently respond to any patient or Board request for records.

.07 Education and Training.

B. The chiropractor may not perform a treatment or provide a service that the chiropractor is not qualified to perform or which is beyond the scope of the chiropractor's education, training, capabilities, experience, and scope of practice.

The Board also charges the Respondent with a violation of its Record Keeping regulations, Code Md. Regs. tit. 10§43.15 (2/23/98):

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(2) "Diagnosis" means the determination by the chiropractor of the nature and cause of a disease or injury through evaluation of patient history, examination, and review of any laboratory and radiological data.

(3) "Examination" means varied procedures such as analysis, assessment, and evaluation performed by the chiropractor to determine a diagnosis.

(4) "History" means the patient's account of past, present, and familial health.

(5) "Subjective, objective, assessment, and plan (SOAP) notes" means the written record maintained by the chiropractor of:

(a) The patient's qualitative or quantitative description of the patient's condition;

(b) Findings pertaining to the patient's condition based on examination and tests;

(c) The chiropractor's clinical opinion of the condition; and

(d) Instructions given to the patient, orthopedic appliances provided to the patient with instructions for usage, and recommendations for treatment, including modalities used and areas treated.

.03 Record Keeping.

A. The chiropractor shall maintain accurate, detailed, legible, and organized records, documenting all data collected pertaining to the patient's health status.

B. The chiropractor may not erase, alter, or conceal patient records but shall initial and date any changes made in the corresponding margin.

C. The Patient Record.

(1) The chiropractor shall create a record for each patient.

(2) The chiropractor shall state the patient's name or identification number on each document contained in the patient record.

(3) The chiropractor shall include the following information in the patient record:

(a) Chiropractor and clinic name identification;

- (b) Patient history;
- (c) Examination findings;
- (d) Diagnoses;
- (e) Treatment plan;
- (f) SOAP notes;
- (g) Financial records;
- (h) Records of telephone conversations;
- (i) Copies of correspondence and reports sent to other health care providers, diagnostic facilities, and legal representatives;
- (j) Records and reports provided by other health care providers and diagnostic facilities; and
- (k) The signed consent of the patient or the parent or guardian of a minor patient or incompetent patient.

E. Maintenance and Release of Patient Records.

- (2) The chiropractor shall release patient records when release is:
  - (b) Compelled by law.
- (4) The chiropractor shall maintain records in accordance with Health-General Article, §4-403, Annotated Code of Maryland.

.04 Supervisory Responsibilities.

A. The chiropractor is responsible for record keeping, consent forms, billing, and other patient-related documentation handled, maintained, or managed by the chiropractor's staff.

B. The chiropractor shall ensure that employees involved in the preparation, organization, and filing of records adhere to the regulations of this chapter.

.05 Patient History.

The chiropractor shall include the following in the patient history:

A. Personal data, including:

- (1) Name,
- (2) Address,
- (3) Telephone number,
- (4) Date of birth,
- (5) Race,
- (6) Sex, and
- (7) Current occupation;

B. Complaint or complaints, including:

- (1) Description of the complaint or complaints,
- (2) Quality and character of the complaint or complaints,
- (3) Intensity,
- (4) Frequency,
- (5) Location,
- (6) Radiation,
- (7) Onset,
- (8) Duration,
- (9) Palliative and provocative factors, and
- (10) History of present complaint or complaints;

C. Family health history;

D. Past health history, including:

- (1) General state of health,
- (2) Previous illnesses,
- (3) Surgical history,
- (4) Previous injuries,
- (5) Hospitalizations,

- (6) Previous treatment and diagnostic testing,
- (7) Prescribed and nonprescribed medications and supplements,
- (8) Allergies, and
- (9) Mental illness;

E. Systems review, including:

- (1) Musculoskeletal,
- (2) Cardiovascular,
- (3) Respiratory,
- (4) Gastrointestinal,
- (5) Neurological,
- (6) Ophthalmological,
- (7) Otolaryngological,
- (8) Endocrine,
- (9) Peripheral vascular, and
- (10) Psychiatric; and

F. Personal history, including:

- (1) Occupational,
- (2) Activities,
- (3) Exercise, and
- (4) Health habits.

The Respondent was given notice of the Board's Charges by letter dated March 20, 2008. Accordingly, a Case Resolution Conference was held on May 8, 2008, and was attended by Issie Jenkins, Esq., Consumer Member of the Board, and Grant Gerber, Board Counsel, Assistant Attorney General. Also in attendance were the Respondent and his



attorney, Michael E. Marr, and the Administrative Prosecutor, Roberta Gill, Assistant Attorney General.

Following the Case Resolution Conference, the parties and the Board agreed to resolve the matter by way of settlement. The parties and the Board agreed to the following:

### **FINDINGS OF FACT**

1. At all times relevant to the charges herein, the Respondent was licensed to practice chiropractic in the State of Maryland. The Respondent was first licensed on March 12, 2003, with no physical therapy privileges. The Respondent did not qualify to practice chiropractic with physical therapy privileges until June 21, 2005. The Respondent's license expires August 31, 2009.

2. At all times relevant hereto, the Respondent practiced in a facility in Baltimore County, called Stripes Family Chiropractic Center, where he was the sole chiropractor.

3. By document dated July 5, 2005, Patient A<sup>1</sup> complained that, from 8/18/04-4/25/05, he was treated by the Respondent for his neck, although he complained about his knees as well. He stated that he paid the Respondent \$1823, using his credit card, for 90 adjustments, six maneuvers, which the Respondent defined as "therapeutic exercises," 12 sessions of traction therapy, seven reexaminations, four x-rays and four workshops.

4. As a result of this complaint, the Board began an investigation which disclosed the following:

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<sup>1</sup>Patients' names are confidential.

A. The Respondent's billing records indicated that Patient A received 102 adjustments, eight reevaluations (re-evals), and four x-rays, depending upon which records were viewed;

B. Based on the outside billing service that the Respondent used, the Respondent stated that Patient A received 102 adjustments; however, the patient chart indicates that Patient A received 103, and the patient ledger indicates 100 adjustments.

C. Medicare paid \$674.46 and AARP paid \$127.12 to the Respondent, and, in addition to the \$1823, Patient A paid \$420 to the Respondent;

D. The total payment to the Respondent for Patient A was \$3,044.58;

E. Patient A had complained to the Respondent in July 2005 about the overcharge and, when the Respondent initially refused to refund his money, the patient complained to the Board;<sup>2</sup>

F. The contract and the travel cards indicate that the Respondent performed traction on Patient A 64 times between 11/15/04 and 4/25/05, even though the Respondent did not have P.T. privileges until 6/21/05; in addition, the Respondent had contracted to perform six therapeutic maneuvers during the time that he lacked physical therapy privileges.

G. The outside billing service used by the Respondent showed 102 adjustments and eight re-evals.

H. The Respondent admitted that he provided and billed for physical therapy services for Patient A before he was authorized to provide these

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<sup>2</sup>The Respondent reimbursed Patient A in September 2005.

services.

5. Based upon the findings in Patient A's record, the Investigator sent another subpoena to the Respondent for 10 patient files to be selected by him. Accordingly, the Investigator met the Respondent at his office on 9/9/05 and selected 10 patient records, which his staff copied, and the Investigator took the originals.

6. A review of the 10 records disclosed the following:

A. The Respondent had little or no documentation of his treatment of his patients;

B. The Respondent's travel cards had a date stamped for the day the patient was seen, but, generally, there was no other documentation of that visit;

C. The Respondent explained that he documented the treatment the patient received on the first visit by circling on the travel card where he found subluxations, but would not document subsequent visits unless there was something significantly different from the last visit;

D. To document some exams—and most exams were not documented—the Respondent would just draw some arrows on a diagram of a skeleton on the back of the travel card;

E. When asked what his examination consisted of, the Respondent stated that he would palpate the spine, do a postural analysis, and that he used to use bilateral weight scales;

F. The Respondent acknowledged that his "flaw is not documenting as well as [he] should be."

7. The Investigator also subpoenaed a record of all the claims that the

Respondent had made to Blue Cross/Blue Shield (BCBS). Those records also show, as will be set forth, *infra*, that the Respondent either contracted, provided or billed for physical therapy for all of the patients in question before receiving physical therapy privileges.

8. As will also be set forth in more detail, *infra*, the Respondent had a contract to treat 11 of the 12 patients whose records the Board reviewed: Respondent overcharged seven of those patients, the majority of whom were 65 years or older. When asked why he hadn't issued refunds to the patients, the Respondent replied that his billing statements were inaccurate and that he would have to check with his billing person. When asked about the billing person, the Respondent answered that he changed billing firms and had "poor software."

9. Based upon the above, the Board engaged an expert to conduct a thorough review of the files subpoenaed by the Board. The expert concluded the following, with regard to all of the patients:

A. The Respondent had patients sign off and initial on an office policy statement form that contained the phrase "chiropractic does not diagnose or treat any disease;" however, the Respondent listed a diagnosis and billed for treatment under a diagnostic code;

B. The Respondent failed to document that he conducted an initial examination;

C. The Respondent failed to review systems, e.g., heart, pulmonary, etc.;

D. There were no radiology reports, which should indicate whether there was any pathology and the Chiropractic Biophysics measurements (CBP), so

that he could compare to other studies of the patient and what CBP considers normal. In addition, the x-rays would determine at what level and angle traction would be applied;

E. New patient examinations were either missing or there was no findings listed. The established patient/expanded office visit, which may be re-exams, lack documentation. Consequently, there are no vitals, Range of Motions (ROM), and no standard signs or tests were recorded, even though same are billed;

F. SOAP notes are either missing or very inadequate, with checks/slashes where notation of some sort should be;

G. There were numbered notes in the lines for manual and intersegmental traction indicating that the Respondent performed P.T. before he was authorized to do so;

H. The date stamped on the notes was, in some instances, illegible;

I. Traction and neuromuscular re-education were contracted for and billed before the Respondent had P.T. privileges;

J. The Respondent's financial records were confusing, with no clear balance indicated anywhere;

K. On the "Health Made Affordable Plan," there was no indication which option the patient chose. Also, if the patient paid the full sum, it did not show up on the billing ledger in that amount;

L. All patients have a billing statement form entitled "Healthcare Data Management," which is one of the billing services that the Respondent

mentioned in his explanation of financial discrepancies to the Investigator. In that document, the Respondent stated that the billing company, not his office software, tracked the patients' financial standings. There was no mention of the "in-office" records that were generated to send to the billing company and the Respondent failed, after several requests, to supply these to the Board;

M. On that Plan, the patient contracted for a certain number of adjustments/manipulations, but more visits were billed to the insurance than were on the contract.

N. Inasmuch as the data service did not show a lump sum on the ledger, a question remained about who tracked the services to be subtracted; thus, the billing records were incomplete;

O. The Respondent's financial records lacked a running balance on the ledger;

P. The Respondent billed for services not provided: the most glaring was for the "Established Patient/Office Visit-Expanded";

Q. The Respondent used the manipulation billing codes indiscriminately: sometimes the notes show one level treated, but he bills for 3-5 levels and vice versa, with the result that the amount billed for manipulation was always the same;

R. Some SOAP notes showed no levels of manipulation, even though a manipulation code was billed;

S. The Respondent billed for a service on the ledger, but there was no corresponding note for that date, or vice versa;

T. There were times when the Respondent billed the insurer after a rather lengthy time from when the service was rendered—up to a year—and payment was denied, with the result that the patient did not benefit from his/her insurance. There were instances where a service was billed to the insurer a second time, a year later, after it was paid the first time. There were also occasions when a service was billed before it was rendered;

U. On some of the patient ledgers, the entries were out of sequence;

V. On the Respondent's "Policies" form, under the heading "Financial Agreements," it states: "It is your payment that allows us to continue providing high levels of professional care." Money should not determine the care received by the chiropractor. Further, under this heading it states that the fee does not include the cost of a take home traction unit—which the Respondent should not have provided prior to his authorization to perform physical therapy. The Respondent failed to note the amount of the weight or the time and frequency of application of traction;

W. Under "Terms of Acceptance" on the Policies form is stated:

"Chiropractic does not diagnose or treat the disease you may have." As a chiropractor, the Respondent has an obligation to the patient, legally and ethically, to make a diagnosis—and, not just on insurance forms.

10. With regard to the specific patients, the expert made the following findings:

A. Patient A:

(1) The Respondent took x-rays, but did not prepare a radiology report;

rather, he listed some findings in the explanation of care in response to a request from the Board, but not in the notes.

- (2) The Respondent failed to take measurements, but checked off that Patient A had "limited range of motion (ROM)";
- (3) The Respondent recorded no vital signs; .
- (4) The Respondent provided therapeutic maneuvers and traction, which is physical therapy, before he had physical therapy privileges, but claimed that these were chiropractic treatments;
- (5) At Patient A's second re-eval, the Respondent stated that Patient A had "increased ROM," yet he had never measured him to begin with to make a comparison;
- (6) The Respondent's travel cards had no indication of the type or location of the subluxation that the Respondent diagnosed and/or treated;
- (7) The Respondent failed to document any postural examination or observation, and failed to document any weight balance;
- (8) The Respondent failed to record SOAP notes;
- (9) The Respondent failed to record the location of the spasms that Patient A complained about;
- (10) It is standard practice to conduct re-evals every 14-30 days; the Respondent failed to do so;
- (11) The Respondent stated that his goal was to make postural changes in Patient A; however, he failed to indicate what the posture was on the initial evaluation in order to measure progress;



- (12) The Respondent's drawing of stick figures is improper documentation;
- (13) The Respondent's travel cards showed no indication of the type of subluxation or the level;
- (14) The Respondent noted that Patient A had "edema, spasms, fixation and limited ROM," but failed to note the locations of same;
- (15) The Respondent circled L5 (Lumbar), but his notes failed to say what vertebrae he worked on, nor did he state what made the condition better or worse;
- (16) Patient A complained of problems with his back and knees, yet the Respondent failed to provide any examination or treatment to the patient's knees; If the Respondent did not want to treat the patient's knees, he should have referred him elsewhere for same.
- (17) The Respondent's "Progress Evaluation" consisted of how much the patient was learning about chiropractic, not about how well the patient was;
- (18) The Respondent's travel cards substituted for his progress notes or SOAP notes, but those were inadequate;
- (19) The Respondent only wrote a narrative report about the first visit after the patient's complaint was filed with the Board. That report contained a phrase, "tremendous forward head thrust;" however, "tremendous" was not defined or measured;
- (20) Although the Respondent routinely billed for "extended office visits," the documentation did not support same.

B. Patient B:

- (1) Patient B was treated 66 times by the Respondent from 6/25/04-8/15/05;
- (2) Patient B signed no permission to treat documents;
- (3) The Respondent used travel cards that have dates stamped at the top to indicate the date the patient visited, but little or no other documentation;
- (4) The Respondent provided Patient B with physical therapy in the form of neuromuscular re-education, prior to his having P.T. privileges;
- (5) The Respondent contracted with Patient B to receive six maneuvers, or therapeutic exercises, again, before the Respondent had P.T. privileges;
- (6) Patient B contracted with the Respondent for treatment for \$2265; he paid \$1219, according to the Respondent's billing statement. His insurance paid \$646.15, according to insurance company records, for a total of \$1865.15, and should owe the Respondent \$699.85.  
  
However, the Respondent's records show that Patient B owes him \$1206—an overcharge;
- (7) At Patient B's first visit on 6/25/04, the Respondent took two sets of x-rays, though there was no x-ray report; on 6/28, 7/1 and 7/9/04, the Respondent performed manipulation; however, all of these things were billed on 6/2/04;

- (8) The Respondent used three different ledgers for Patient B, which he claims came about as a result of switching billing services and software;
- (9) The Respondent failed to review Patient B's history, which was incomplete, and failed to review his systems, e.g., heart, lungs, etc.;
- (10) The Respondent failed to accurately reflect the visits, the lump sum paid by the patient, or the subsequent payments;
- (11) There were no x-ray reports for cervical and lumbar series dated 6/25/04, which billing shows up on the ledger between 10/1 and 10/4/04;
- (12) The Respondent failed to record examinations or re-exams;
- (13) The Respondent failed to take a complete history;
- (14) The Respondent's diagnosis was not supported by the facts, especially that of "Brachial neuritis," because there were no arm symptoms described/complained of;
- (15) The Respondent's notes were incomplete and there was great difficulty reading dates;
- (16) There were billing irregularities in that the dates of 6/20, 7/12, 14, 26 and 28, 8/16, 18, 20, 23, 25, 27 and 30, 10/18, and 21, 11/3, and 12/8 and 20/04; and, 1/20 and 25 or 26—illegible--/05 have a note but were not billed to the ledger or the insurer;
- (17) The patient's lump sum payment, if any, does not show on the ledger and there is not a running balance;

(18) The Respondent billed Patient B's first five visits to the insurer, but only three appear on the ledger and in his notes;

(19) 10/22/04 is on the ledger and was billed to the insurer, but there are no notes with that date;

(20) Although there are charges on the ledger from 2/20-9/1/05, there are no notes for those and, about six weren't billed to the insurer;

C. Patient C:

(1) The Respondent treated Patient C 78 times between 2/14/04 and 8/12/05, without any signed permission form;

(2) The Respondent's travel cards are date-stamped, but contain little or no other documentation;

(3) Patient C received traction therapy 22 times, from 4/7/04-5/26/04, before the Respondent had P.T. privileges;

(4) Patient C contracted with the Respondent to receive 90 adjustments, six maneuvers, seven re-exams and four x-rays for \$2250. Patient C paid the Respondent \$1509; her insurer paid \$ 1596. The Respondent's billing records, however, showed that Patient C only received 78 of the 90 adjustments, that her insurer paid \$3105, and that she still owes \$184, rather than having a credit of \$855;

(5) The Respondent overcharged Patient C;

(6) The Respondent failed to take a complete history of Patient C; no documented review of systems; and failed to document that exams or

re-exams were conducted;

- (7) The Respondent made no x-ray reports for the initial or follow-up x-rays;
- (8) The Respondent had few notes and those that he had are incomplete and it is difficult to read the dates of treatments;
- (9) 2/11 and 12, 6/17 and 24, 7(illegible), 22 and 29, 8/15 and 25, 11/3, 17 and 24, and 12/14/04 were not billed to the ledger;
- (10) The Respondent billed five levels of manipulation but, failed to indicate which was the 5<sup>th</sup> area that was treated and had no diagnosis to support the billing;

D. Patient D:

- (1) The Respondent treated Patient D 108 times between 2/27/04 and 5/16/05, with no signed permission form;
- (2) Travel cards are date-stamped but contain little or no other documentation;
- (3) If re-exams were documented—and most were not—it is with some arrows drawn on the picture of a skeleton printed on the back of the travel card;
- (4) Patient D received traction therapy on 4/21/04 and was billed for neuromuscular education, both of which constitute the practice of physical therapy, before the Respondent had P.T. privileges;
- (5) In addition, Patient D signed a contract with the Respondent to receive six maneuvers, which in fact, the Respondent defined as “therapeutic

exercises," which is, in fact, the practice of physical therapy, before the Respondent had P.T. privileges;

(6) Patient D paid \$2024 on a contact for \$2250, a difference of \$226, but the Respondent's billing statement shows a balance of \$504. The Respondent overcharged Patient D;

(7) The Respondent's history was incomplete; there was no review of systems or x-ray reports, and the exams and re-exams were not dated and lacked pertinent information;

(8) The Respondent's notes were incomplete or totally lacking information;

(9) There were two ledgers for Patient D, covering the same time period and they have inconsistencies;

(10) Data from BC/BS showed a date of service billed as being provided on 3/10/04 that was actually received by BC/BS on 3/1/04; the service was billed before it was actually provided;

(11) The following progress notes were not on the ledger: 3/23, 4/1 and 16, 5/14 and 26, 6/16 and 22, 7/9, 8/16, 23 and 30, 10/18, 11/8, and 12/1, and 29/04; 1/19, 2/21 and 3/2/05;<sup>3</sup>

(12) There was a ledger date of 6/28/04, but no progress note for that date;

(13) The ledger showed a charge for a date that the patient was not there—6/2/04;

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<sup>3</sup>When this occurs, the patients are not able to receive the benefits of treatment from his/her insurance.

(14) The following ledger date was not billed to BC/BS: 2/7/04 for x-rays and an expanded exam;

(15) The Respondent billed BC/BS for 4/5/04, but it does not show that that treatment occurred, as per the 1<sup>st</sup> ledger;

(16) There is no running balance on the 1<sup>st</sup> ledger;

#### E. Patient E

(1) The Respondent treated Patient E 142 times between 9/27/03 and 3/15/06;

(2) The Respondent's travel card indicated that the Respondent performed traction therapy on Patient E 89 times between 10/21/03 and 6/15/05, when the Respondent did not have P.T. privileges;

(3) The Respondent billed BC/BS \$300 in July, August and September 2005, after he received physical therapy privileges, for traction therapy he performed on Patient E in May through August 2004, before he had P.T. privileges. BC/BS refused to pay the claims. The Respondent stated that he didn't know why it had been backbilled;

(4) The Respondent also contracted with Patient E to provide her with six maneuvers, which the Respondent claimed were "therapeutic exercises". The Respondent performed this physical therapy modality on Patient D from 10/8/03-6/15/05, even though he did not have P.T. privileges;

(5) The Respondent failed to supply the Board with billing records, pursuant to a subpoena, for Patient E;

- (6) The Respondent maintained three ledgers for Patient E;
- (7) The Respondent did not state which plan the patient chose;
- (8) The Respondent's notes did not reflect the proper adjustment codes and three different ones may have been used; the billing indicated five levels were adjusted but the notes did not substantiate same.<sup>4</sup>
- (9) There were no SOAPs for many of the services billed;
- (10) The Respondent took an incomplete history, conducted no review of systems, and had no x-ray reports;
- (11) The Respondent's payment plan lacked dates and indicated the performance of traction and other maneuvers, which he was unauthorized to do;
- (12) The Respondent had two sets of SOAPs covering the same dates for Patient E; the printed ones appeared to be computer-generated and "canned" and mentioned an exam which was not in existence;
- (13) As per the Respondent's notes, traction began on 10/20/03, and was first billed to BC/BS on 5/19/04;
- (14) The dates of some of the notes were illegible;
- (15) The Respondent failed to document that he examined Patient E for the automobile accident of 5/16/04;
- (16) The Respondent failed to take notes to support the billing for 2/15, 3/26/ and 4/4/05;

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<sup>4</sup>The billing code indicates treatment to one-two levels of the spine; 2nd, indicates three-four levels; the



(17) Comparing the three ledgers to each other and to the notes, there were different levels of manipulation noted on the same dates.

(18) Neuromuscular re-education was provided by the Respondent to Patient E on 10/8/03, prior to his being authorized to perform P.T.;

(19) There were progress notes not on the first ledger for 9/1 and 27, 12/11 and 17 /03; 2/9, 5/7, 6/23 and 25, 7/26 and 30, and 8/6, 9 and 16/04;

(20) There was no running balance on the first ledger;

F. Patient F:

(1) Patient F was seen by the Respondent 82 times from 9/20/04-5/6/05;

(2) There was no permission to treat document;

(3) Travel cares were date-stamped, but had little or no other documentation;

(4) Re-exams were not documented;

(5) The Respondent failed to document Patient F's initial examination, other than circling where subluxations were found;

(6) The Respondent provided Patient F with manual traction 71 times between 11/13/04-5/6/05, even though he was not authorized to provide P.T.;

(7) Patient F contracted with the Respondent on 9/22/04 for \$2265.

Patient F and his insurer paid the Respondent \$2722.27, but, according to the Respondent's records, Patient F still owes the

according to the Respondent's records, Patient F still owes the Respondent \$456.41. Patient F is due a refund of \$157.27; the Respondent overcharged Patient F;

- (8) The Respondent's intake form was incomplete, lacking the chief complaint and other information, including the date;
- (9) The Respondent failed to document exams or x-rays; consequently, despite billing Medicare for those services, Medicare should not have been billed because the presence of subluxation had not been demonstrated;
- (10) The Respondent's Health Plan stated that the patient was to receive traction and maneuvers, before the Respondent was authorized to perform P.T.;
- (11) Furthermore, x-rays are included in the plan, but were not received;
- (12) Progress notes not listed on the ledger were as follows: 9/22, 23/, 27 and 29, 10/1, and 18, 11/3 and 17, 12/18, 27 and 29/04, and 1/6 and 28/05;<sup>5</sup>
- (13) The Respondent has a date on the ledger for 12/17/04, but no notes;
- (14) The dates of service on the Respondent's ledger were out of sequence in early 2005;

G. Patient G:

- (1) Patient G was treated by the Respondent 77 times from 10/15/03-

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<sup>5</sup> The ledger should be an accurate representation of what has been provided and what has been paid.

11/30/04;

- (2) The Respondent failed to obtain a permission to treat form from Patient G;
- (3) Travel cards were date-stamped but had little or no other documentation;
- (4) If re-exams were documented, and most were not, it was with some arrows drawn on the picture of a skeleton printed on the back of the travel card;
- (5) The Respondent signed the contract with Patient G to provide six maneuvers, or therapeutic exercises, before the Respondent had P.T. privileges;
- (6) Patient G and her insurer paid the Respondent \$2538.52, although she contracted for \$2250. The Respondent failed to refund the difference to Patient G, even though she discontinued care before all treatments she had contracted for had been received;
- (7) The Respondent stated that his billing statement is inaccurate. The Respondent overcharged Patient G;
- (8) The Respondent failed to take a complete history or to review Patient G's systems;
- (9) The Respondent failed to document initial or re-examination findings;
- (10) The Respondent's diagnosis is not documented, though the Respondent billed for treatments;
- (11) The Respondent's notes was incomplete;

- (12) The Respondent failed to generate x-ray reports;
- (13) The Respondent maintained two ledgers for Patient G, which were inconsistent;
- (14) The following dates of progress notes are not on the first ledger:  
12/17/03, 3/11, 15, 18, and 22, 5/17 and 24, 8/15, 23 and 30, and  
9/8/04;
- (15) The following dates were in the first ledger, but there were no progress notes on 5/19, 11/15 and 11/30/04;
- (16) The dates on some of the Respondent's notes are not readable;

H. Patient H:

- (1) The Respondent treated Patient H 72 times between 9/20/04-8/29/05;
- (2) The Respondent failed to obtain a permission to treat document from Patient H;
- (3) The Respondent's travel cards were date-stamped, but contained little or no other documentation;
- (4) The Respondent failed to record re-exams;
- (5) The Respondent's initial exam consisted of circling where subluxations were found;
- (6) The Respondent contracted with Patient H to provide six maneuvers and manual traction, prior to the time that the Respondent had P.T. privileges;
- (7) The Respondent signed a contract with Patient H for \$2565; Patient H

has paid \$1285.40, and should owe the Respondent \$1279.60;  
however, the Respondent's billing statement showed that Patient H  
owed him \$1394.60, which is an overcharge;

- (8) The Respondent failed to obtain a complete history or conduct a  
review of systems;
- (9) The Respondent failed to document an examination or prepare an x-  
ray report;
- (10) The Respondent's SOAPs are void of information;
- (11) The Respondent's diagnoses of intervertebral disc without myelopathy  
and segmental dysfunction are unsupported;
- (12) The following dates represent times when progress notes were not on  
the ledger: 9/22, 10/13, 11/9, and 12/16/04, 2/3; and, 15, 3/1, 5/10 and  
30, 6/1, 7/5, 11 and 18, and 9/8/05;
- (13) The Respondent's ledger was out of sequence in November 2004  
and January 2005, which is further evidence that the Respondent's  
notes are disorganized and he has poor record-keeping;
- (14) The Respondent placed charges on the ledger for 12/13/04 and  
3/28/05, for which there were no notes;

I. Patient I:

- (1) The Respondent treated Patient I 84 times between 5/17/04-8/15/05;
- (2) The Respondent failed to document an initial exam, other than circling  
on the travel card where subluxations were found;
- (3) The Respondent signed a contract with Patient I on 5/19/04 to include

six maneuvers; the patient received manual traction on 1/10/05—both of these treatments are physical therapy modalities, which the Respondent was not then authorized to perform;

- (4) Patient I and her insurer paid the Respondent \$2538.52 for contacted care, which was for \$2250, including 90 adjustments; however, Patient I only received 47 adjustments;
- (5) On 6/21/05, Patient I signed another contract to receive more treatments for an additional \$1295, even though she had not received all of the services she had contracted for originally;
- (6) The Respondent's billing statement showed that Patient I still owed \$166.02, an overcharge;
- (7) The Respondent's history was incomplete and there was no review of systems;
- (8) The Respondent documented no exams or x-ray findings;
- (9) The Respondent's diagnoses of segmental dysfunction, neuralgia, and myospasm are unsupported;
- (10) The Respondent's notes were void of information, other than the date;
- (11) Some dates on the notes are not readable;
- (12) The Respondent gave Patient I home traction, with no instructions for frequency or weight--all before he was authorized to provide P.T.;
- (13) The Respondent's ledger on Patient I had dates of services out of

sequence;

(14) The ledger had the following dates, but no notes: 6/14 and 7/10/04, and 6/22, 7/1, 6, 11 and 18, and 8/8 and 15/05;

(15) The Respondent's ledger showed a charge for a date, 2/9/05, when the patient was not there;

(16) The Respondent acknowledged that he could not determine by the patient file what the patient paid;

J. Patient J:

(1) The Respondent treated Patient J 31 times between 1/5 and 8/30/05;

(2) The Respondent obtained no signed permission to treat form;

(3) The Respondent's travel cards are date-stamped, but contain little or no other documentation;

(4) The Respondent failed to document his re-exams;

(5) Patient J received traction therapy on three occasions before the Respondent was authorized to perform same;

(6) Patient J signed a contract with the Respondent for six maneuver treatments, before the Respondent was authorized to provide physical therapy;

(7) Patient J signed a contract with the Respondent for \$2563 and paid \$236, however, the Respondent's statement shows that the patient owes only \$1960, a lesser amount than actually due;

(8) The Respondent's history is incomplete and he conducted no systems review;

- (9) The Respondent failed to list a chief complaint;
- (10) The Respondent documented no initial or re-examinations;
- (11) The Respondent failed to write an x-ray report;
- (12) The Respondent's diagnoses of intervertebral disc with myelopathy, segmental dysfunction and spondylolisthesis were unsupported;
- (13) Most of the Respondent's notes were void of information;
- (14) The Respondent's ledger entry of 1/8/05 was out of sequence;
- (15) Ledger entries of 1/15 and 2/2/05 weren't supported by notes;
- (16) The Respondent's ledger showed a charge for a date when the patient was not there, 2/9/05;

K. Patient K:

- (1) The Respondent treated Patient K 72 times between 9/20/04-8/29/05;
- (2) The Respondent's travel cards were date-stamped, but had little or no other documentation;
- (3) The Respondent failed to document any re-exams;
- (4) Patient K signed a contract with the Respondent on 9/22/04 to receive six maneuvers/therapeutic exercises, prior to the time that the Respondent had PT privileges;
- (5) Patient K signed a contract with the Respondent on 9/22/04 for \$2565. The patient and his insurer paid the Respondent \$2246.76; however, the Respondent's ledger shows that Patient K owes \$127.73, instead of the \$318.24 actually due;
- (6) The Respondent took an incomplete history and failed to do a systems



review;

- (7) The Respondent took no x-rays, even though the patient paid for them in the lump sum;
- (8) The Respondent recorded no exam findings to support the billing charges;
- (9) There were no SOAP notes, only dates of service;
- (10) The Respondent's diagnoses of disc degeneration and segmental dysfunction were unsupported;
- (11) The ledger was out of sequence for 11/04, and 1 and 3/05;
- (12) There were notes without charges on the ledger for the following dates: 9/21 and 22, 10/?, 11 and 13, and 11/29/04, 1/20, 2/15, 3/1, 5/10, 6/1 and 5 and 9/6/05;

L. Patient L:

- (1) The Respondent treated Patient L 36 times between 4/19-8/31/05;
- (2) The Respondent failed to obtain a permission to treat form;
- (3) Travel cards were date-stamped, but had little or no other documentation;
- (4) The Respondent supplied no travel card for treatment between 6/27/05-8/31/05;
- (5) The Respondent failed to document re-exams;
- (6) Patient L received manual traction five times between 4/28-5/12/05, prior to the Respondent's being authorized to provide P.T.;

- (7) Patient L did not sign a contract , but paid as she went;
- (8) Patient L received 36 adjustments @ \$35 each and 12 manual traction sessions @ \$25 each for a total of \$1560. The patient should owe \$732.40, but the Respondent's billing statement shows that Patient L owed \$867.40, an overcharge;
- (9) The Respondent documented an incomplete history and failed to conduct a review of systems;
- (10) The Respondent failed to document exam findings;
- (11) The Respondent failed to document x-ray findings;
- (12) The Respondent's diagnoses of disc degeneration, segmental dysfunction and kyphosis (hump) of the neck were unsupported;
- (13) The Respondent's notes were void of information in most cases and stopped on 6/23/05, even though billing went until 8/31/05;
- (14) The Respondent performed traction on Patient L, even though he was unauthorized to do so;
- (15) The Health Plan shows that Patient L was to receive x-rays, re-exams, maneuvers and workshops, but there was no record that these were received. In addition, the document was not signed by either party;
- (16) The Respondent's ledger showed that Patient L received therapeutic exercise, but same was not recorded in the note or the file;
- (17) The Respondent had two notes for 4/28/05;
- (18) There were notes without a charge on the ledger for the following

dates: 4/19 and 20, 5/4, 5, 12 and 28/05;

(19) The following dates represented charges on the ledger without a note:

5/23 and 30/05;

(20) The ledger date of 5/12/05 was out of sequence.

### **CONCLUSIONS OF LAW**

Based upon the foregoing Findings of Fact, the Board finds that Respondent violated § 3-313 (2), (8), (9), (12), (16), (19), (22), (25), (26) and (28). In addition, the Board finds that the Respondent violated § 3-301 (a)(1) and (2)(c) of the Act, as well as § 3-306 (b)(2). The Respondent also violated the following regulations: Code Md. Regs. tit. 10. § 43.14 (Code of Ethics) .03 A., C. (1), (2), (3), (4), (5), (6), (8) (a), (b), (c) and (d), D. (1) and (2); .04 A. (a), (11) (a), (b), (c), (d) and (e), (12), B. (4) (b) (i) and (ii); .06 B., D. (1), (2), (3) and (4) and G.; .07 B.; .02 A., B. (2), (3), (4) and (5) (a), (b), (c) and (d); .03 A., B., C. (1), (2), and (3) (a), (b), (c), (d), (e), (f), (g), (h), (i), (j) and (k), E. (2) (b) and (4); .04 A and B; .05 A. (1), (2), (3), (4), (5), (6) and (7), B. (1), (2), (3), (4), (5), (6), (7), (8), (9) and (10), C., D. (1), (2), (3), (4), (5), (6), (7), (8) and (9), E. (1), (2), (3), (4), (5), (6), (7), (8), (9) and (10), F. (1), (2), (3) and (4).

### **ORDER**

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 18<sup>th</sup> day of June, 2008, by a majority of a quorum of the Board,

**ORDERED** that the Respondent's license to practice is hereby **SUSPENDED**, and that the Suspension be immediately **STAYED**, and the Respondent shall be immediately placed on **PROBATION** for three years, subject to the following conditions:

- A. The Respondent shall take and pass, with the requisite percentage, the Board's jurisprudence examination and a Board-pre-approved ethics course or tutorial;
- B. The Respondent shall have a Mentor, selected and approved by the Board, to review his records for accurate diagnoses, billing and proper documentation;
- C. The Mentor shall meet with the Respondent weekly for the first three months of his Probation; then, monthly for the next nine months, and quarterly for the second year of Probation. ~~Thereafter, the Respondent shall take the National Examination on the parts dealing with diagnoses. Should the Respondent fail to achieve a passing percentage, the Respondent's license shall be suspended until he achieves same;~~ *JM 6/18/08*
- D. The Respondent shall be responsible for promptly paying the Mentor's fee, as determine by the Board, including mileage and reports;
- E. Any reports from the Mentor which indicate that the Respondent is non-compliant with the Consent Order or is not progressing in the

mentorship regarding recording accurate diagnoses, billing and proper documentation, shall be deemed a violation of the Consent Order and may subject the Respondent to additional conditions of Probation or other disciplinary measures;

- F. The Respondent shall pay a fine to the Board of \$750 per patient that he performed physical therapy on prior to his obtaining physical therapy privileges . That amount, \$9000, shall be paid before the end of the probationary period in one lump sum;

**ORDERED** that the Consent Order is effective as of the date of its signing by the Board; and be it

**ORDERED** that should the Board receive a report that the Respondent has violated the Act or, if the Respondent violates any conditions of this Order or of Probation, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further disciplinary action against the Respondent, including lifting the Stay on the suspension, or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it

**ORDERED** that the Respondent shall practice in accordance with the laws and regulations governing the practice of chiropractic in Maryland; and be it further

**ORDERED** that, at the end of the Probationary period, the Respondent may petition the Board to have the conditions or restrictions on his license removed/terminated,

provided that he can demonstrate compliance with this Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions of Probation, as it deems necessary;

**ORDERED**, that for purposes of public disclosure, as permitted by Md. State Gov't. Code Ann. §10-617(h) (Repl. Vol. 2004), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order, and that the Board may also disclose same to any national reporting data bank that it is mandated to report to.

**J. J. VALLONE J.D.**

**Executive Director**

*(Signature for direction)*

Duane Sadula, D.C., President  
State Board of Chiropractic Examiners

**CONSENT OF ANDREW JOYCE, D.C.**

I, Andrew Joyce, by affixing my signature hereto, acknowledge that:

1. I am represented by an attorney, Michael E. Marr, and have been advised by him of the legal implication of signing this Consent Order;
2. I am aware that, without my consent, my license to practice chiropractic in this State cannot be limited except pursuant to the provisions of § 3-313 of the Act and the Administrative Procedure Act (APA) Md. State Govt. Code Ann. §10-201, et seq., (2004 Repl. Vol.).
3. I am aware that I am entitled to a formal evidentiary hearing before the Board.

By this Consent Order, I hereby consent and admit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in

its entirety. By doing so, I waive my right to a formal hearing as set forth in § 3-315 of the Act and §10-201, et seq., of the APA, and any right to appeal as set forth in § 3-316 of the Act and §10-201, et seq., of the APA. I acknowledge that my failure to abide by the conditions set forth in this Order and following proper procedures, I may suffer disciplinary action, possibly including revocation, against my license to practice chiropractic in the State of Maryland.

6/12/08  
Date

Andrew J. Joyce D.C.  
Andrew Joyce, D.C.

STATE OF Maryland :  
CITY/COUNTY OF Baltimore :

I HEREBY CERTIFY that on this 12<sup>th</sup> day of June, 2008, before me, Andrew J. Joyce, a Notary Public of the foregoing State and (City/County),  
(Print Name)  
personally appeared Andrew Joyce, License No.02160, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Susan L. Marr  
Notary Public

My Commission Expires: 2-1-2010

