

# The Role of the Chiropractic Expert

How to pick the right one

Christopher Greene, DC, CPCO, CDEO, CPMA



Rules and  
regulations  
help to  
maintain  
public safety

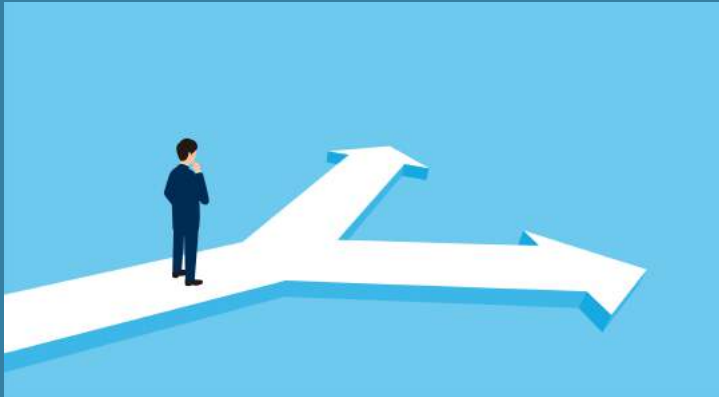




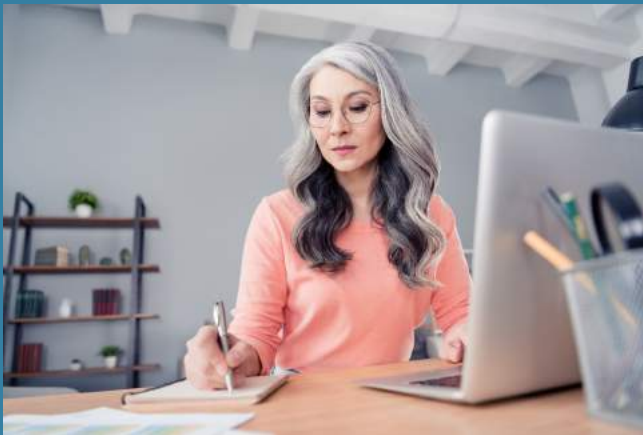
## Investigate non-compliant chiropractors



Consumer Complaints  
Patients - Anonymous  
HCP's  
Insurance  
Malpractice  
Other agencies



no violation



Well informed  
Non-biased  
Thoughtful

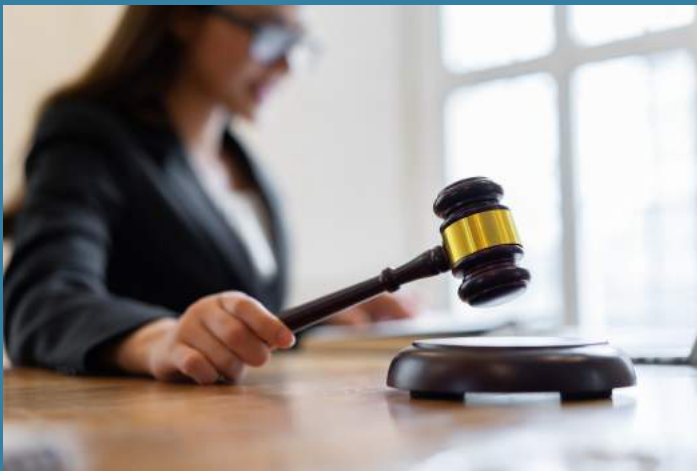
## EXPERT OPINION

- SKILL
- KNOWLEDGABLE
- CAREFUL



Board analyst  
Executive Director  
DAG  
ALJ

medically specific  
easily understood



Experts do  
not *decide*  
violation



- Objective
- Well-informed
- Skilled writer
- Cool-under-fire

## **Knows the Rules and Regulations**

**Concise and easily understood med-leg**

**ulate and composed while giving testi**

**“The expert review is the most critical  
component of our enforcement process.”**

And continued...

**“A well-investigated case can be ruined by a  
poor expert opinion and a well-prepared expert  
review can salvage a poor investigation.”**

# The Chiropractic Expert arguably plays the most critical role in the enforcement process!



Well versed in the rules and regulations  
specific to chiropractic for your State.

Has a firm grasp on clinical  
standards involving examination  
procedures and treatment.

Can detect discrepancies in  
coding and billing.



Chiropractic  
Expert





Appreciates the sensitive nature of sexual boundary complaints, yet handles these cases with clarity and reason.

Has an understanding of statutes regarding advertisements and professional corporations.

Knows federal law such as Medicare, False Claims Act and the Anti-Kickback Statute.



Chiropractic  
Expert

Writes a report that is concise, providing easily understood explanations of technical terms and clinical concepts, and meets the standards of Administrative law.

Articulate and composed while giving testimony.



Chiropractic  
Expert





“Expert witnesses are supposed to be independent analysts, not advocates. The worst accusation you can make against an expert witness is that the expert altered his or her opinion to fit a party’s needs.”

(Lubet, Modern Trial Advocacy (3rd ed. 2004) Expert Testimony, p. 248.)



You are not asked to be an advocate for the Board, the chiropractor, or the patient.

CA BCE



Everyday Chiropractor

Volunteer

## OUR GOAL

Create a framework for selecting the best candidate to serve as Expert Consultant

## OUR METHOD

EXPERT WITNESS FUNDAMENTALS  
DOCUMENTATION  
PROFESSIONAL BOUNDARIES

Christopher Greene, DC, CPCO, CDEO, CPMA

## IDENTIFY STANDARD OF CARE

Except for matters of common knowledge known to a lay person\*, **the standard of care must be established by experts**, not a judge or jury.

(N.N.V. v/ American Assn. of Blood Banks (1995) 75 Cal.App.4th 1358, 1385.)



\*e.g.- surgical instrument/sponge left in the body post-surgery

## STANDARD OF CARE

“That level of skill, knowledge and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent chiropractors in the same or similar circumstances at the time in question.”



# STANDARD OF CARE

- SKILL
- KNOWLEDGE
- CARE
- REASONABLY PRUDENT

## CACI No. 501. Standard of Care for Health Care Professionals

Judicial Council of California Civil Jury Instructions (2022 edition)

### 501. Standard of Care for Health Care Professionals

[A/An] [insert type of medical practitioner] is negligent if [he/she/nonbinary pronoun] fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as "the standard of care."

[You must determine the level of skill, knowledge, and care that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances, based only on the testimony of the expert witnesses [including [name of defendant]] who have testified in this case.]

## EXPERT IN STANDARD OF CARE



It can be a moving target

Influenced by the particulars of a case

## HOW IS STANDARD OF CARE DETERMINED?



- What is customary
- According to risk
- Minimal Competence
- Clinical Practice Guidelines

## EXPERTS STRUGGLE WITH STANDARD OF CARE



58. Neither Dr. [REDACTED] nor Dr. [REDACTED] adequately specified how the standard of care is defined. The statutory and regulatory provisions governing the profession provide specific requirements and prohibitions for the profession. However, these do not exclusively define the standard of care. Given that chiropractors can be disciplined for gross negligence, repeated negligent acts, and incompetence (Cal. Code. Regs., tit. 16, § 317), and since those terms are not defined in the Chiropractic Act, the trier of fact must look beyond the regulations to determine the standard of care. As somewhat



## EXPERTS CAN DEFINE STANDARD OF CARE

- What is customary
- According to risk
- Minimal Competence

## WHAT IS CUSTOMARY?

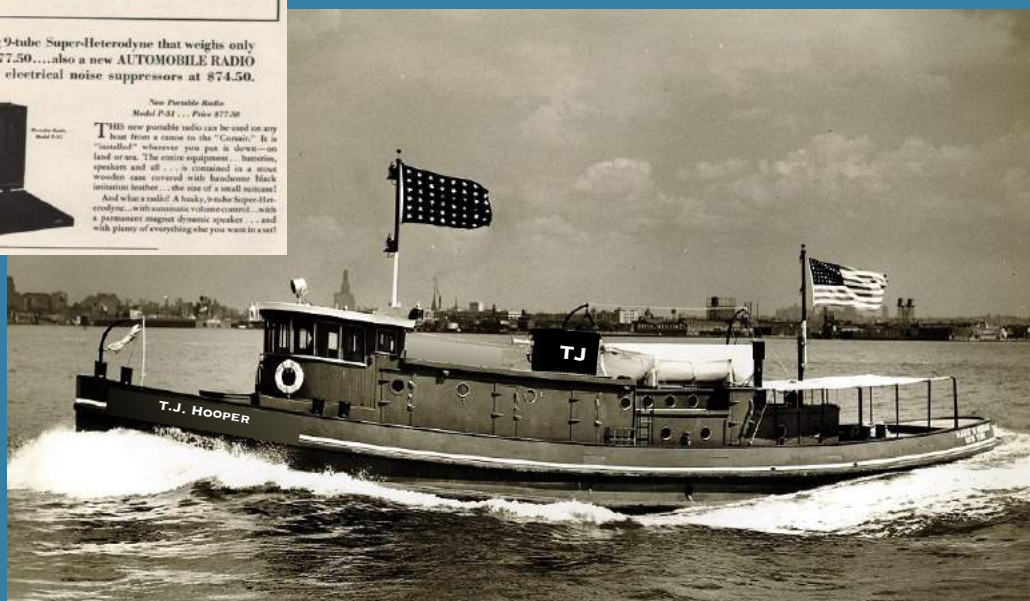
**A Sea-going Radio  
in a "Suitcase"**

A walloping big 9-tube Super-Heterodyne that weighs only 45 pounds at \$77.50....also a new AUTOMOBILE RADIO equipped with electrical noise suppressors at \$74.50.

New Portable Radio  
Model P-31 ... Price \$77.50

Model P-31

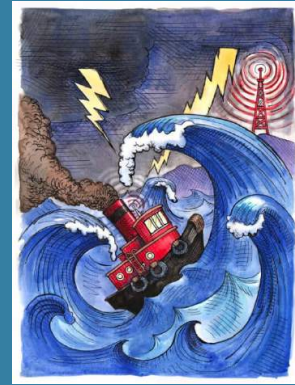
THIS new portable radio can be used on any boat from a canoe to the "Corvette." It is "installed" wherever you put it down--on land or sea. The entire equipment... batteries, speakers and all... is contained in a stout wooden case covered with handsome black imitation leather... the size of a small suitcase! And what a radio! A bawdy, 9-tube Super-Heterodyne... with automatic volume control... with a permanent magnet dynamic speaker... and with plenty of everything else you want in a set!





“In most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.”

The T.J. Hooper, 60 F:2d 737 (2d Cir.), cert. denied, 287 U.S. 662 (1932).  
**PBI**  
EDUCATION



REASONABLE

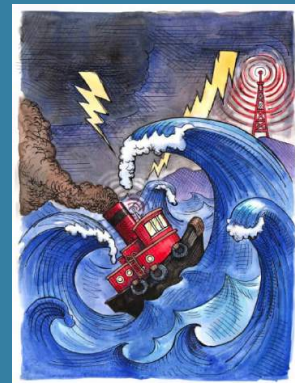
not extreme or excessive,  
moderate, fair,  
practical, sensible

PRUDENCE

caution as to danger or risk,  
alert, heedful,  
circumspect, wary

In other words, if there is a practice that is reasonable but not universally “customary” it may still be used as a measure of standard of care.”

Who decides this “reasonable prudence?” The Courts!



REASONABLE

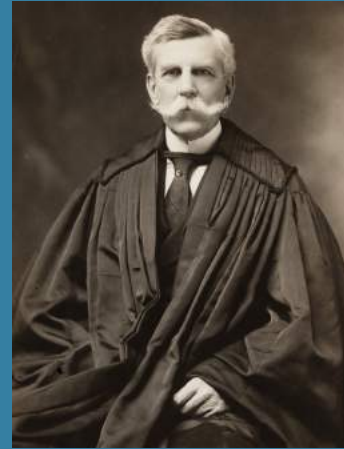
not extreme or excessive,  
moderate, fair,  
practical, sensible

PRUDENCE

caution as to danger or risk,  
alert, heedful,  
circumspect, wary



“What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not.”

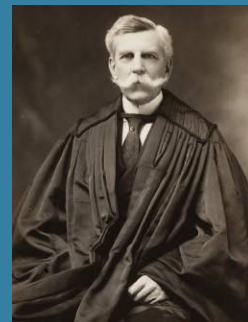


Oliver Wendell Holmes, Jr.



### T.J. Hooper Takeaway

- 1) What is customary DOES NOT necessarily define standard of care.
- 2) Must consider the reasonably prudent chiropractor.



# STANDARD OF CARE

The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by **reasonably prudent** similar health care providers.

FL Statute 766.102



Skill  
Knowledge  
Care  
Reasonably Prudent

Prevailing (amongst) similar  
health care providers  
**SoC = Customary?**



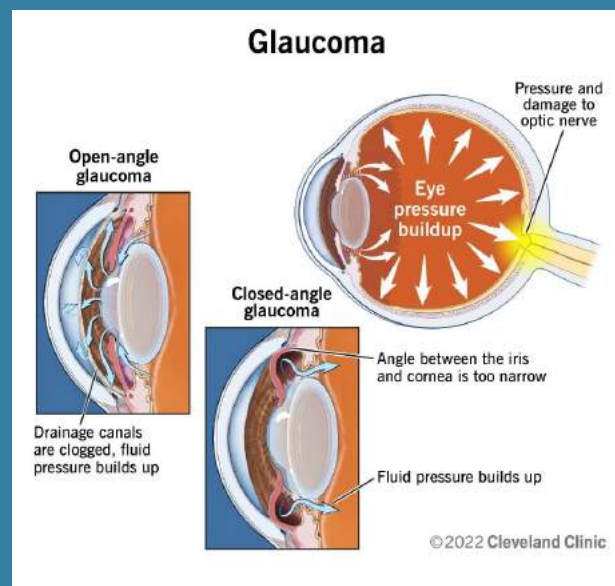
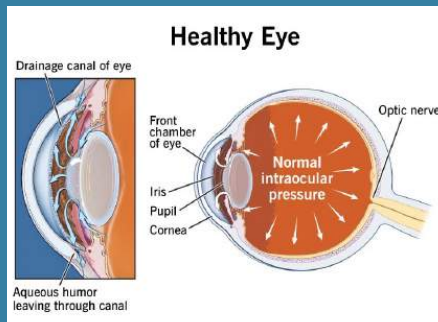
STANDARD OF CARE  
IS NOT CONFINED TO  
CUSTOMARY

A PROFESSION MAY NOT  
HAVE ADOPTED  
REASONABLY PRUDENT  
PRACTICES



## DOES RISK DETERMINE STANDARD OF CARE?

## DOES RISK DETERMINE STANDARD OF CARE?



## Barbara Helling is a patient of Ophthalmologist Dr. Thomas Carey.



PBI  
EDUCATION

1959- Helling (23 y/o) sees Carey for  
nearsightedness.

Fitted with contact lenses (hard).

09/63- Helling sees Carey with CC of  
eye irritation due to contacts.

Additional visits for the same  
complaint (irritation due to contact  
lenses):

10/63, 02/67, 09/67, 10/67, 05/68,  
07/68, 08/68, 09/68, 10/68.

### NORMAL VISION



10/68 Dr. Carey performs eye-  
pressure test (Tonometry) and  
field of vision for the first time.  
Helling is diagnosed with  
glaucoma: lost all peripheral  
vision and some central vision.  
Helling is now 32 y/o.



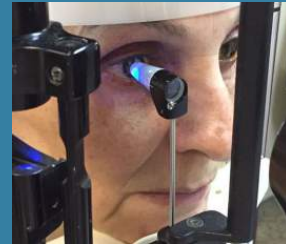
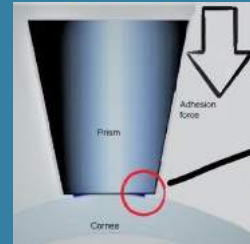
### GLAUCOMA

PBI  
EDUCATION

## COMPLAINT FILED CLAIMING NEGLIGENCE

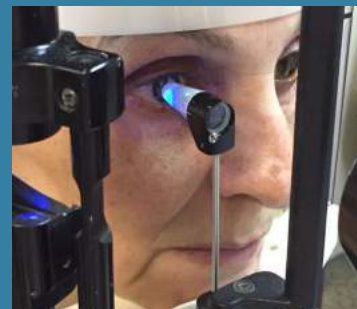
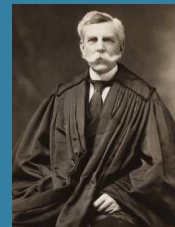
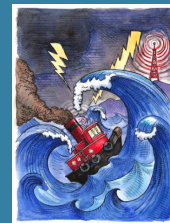
Experts for both sides confirm the professional standard in similar circumstances (32 y/o) do not require routine tonometry for glaucoma under the age of 40 due to the rare occurrence in this group (1/25,000).

**Defense verdict goes to appeals  
and is affirmed.**



## WASHINGTON SUPREME COURT **REVERSES** FINDS FOR HELLING

Citing T.J. Hooper and O.W. Holmes, the court determined that even though the professional standards had been followed, because testing was inexpensive and harmless, it should have been offered.





## HELLER TAKEAWAY

- 1) The high bar of reasonably prudent.
- 2) Cost and ease determine what is reasonably prudent.

### REASONABLE

not extreme or  
excessive,  
moderate, fair,  
practical, sensible  
and...  
inexpensive.



## THE HIGH BAR OF REASONABLY PRUDENT

WASHINGTON STATE LEGISLATURE

RCWs > Title 4 > Chapter 4.24 > Section 4.24.290

4.24.264 << 4.24.290 >> 4.24.300

PDF RCW 4.24.290

**Action for damages based on professional negligence of hospitals or members of healing arts—Standard of proof—Evidence—Exception.**

In any civil action for damages based on professional negligence against a hospital which is licensed by the state of Washington or against the personnel of any such hospital, or against a member of the healing arts including, but not limited to, an acupuncturist or acupuncture and Eastern medicine practitioner licensed under chapter 18.06 RCW, a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a chiropractor licensed under chapter 18.25 RCW, a dentist licensed under chapter 18.32 RCW, a podiatric physician and surgeon licensed under chapter 18.22 RCW, or a nurse licensed under chapter 18.79 RCW, the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession, and that as a proximate result of such failure the plaintiff suffered damages, but in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.

[ 2019 c 308 § 15; 2010 c 286 § 12; 1995 c 323 § 2; 1994 sp.s. c 9 § 702; 1985 c 326 § 26; 1983 c 149 § 1; 1975 1st ex.s. c 35 § 1.]

## DOES RISK DETERMINE STANDARD OF CARE?



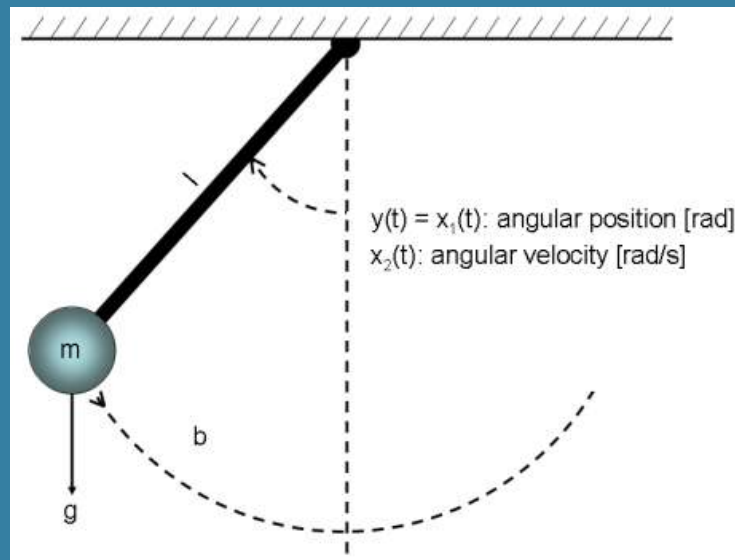
MAYBE  
(risk vs. cost)

**EXPERT MUST KNOW SoC FOR THEIR STATE**

## DOES “MINIMAL COMPETENCE” DETERMINE STANDARD OF CARE?



## FROM HELLING TO HALL



- Pt. has surgery.
- Abdominal pain and abnormal vitals through the night.
- Pt. dies the next morning.
- Staff did not notify the surgeon of pain and vitals (no instructions were given).
- Surgeon did not check on pt.

PT: Hall  
DX: Bowel  
Obstruction

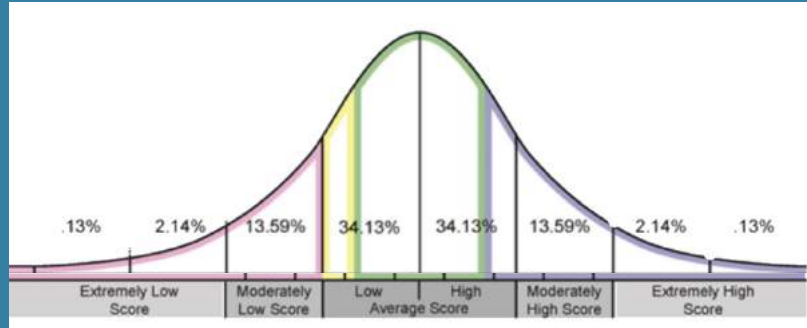
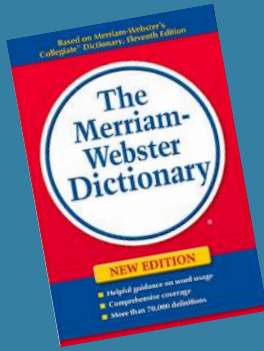


By James Heilman, MD - Own work, CC BY-SA 3.0.  
<https://commons.wikimedia.org/w/index.php?curid=8384519>

COURT DECISION:  
Failure to meet SoC

Chief Justice C.J. Robertson stated:  
to use minimally sound medical judgment and render m

e in diagnosing a condition is that which would be exercis  
an is not required to guarantee results. He undertakes onl



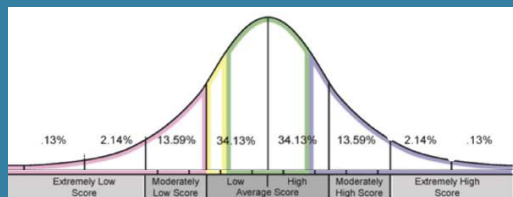
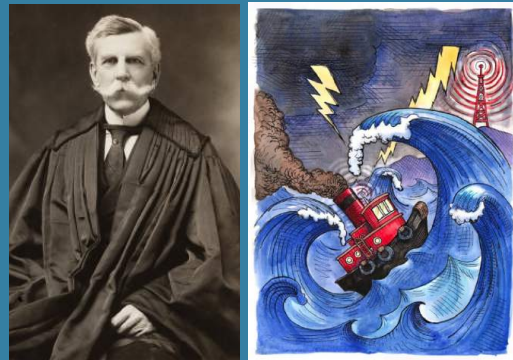
Competent-  
Acceptable and  
satisfactory,  
though not  
outstanding.

- Use minimally sound medical judgment.
- Render minimally competent care.
- Exercised by competent practitioners.
- Skill possessed generally by other practitioners.

## THE CHIROPRACTIC EXPERT

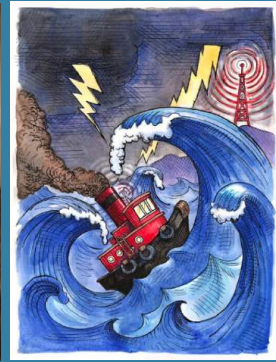
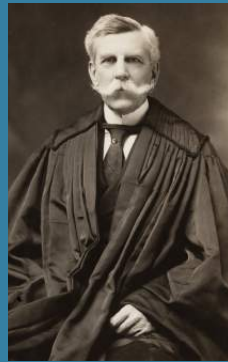
Skilled at explaining  
the basis for Standard of Care  
(i.e, the “how and why” of their  
definition)

- **Customary vs. Prudent**  
T.J Hooper
- **High bar of Risk**  
Heller-Glaucoma/Tonometry
- **Minimally Competent**  
Grading on a curve

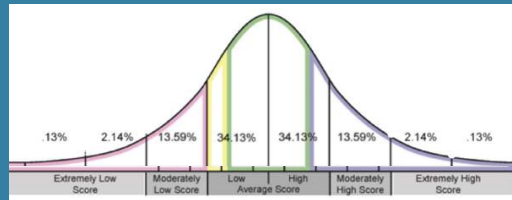


# THE CHIROPRACTIC EXPERT

Takes into consideration  
historical views on  
Standard of Care



PBI  
EDUCATION

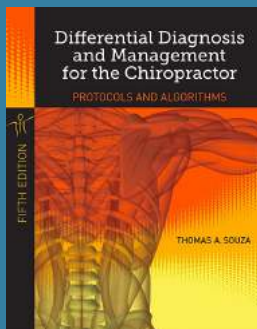


# THE CHIROPRACTIC EXPERT

Cites Sources  
Explains Relevance



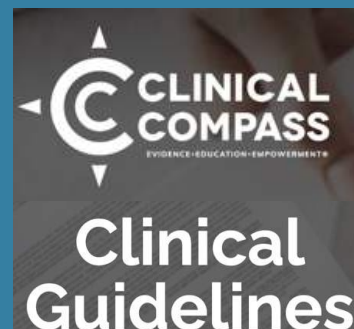
Texts



Journals



CPG's



PBI  
EDUCATION

# DO CPG's DETERMINE STANDARD OF CARE?



## CLINICAL PRACTICE GUIDELINES

# DO CPG's DETERMINE STANDARD OF CARE?

“systematically  
developed statements to  
assist practitioner and  
patient decisions about  
appropriate health care  
for specific clinical  
circumstances”

- Algorithms
- Practice Parameters
- Clinical Pathways

Noah L: Medicine's epistemology: mapping the haphazard  
diffusion  
of knowledge in the biomedical community. Ariz Law Rev  
44:373- 466, 2002

Field MJ, Lohr KN (editors): Institute of Medicine: Clinical  
Practice Guidelines: Directions for a New Program.  
Washington, DC: National Academy Press, 1990



## CLINICAL PRACTICE GUIDELINES



# CPG PUSHBACK



Federal Rules of Evidence

Relevance - Rule 702

Heresay - Rule 801/803

Explain how the CPG  
helps to define SoC

Ensure conclusions are  
supported by the CPG.

## EXPERTS MUST BE PREPARED TO EXPLAIN

# **POOR** RELIABILITY

PROCESS OF CARE- the clinical process  
many paths can lead to a positive outcome

“The consistency and reliability of  
opinions between (peer) reviewers  
has been shown to be poor.”

Smith MA, Atherly AJ, Kane RL, Pacala JT. Peer review of the quality of care:  
reliability and sources of variability for outcome and process assessments.  
JAMA 1997;278:1573-8

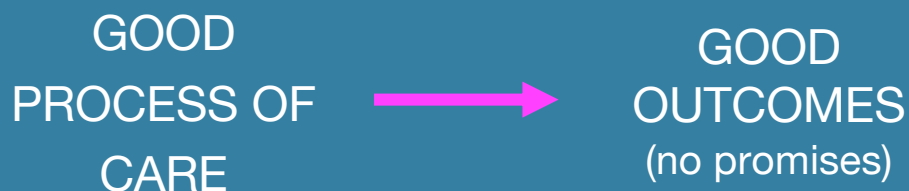
## CLINICAL EXPERTISE fused with EVIDENCE BASED MEDICINE

“Good doctors use both individual clinical expertise and the best available external evidence and neither alone is enough. Without **clinical expertise**, practice risks becoming tyrannized by external evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without **current best external evidence**, practice risks becoming rapidly out of date, to the detriment of patients.”

Sackett DL. Evidence-based medicine. Semin Perinatol 1997;21:3-5

## STANDARD OF CARE

### CLINICAL EXPERTISE fused with EVIDENCE BASED MEDICINE\*





# STANDARD OF CARE

CLINICAL EXPERTISE  
fused with  
EVIDENCE BASED MEDICINE\*

DUE  
PROCESS

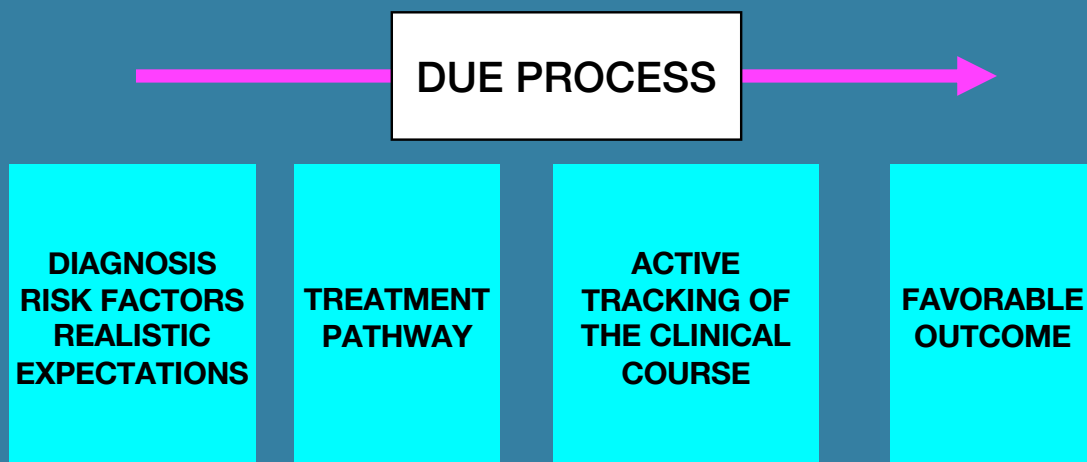


FAVORABLE  
OUTCOMES  
(no promises)

“Where due process has been followed, then provider decision making should not be questioned.”

# STANDARD OF CARE

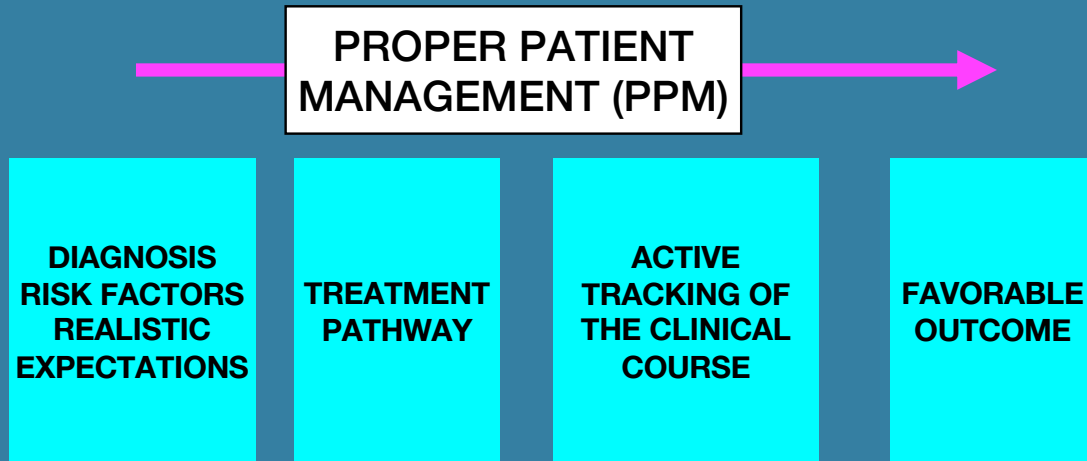
CLINICAL EXPERTISE + EBM



“Where due process has been followed, then provider decision making should not be questioned.”

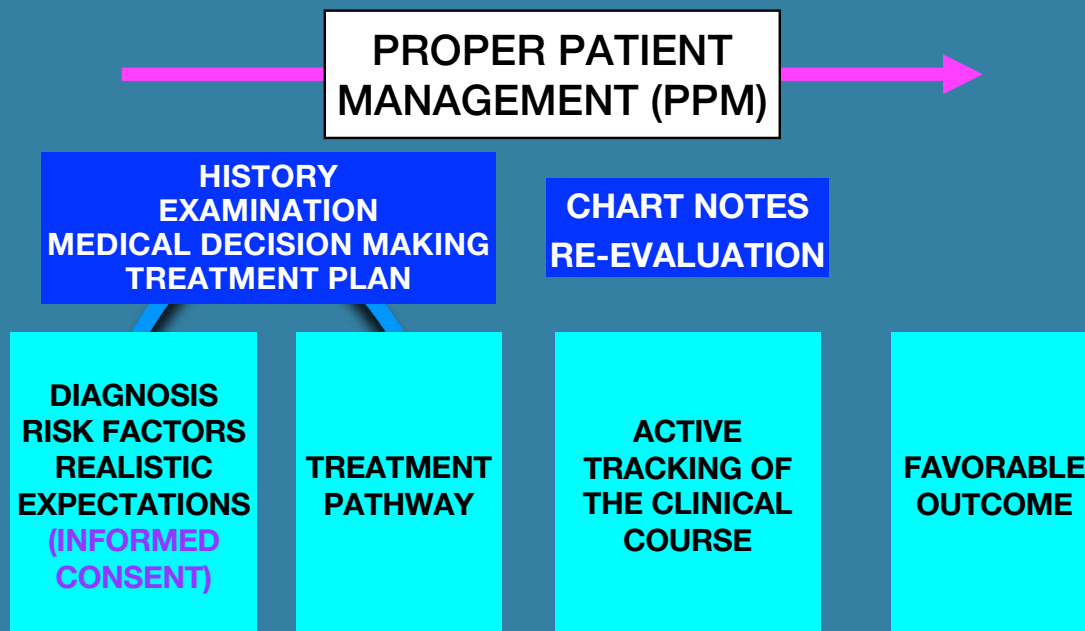
# STANDARD OF CARE

CLINICAL EXPERTISE + EBM\*



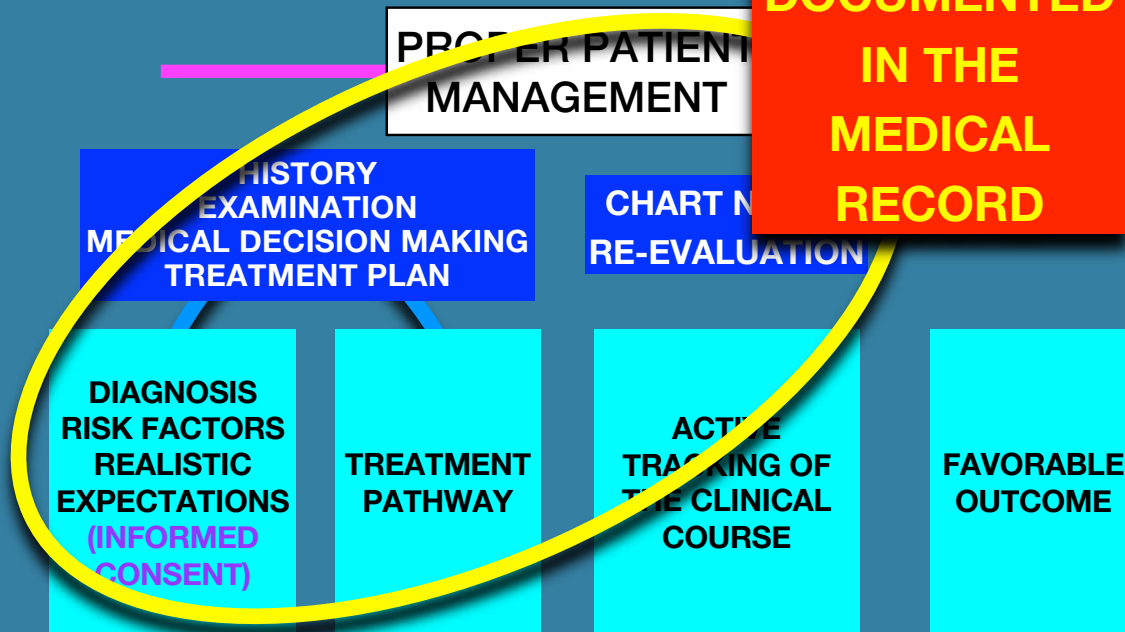
“Where due process (PPM) has been followed, then provider decision making should not be questioned.”

# STANDARD OF CARE



“Where due process (PPM) has been followed, then provider decision making should not be questioned.”

# STANDARD OF CARE



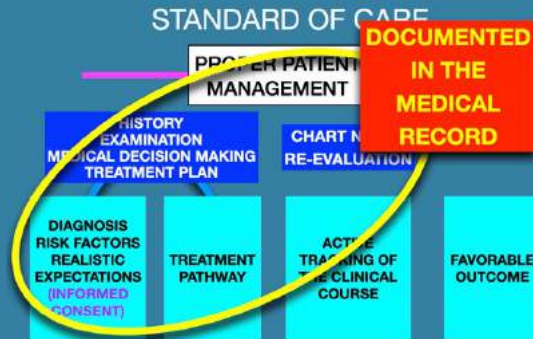
“Where due process (PPM) has been followed, then provider decision making should not be questioned.”

## The Value of CPG's



- Multiple treatment paths can be supported by CPG's
- Good doctors balance clinical experience with best evidence
- If PPM is demonstrated, provider decision making should not be questioned
- Proper patient management is found in the medical record

## Strike or Ball?



## Proper Patient Management?



## THE CHIROPRACTIC EXPERT is a DOCUMENTATION EXPERT

PPM IS FOUND  
IN THE  
**MEDICAL  
RECORD**  
aka  
DOCUMENTATION

- HISTORY
- EXAMINATION
- RISK FACTORS
- DIAGNOSIS
- TREATMENT PLAN
- INFORMED CONSENT
- CHART NOTES
- RE-EVALUATION



THE CHIROPRACTIC EXPERT *EDUCATES*

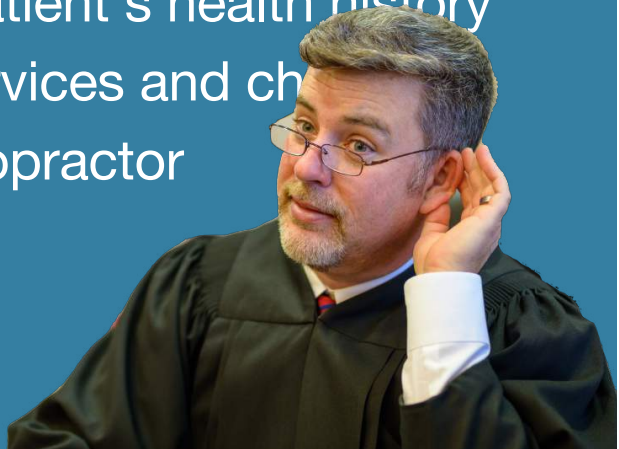
## WHAT IS THE MEDICAL RECORD?

1. Chronicles the patient's health history
2. Substantiates services and charges
3. Protects the chiropractor

THE CHIROPRACTIC EXPERT *EDUCATES*

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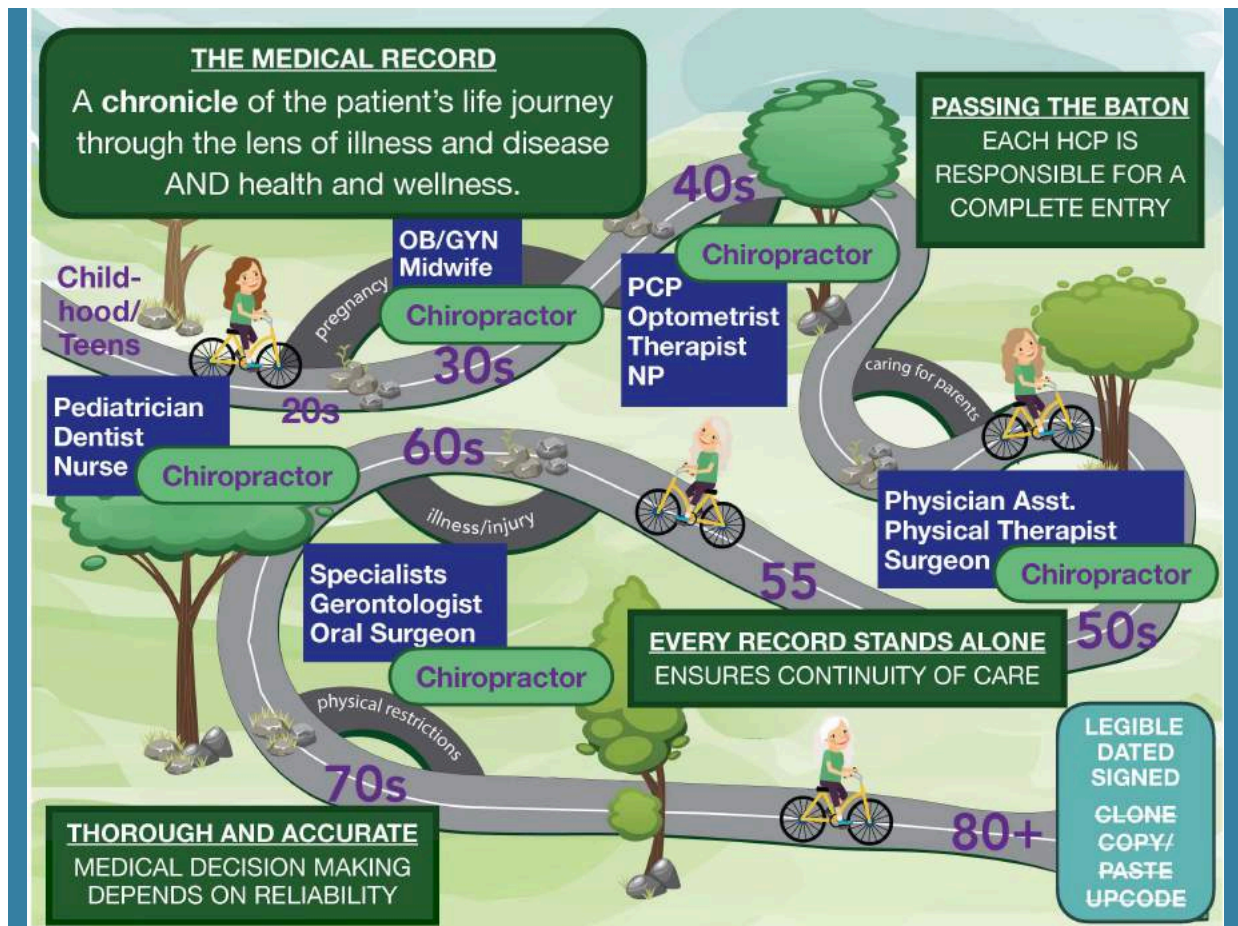
# THE CHIROPRACTIC EXPERT *EDUCATES*

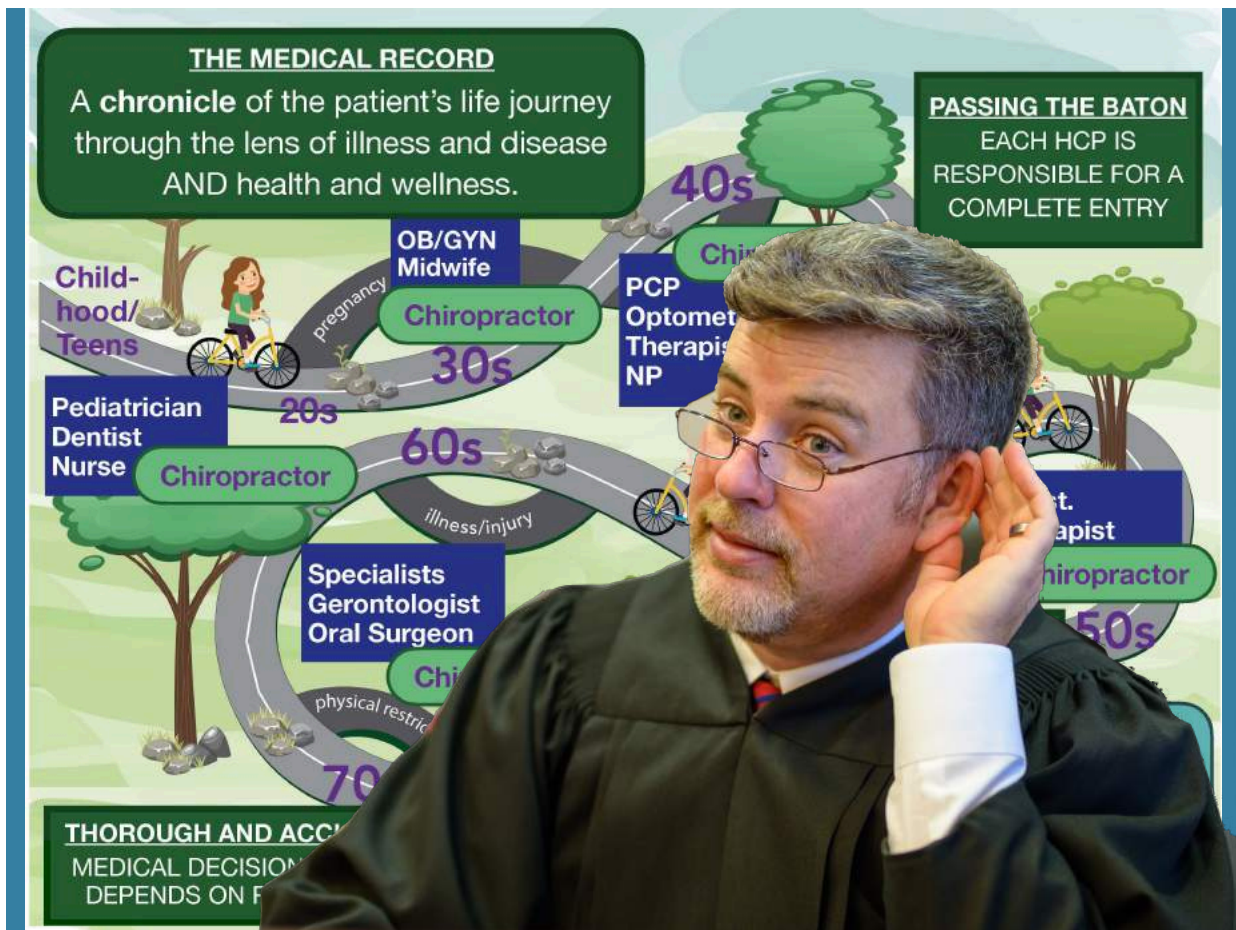
## WHAT IS THE MEDICAL RECORD?

### 1. CHRONICLES THE PATIENT'S HEALTH HISTORY

— *MY HEALTHCARE STORY* —

A chronicle of a patient's life-journey through the lens of illness and disease *and* health and wellness.





## THE CHIROPRACTIC EXPERT *EDUCATES*

# IS THE MEDICAL RECORD SO IMPORTANT?

### 1. CHRONICLES THE PATIENT'S HEALTH HISTORY

The succession of HCP's in a patient's life rely on accurate and complete entries — Medical Decision Making (MDM).



THE CHIROPRACTIC EXPERT *EDUCATES*

# WHAT IS THE MEDICAL RECORD?

## 2. SUBSTANTIATES SERVICES AND CHARGES

Medically Necessary - Acute/Active Treatment  
Clinically Appropriate - Maintenance/Wellness

**IRRESPECTIVE OF PHASE OF CARE,  
THE MEDICAL RECORD MUST BE COMPLETE**

THE CHIROPRACTIC EXPERT *EDUCATES*

# WHAT IS THE MEDICAL RECORD?

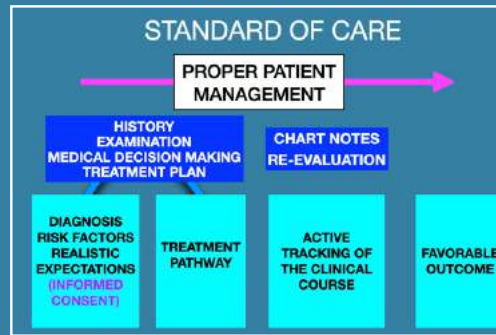
## 2. SUBSTANTIATES SERVICES AND CHARGES

Personal Injury, Work Comp, Insurance, Medicare  
**CASH**

**IRRESPECTIVE OF REIMBURSEMENT,  
THE MEDICAL RECORD MUST BE COMPLETE**

# WHAT IS THE MEDICAL RECORD?

## 3. Protects the Chiropractor (Demonstrates Proper Patient Management)



- Excessive Tx.
- Negligence
- Fraud
- Boundaries

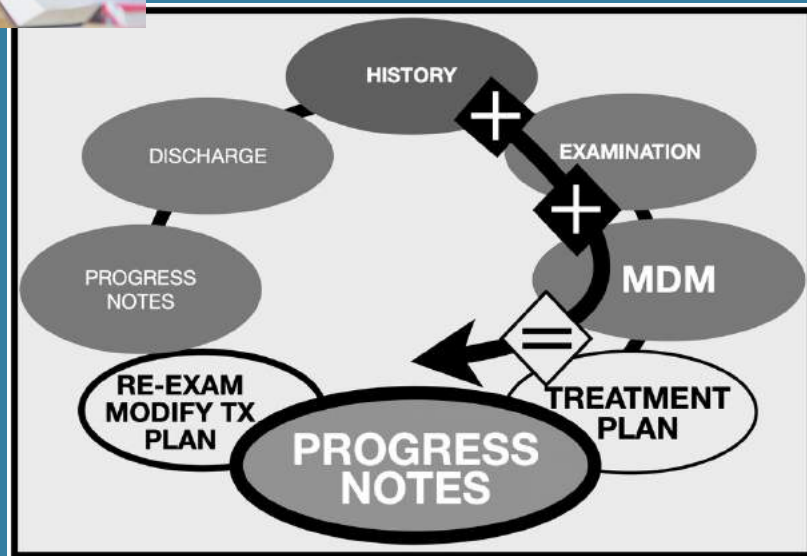
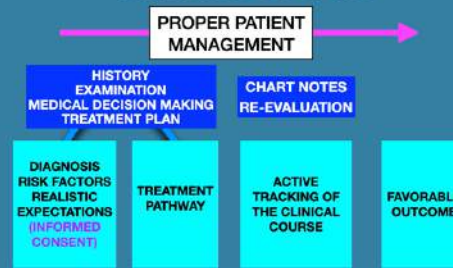
# WHAT IS THE MEDICAL RECORD?

What should be there?

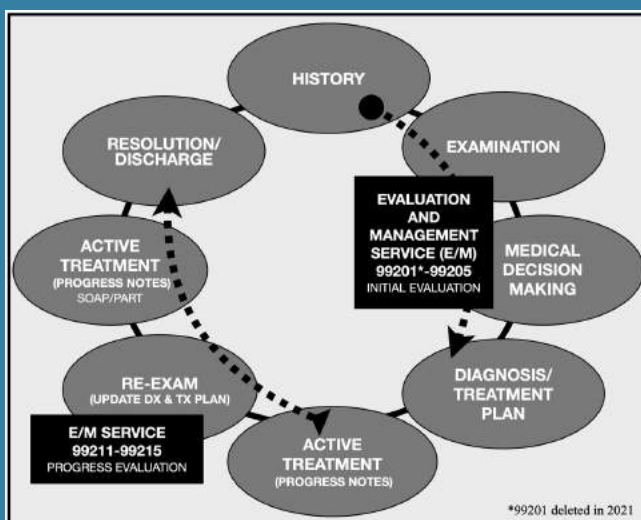
State Regulation or Minimum Required



## STANDARD OF CARE



## E/M Services Required Elements

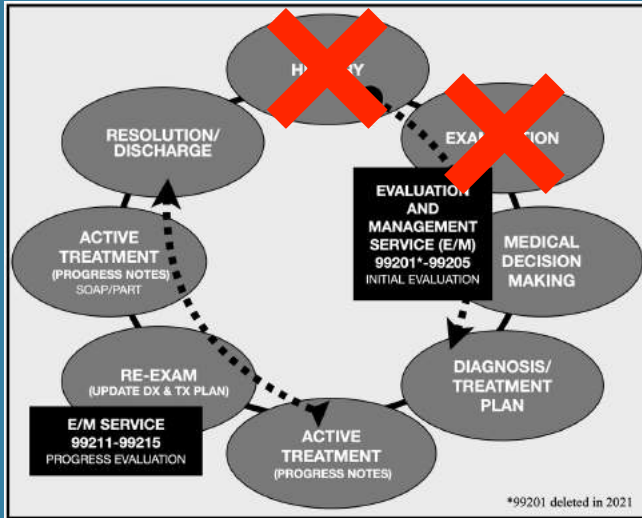


(if it isn't documented, it didn't happen)

History  
Examination  
MDM



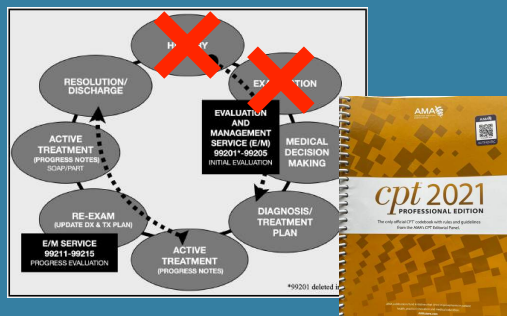
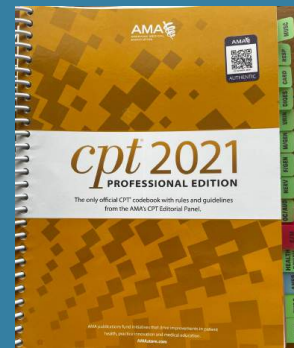
## E/M Services Required Elements



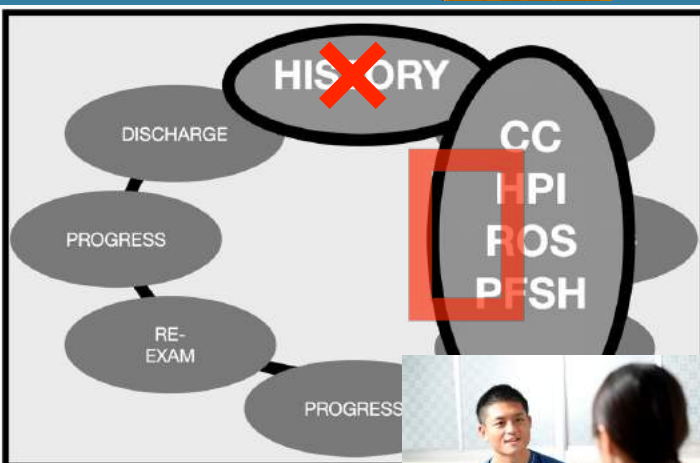
(if it isn't documented, it didn't happen)

BIG change in 2021

History  
Examination  
MDM



**HISTORY AND  
EXAMINATION  
ARE NOT  
REQUIRED?!**



- Chief Complaint
- HPI (OPQRST)
- Review of Systems
- Personal, Family, Social History





Prior Guidelines were burdensome!

PPM necessitates History and Examination. (explain abnormal findings)

MDM is the focal point.

## WHAT IS MEDICAL DECISION MAKING (MDM)?

...oses, assessing the status of a condition, and/c

## MDM IS DEFINED BY THREE ELEMENTS

(level of MDM e.g., 99202, 99203, etc.)

1. The number of possible diagnoses and/or the number of management options that must be considered.
2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.
3. The risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.



BIG change in 2021

E/M Services  
Required Elements

History  
Examination  
MDM

### Elements of Medical Decision Making

CODE	LEVEL OF MDM (Based on 2 out of 3 elements of MDM)	NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED (DIAGNOSES)	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED	RISK OF SIGNIFICANT COMPLICATIONS AND/OR MORBIDITY, OR MORTALITY OF PATIENT MANAGEMENT
99202 new* 99212 established	Straightforward	Minimal	Minimal or None	Minimal
99203 new* 99213 established	Low	Low	Limited	Low
99204 new* 99214 established	Moderate	Multiple	Moderate	Moderate
99205 new* 99215 established	High	High	Extensive	High

\* new- 3 years by same HCP or similar  
HCP (specialists) in the same group

99211-  
Minimal Problem





E/M Services  
Required Elements

BIG change in 2021

History  
Examination  
MDM

### Elements of Medical Decision Making

CODE	LEVEL OF MDM (Based on 2 out of 3 elements of MDM)	NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED (DIAGNOSES)	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED	RISK OF SIGNIFICANT COMPLICATIONS AND/OR MORBIDITY, OR MORTALITY OF PATIENT MANAGEMENT
99202 99212	Straightforward	Minimal 1 self-limited or minor problem	Minimal or None	Minimal risk of morbidity from additional diagnostic testing or treatment

### Elements of Medical Decision Making

CODE	LEVEL OF MDM (Based on 2 out of 3 elements of MDM)	NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED (DIAGNOSES)	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED	RISK OF SIGNIFICANT COMPLICATIONS AND/OR MORBIDITY, OR MORTALITY OF PATIENT MANAGEMENT
99203 99213	Low	<b>Low</b> <ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems; or</li> <li>• 1 stable chronic illness; or</li> <li>• 1 acute, uncomplicated illness or injury</li> </ul>	<b>Limited</b> (must meet the requirements of at least 1 of the 2 categories) <b>Category 1:</b> Tests and Documents Any combination of 2 from the following: -Review of prior external note(s) from each unique source; -review of result(s) of each unique test; -ordering of each unique test; <b>Category 2:</b> Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	<b>Low</b> Low risk of morbidity from additional diagnostic testing or treatment

## Elements of Medical Decision Making

CODE	LEVEL OF MDM (Based on 2 out of 3 elements of MDM)	NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED (DIAGNOSES)	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED	RISK OF SIGNIFICANT COMPLICATIONS AND/OR MORBIDITY, OR MORTALITY OF PATIENT MANAGEMENT
99204 99214	Moderate	<b>Moderate</b> 1 or more chronic illnesses w/exacerbation, progression, or side effects of treatment; OR - 2 or more stable chronic illnesses; OR - 1 undiagnosed new problem with uncertain prognosis; OR - 1 acute illness with systemic symptoms; OR - 1 acute complicated injury.	<b>Moderate</b> (must meet the requirements of at least 1 of 3 categories) <b>Category 1:</b> Tests/documents or independent historian(s) Any combination of 3 from the following: -Review of prior external note(s) from each unique source; -Review of result(s) of each unique test; -Ordering of each unique test; -Assessment requiring an independent historian(s) OR <b>Category 2:</b> Independent interpretation of tests; -Independent interpretation of a test performed by another physician/other qualified HCP (not separately reported); OR <b>Category 3:</b> Discussion of management or test interpretation. -Discussion of management or test interpretation with external physician/other qualified HCP/appropriate source (not reported separately).	<b>Moderate</b> Moderate risk of morbidity from additional diagnostic testing or treatment. Examples only: -Prescription drug management. -Decision regarding minor surgery with identified patient or procedure risk factors. -Decision regarding elective major surgery without identified patient or procedure risk factors. -Diagnosis or treatment significantly limited by social determinants of health.

## Elements of Medical Decision Making

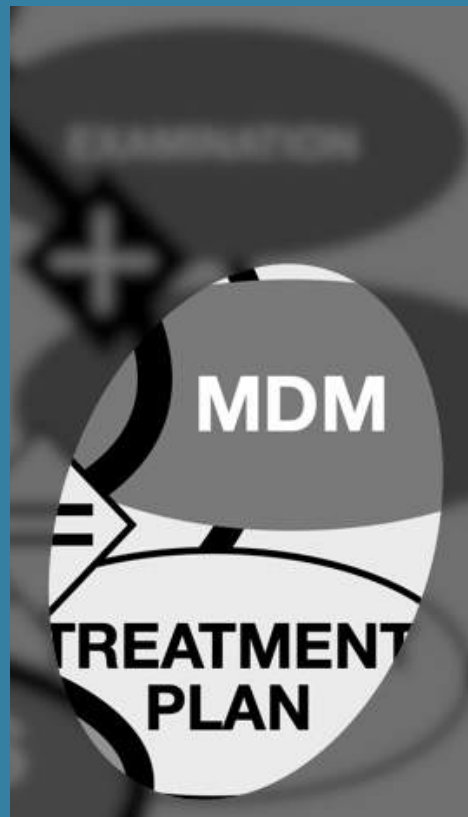
CODE	LEVEL OF MDM (Based on 2 out of 3 elements of MDM)	NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED (DIAGNOSES)	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED	RISK OF SIGNIFICANT COMPLICATIONS AND/OR MORBIDITY, OR MORTALITY OF PATIENT MANAGEMENT
99205 99215	High	<b>High</b> 1 or more chronic illnesses w/severe exacerbation, progression, or side effects of treatment; OR 1 acute or chronic illness or injury that poses a threat to life or bodily function	<b>Extensive</b> (must meet the requirements of at least 2 of 3 categories) <b>Category 1:</b> Tests/documents or independent historian(s) Any combination of 3 from the following: -Review of prior external note(s) from each unique source; -Review of result(s) of each unique test; -Ordering of each unique test; -Assessment requiring an independent historian(s) OR <b>Category 2:</b> Independent interpretation of tests; -Independent interpretation of a test performed by another physician/other qualified HCP (not separately reported); OR <b>Category 3:</b> Discussion of management or test interpretation. -Discussion of management or test interpretation with external physician/other qualified HCP/appropriate source (not reported separately).	<b>High</b> High risk of morbidity from additional diagnostic testing or treatment.

## WHAT IS A TREATMENT PLAN?

Treatment plan derived from a clinically appropriate History, Exam and MDM.



PBI  
EDUCATION



Treatment plan derived from a clinically appropriate History, Exam and MDM.

### EXPLAIN THE PLAN

- What we expect to find
- How we get there (how long it will take)
- Likelihood of getting there
- Alternative routes
- Possible hazards (risks)



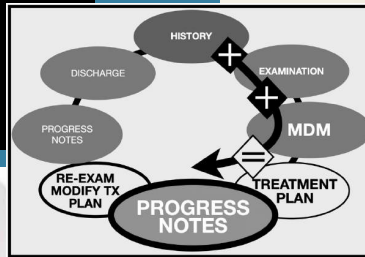
PBI  
EDUCATION

## 5 BEDROCK ELEMENTS OF INFORMED CONSENT

1. NATURE OF THE AILMENT
2. NATURE OF PROPOSED TREATMENT
3. PROBABILITY OF SUCCESS
4. ALTERNATIVE TREATMENTS/OPTIONS
5. DISCLOSURE OF RISK



Berg, J., Appelbaum, P., Lidz, C., Parker, L. (2001). Informed Consent: Legal Theory and Clinical Practice-Second Edition. New York, NY: Oxford University Press. Pg. 46.

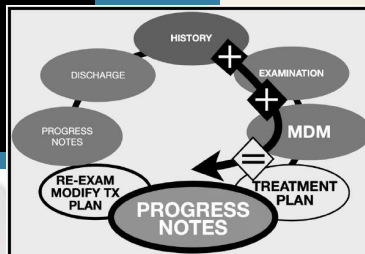


## 5 BEDROCK ELEMENTS OF INFORMED CONSENT

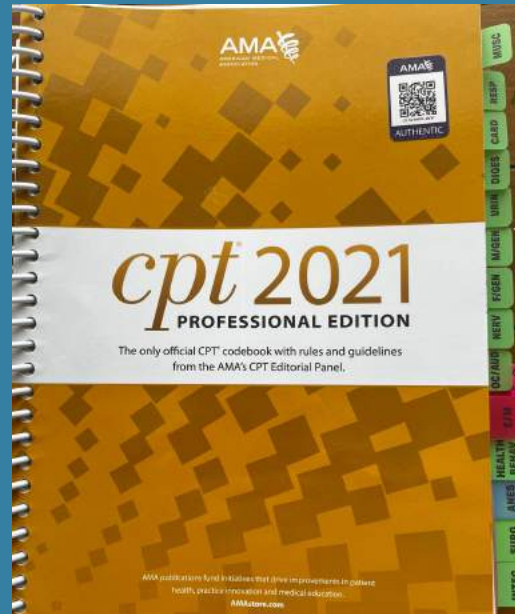
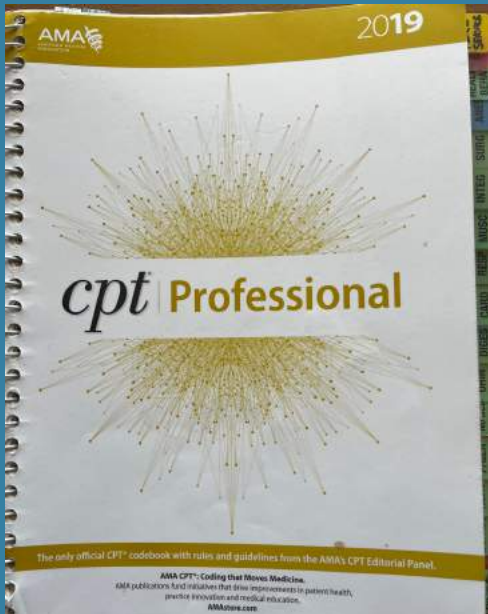
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Berg, J., Appelbaum, P., Lidz, C., Parker, L. (2001). Informed Consent: Legal Theory and Clinical Practice-Second Edition. New York, NY: Oxford University Press. Pg. 46.



The expert must know rules and regs in force at the time services were rendered.



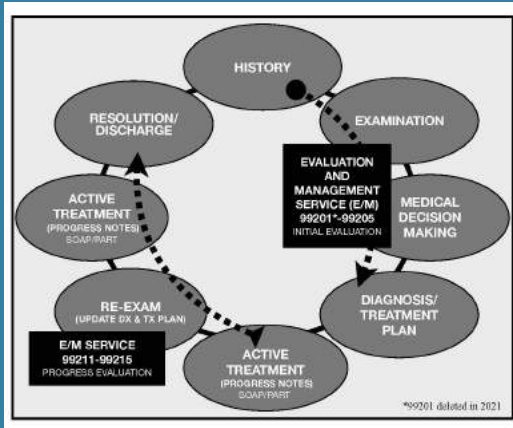
## WHAT IS THE MEDICAL RECORD?

What should be there?

State Regulation or Minimum Required



## REASONABLE and NECESSARY



## MEDICARE

Reason for encounter  
History, findings  
Diagnosis  
Plan of care  
Supports claim (level of service)  
Identifies provider  
Progress notes detailed  
Dated and signed by provider

### Rule 22 - COLORADO

Documentation of the patient's health history, presenting complaint(s), progression of care, diagnosis, prognosis and treatment plan must be reflected in the record keeping and written reports of the patient file. Records are required to be contemporaneous, legible, utilize standard medical terminology or abbreviations, contain adequate identification of the patient, contain adequate identification of the provider of service and indicate the date the service was performed. All professional services rendered during each patient encounter should be documented. Any addition or correction to the patient file after the final form shall be signed and dated by the person making the addition or correction. The following minimum components must be documented within the patient file:



## A. Initial Patient Visit:

### 1. History:

- Chief complaint(s) described in terms of onset, provocative, palliative, quality, radiation, setting, and timing.
- Surgical, hospitalization, past/recent illness, trauma, family, social, past/recent system review, and past/recent allergies.
- Non-prescription, prescription, botanical, homeopathic medicines, and vitamin supplements.
- A reasonable effort should be made to obtain and review pertinent records as clinically indicated from other health care providers, imaging facilities, or laboratories.

### 2. Examination:

- Vital signs as clinically indicated.
- Document examinations or tests ordered or performed and the results of each as necessitated by the patient's clinical presentation consistent with common healthcare practices.
- Document examinations of neuromusculoskeletal conditions using a format of inspection, palpation, neurological testing, range of motion, and orthopedic testing.
- Document prognosis and/or outcome expectations.
- When clinically indicated, treatment options/alternatives should be documented.
- When referring to another healthcare provider, correspondence may be provided for patient care coordination.

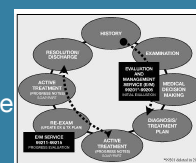


## B. Established Patient Visit:

- Subjective Complaint:** The patient's description of complaints should be recorded at each visit indicating improvement, worsening, or no change.
- Objective Findings:** Changes in the clinical signs of a condition should be described by the chiropractor at each visit.
- Assessment or Diagnosis:** It is not necessary to update this category at each visit. However, periodic clinical re-evaluations should be performed, specifically documented and recorded in the daily entries. Changes in the patient's diagnosis should be recorded in the daily entries when clinically indicated. Prognosis and/or outcome expectations should be updated periodically consistent with the clinical presentation.
- Plan of Management:** A provisional plan of management should be recorded initially and further entries should be made as this plan is modified and/or as a patient enters a new phase of treatment or has a diagnosis change. Changes in procedures should be documented and based on clinical assessment and reasoning.
- Procedures:** Daily recording of procedures performed should include a description of type and location of procedure. Units of time should be recorded when appropriate.

## C. Ancillary Documentation:

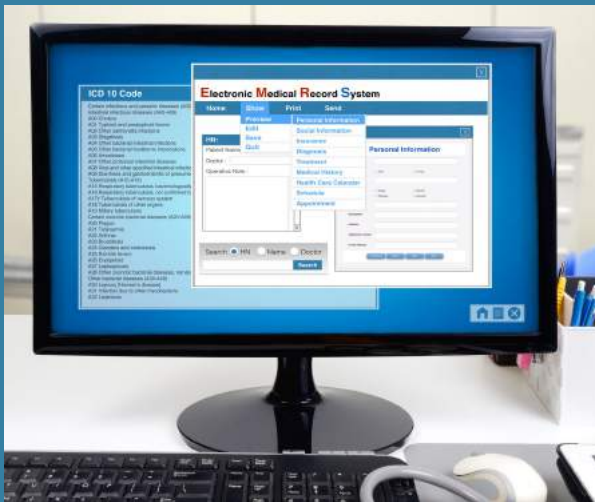
- Correspondence sent and received.
- Specialty reports (diagnostic imaging, laboratory results, nerve conduction studies, etc.).
- Communications (telephone conversations, dialogue with patient guardian or other healthcare providers).



# WHAT IS THE MEDICAL RECORD?

ELECTRONIC

## EHR's



- Cloning
- Copy/paste-SALT
- Drop-downs
- Autofill
- Note Bloat
- Dilutes the record
- Fraud

EHR's- It's documented but did it happen?

(if it isn't documented, it didn't happen)



## DOCUMENTATION CONCLUSION:

1) Proper Patient Management (Due Process) is a central question the Expert must determine. Failure to meet a minimum threshold is failure to meet Standard of Care.

2) Proper Patient Management is found in the medical record.

3) Medical Record = MDM, Tx Plan, Progress notes/re-exams, Informed Consent

\*\*Documentation Expertise is essential in determining Standard of Care



## DOCUMENTATION CONCLUSION:

4) EHR's have certain features that increase the chance for unreliable documentation: cloning, copy/paste, drop-downs, autofill, SALT, note bloat.

5) EHR's introduce the ability to create documentation that can give the appearance of a legitimate patient encounter, allowing for fraud and abuse.

\*\*Understanding the nuances of EHR's is essential in detecting fraud and dishonesty.

The Chiropractic Expert arguably plays  
the most critical role in the enforcement  
process!



**“A well-investigated case can be ruined by a  
poor expert opinion and a well-prepared expert  
review can salvage a poor investigation.”**

## OUR GOAL

Create a framework for selecting the best candidate to serve as Expert Consultant

## OUR METHOD

EXPERT WITNESS FUNDAMENTALS  
DOCUMENTATION  
PROFESSIONAL BOUNDARIES

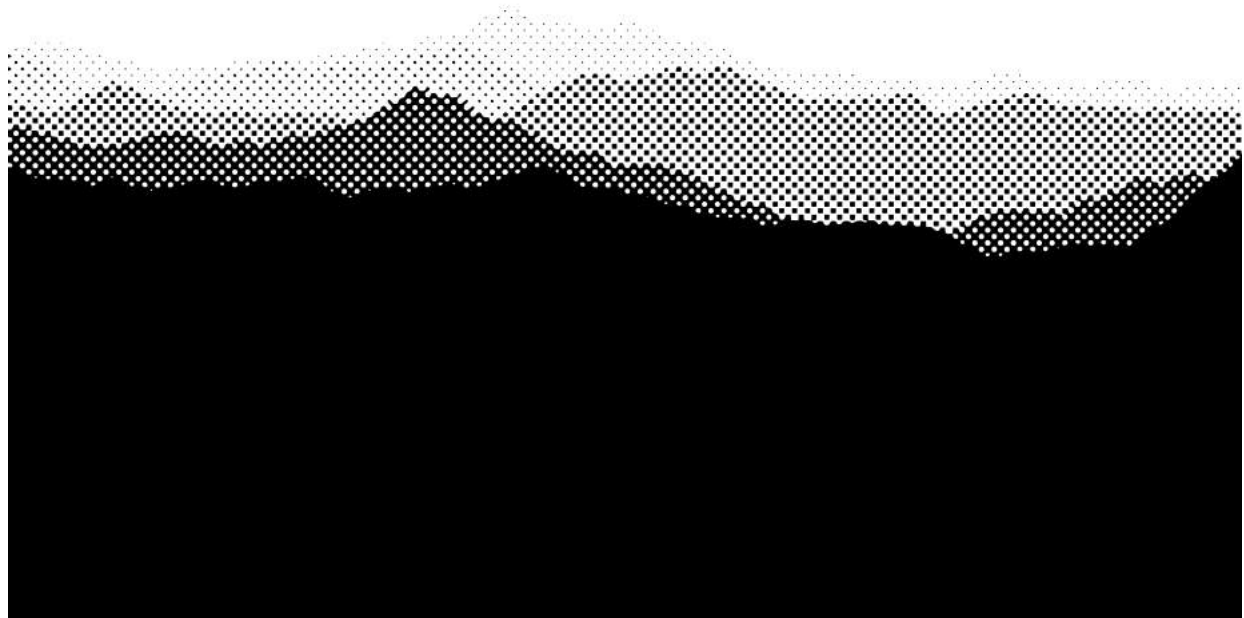
Christopher Greene, DC, CPCO, CDEO, CPMA



CHIROPRACTIC EXPERT FUNDAMENTAL #2

PROFESSIONAL BOUNDARIES





EXPERT OPINION ON INTERPERSONAL BEHAVIOR  
—  
THE CHALLENGE OF SUBJECTIVE ASSESSMENT





# FOUNDATION OF PROFESSIONAL BOUNDARIES

# FOUNDATION OF PROFESSIONAL BOUNDARIES

- 1) WHAT ARE BOUNDARIES?
- 2) WHY ARE PROFESSIONAL BOUNDARIES DIFFERENT?
- 3) HOW DO BOUNDARY VIOLATIONS HAPPEN?

## Question #1 What are boundaries?

## Question #1 What are boundaries?



## Question #1 What are boundaries?



Where I end and you begin

## Question #1 What are boundaries?

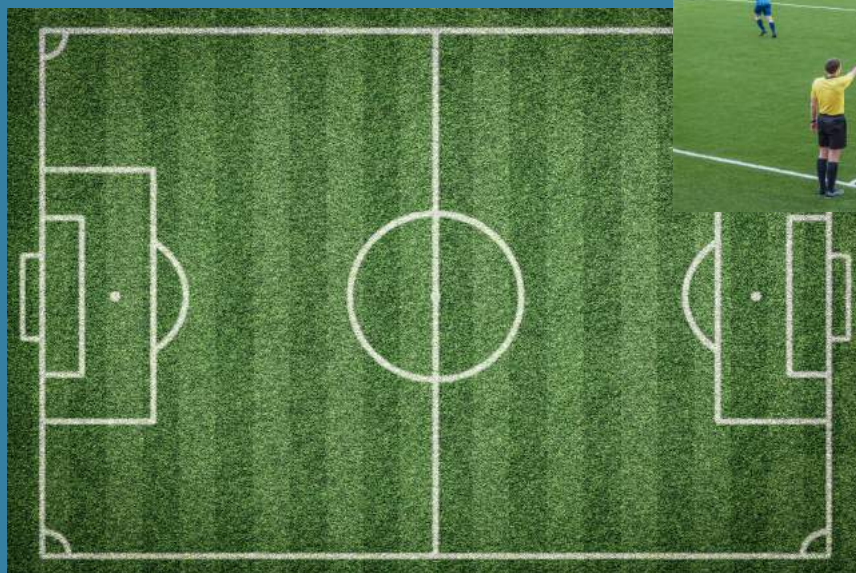


## Question #1 What are boundaries?



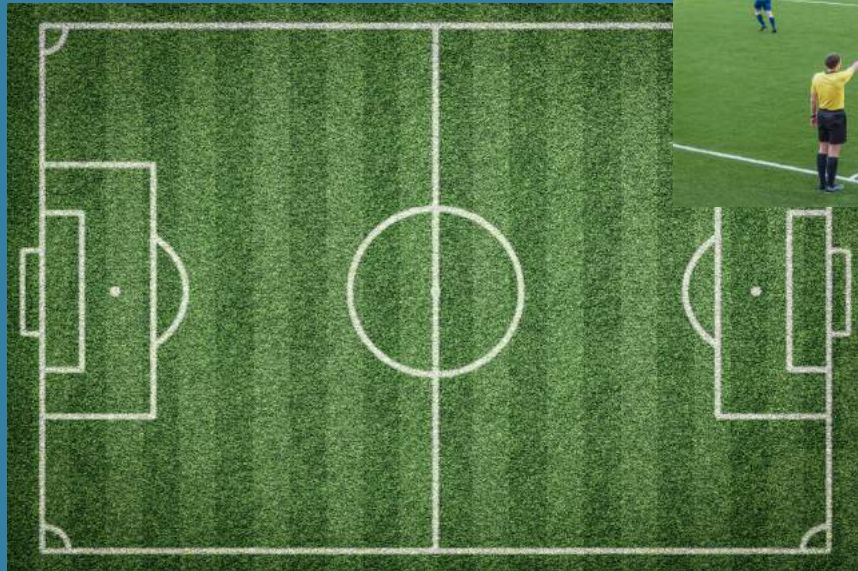
Protection

## Question #1 What are boundaries?





## Question #1 What are boundaries?



Constraints on interactions

## Question #1 What are boundaries?

We HONOR one another by respecting boundaries.

## Question #1 What are boundaries?

TRUST is built on the pledge to respect boundaries.

## Question #1 What are boundaries?

In the Doctor/Patient interaction, boundaries have the same

- where you begin and I end
- physical protection
- constraints on the interaction



Question #2 -WHY ARE PROFESSIONAL BOUNDARIES DIFFERENT?

...or, What makes the Doctor/Patient relationship special?





## Power Differential

The doctor's expert knowledge

Societal ascription

Patient's expectations and hope for cure - they submit and defer for this reason

## DOCTOR/PATIENT POWER DIFFERENTIAL IS UNIQUELY DIFFERENT

The seriousness of the engagement- the person's health or more to the point, pain, sickness and or disease

The degree of intimacy by way of personal information and the person's body; their physical being and emotional being.

## THE POWER DIFFERENTIAL EXTENDS BEYOND THE PATIENT

- Spouse
- Family
- Caregivers



hip with the clinician (chiropractor), and no such thing as

## A FOUNDATION OF TRUST



## THE HIGHEST LEVEL OF TRUST



- Banks
- Attorneys
- Trustees

A fiduciary's responsibility is to conduct themselves in the best interest of their client or patient.

## THE HIGHEST LEVEL OF TRUST



...and Chiropractors

The chiropractor's conduct is guided by the patient's best interests.

## Question #2 -WHY ARE PROFESSIONAL BOUNDARIES DIFFERENT?

Or, what makes the Doctor/Patient relationship special?



ntial built on a level of trust which is guided by the patient

## HOW DO BOUNDARY VIOLATIONS HAPPEN?



## BOUNDARY VIOLATION CONTRIBUTING FACTORS

- 1) Risk Factors inherent to chiropractic
- 2) Dual Relationships
- 3) Slippery Slope

## CHIROPRACTIC RISK FACTORS

### 1) Physical Contact with the Patient

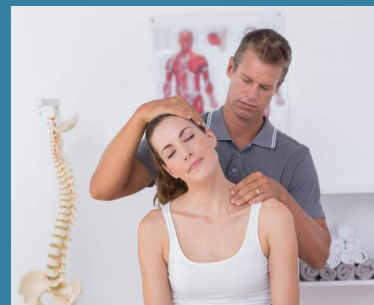
Examination

Treatment

-Adjustment (up close and personal ie-anterior thoracic)

-Modalities (myofascial release, ultrasound and gels, anterior rib)

Unfamiliarity with the methodology (patients don't know what to expect)



# CHIROPRACTIC RISK FACTORS

## 1) Physical Contact with the Patient



Unfamiliarity with the methodology  
(patients don't know what to expect)

**PERCEPTION IS  
9/10 OF THE LAW**



## 2) Dual Relationships

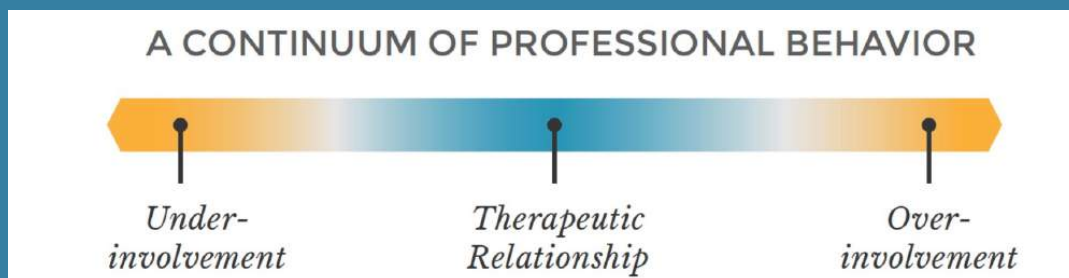
## DUAL RELATIONSHIPS

- Diminish objectivity
- Cloud clinical judgement

Chiropractor	Patient	✓
Employer	Employee	
Co-worker	Co-worker	
Supervisee	Supervisor	
Spouse	Spouse	
Parent	Child	
Sibling	Sibling	
Child	Mom or Dad	
Friend/Neighbor	Friend/Neighbor	
Customer/Client	Banker, Hairstylist, etc.	
Coach	Player	
Social contacts	Church, Clubs, Groups	

\*trade for services?

## DUAL RELATIONSHIPS CREATE IMBALANCE



(The National Council of State Nursing Boards-NCSBN)

**Due Process**  
**Proper Patient Management**

# THE EFFECT OF DUAL RELATIONSHIPS



(The National Council of State Nursing Boards-NCSBN)

- little or no documentation
- inadequate or no examination
- insufficient MDM
- no treatment plan
- discounting patient input (subjective complaints)
- avoiding painful procedures (emotional involvement)
- Ordering additional tests (overly cautious)
- Unnecessary/unwarranted procedures or therapies

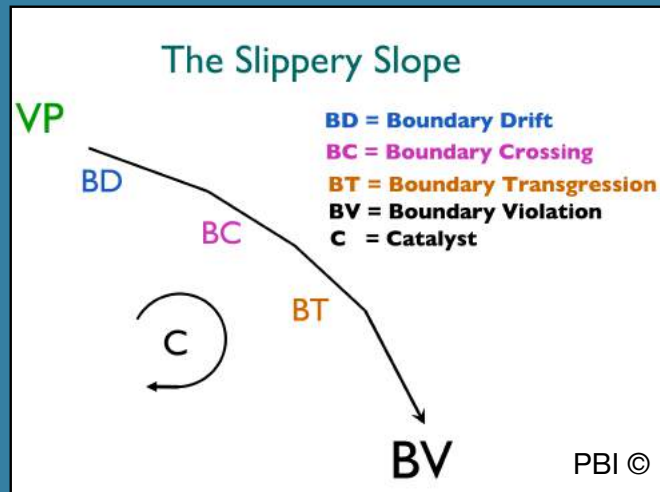
## Dual Relationships

Chiropractor	Patient	✓	under-involvement	over-involvement	steps to ensure PPM	avoid all together
Employer	Employee					
Co-worker	Co-worker					
Supervisee	Supervisor					
Spouse	Spouse					
Parent	Child					
Sibling	Sibling					
Child	Mom or Dad					
Friend/Neighbor	Friend/Neighbor					
Customer/Client	Bank, Hairstylist, etc.					
Coach	Player					
Social contacts	Church, Clubs, Groups					

### 3) The Slippery Slope

everyone has a Violation Potential that is constantly changing

Everyone has a Violation Potential that is constantly changing.



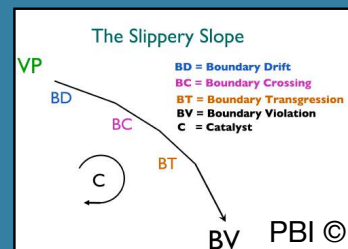
From Professional Boundaries-24 Course

## The Slippery Slope **Boundary Drift**

Characterized by a change in thinking — headspace.

Slipping out of doctor-mode, and into buddy-mode (patients, employees, co-workers).

Thoughts about the patient other than the context of HCP.





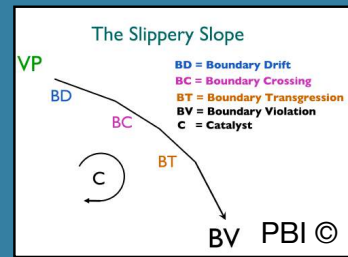
## The Slippery Slope

### Boundary Crossings

Stepping outside the role  
definition of Doctor.

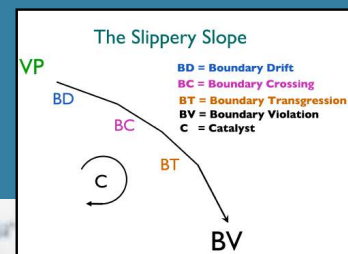
Sliding on Standard of Care.

Extending beyond a typical  
interaction (extra/excessive  
time, appt. after hours)



## The Slippery Slope

### Boundary Crossings



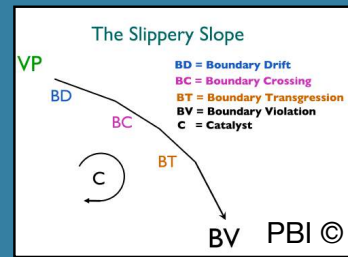
**HUGGING**

## The Slippery Slope

# Boundary Transgression

Sharing personal information -  
dreams, desires, aspirations.

Engaging in a dual-relationship.



## The Slippery Slope

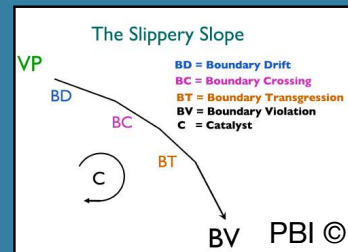
# Boundary Violation

Frank sexual contact, language,  
images  
(current patient, supervisee,  
employee)

Former patients (when do they  
stop being a patient?)

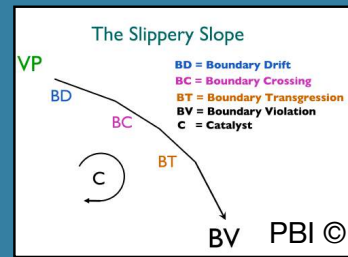
Third-party involvement

Treating dual relationships



## The Slippery Slope

### Catalyst

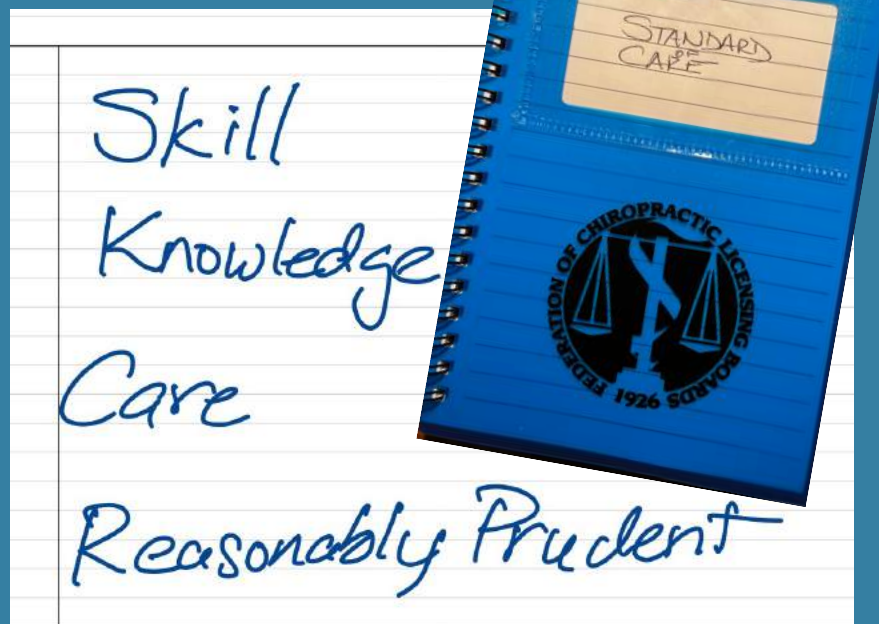


- Major life changes
- Age
- Seductive patient
- HALT



## CONCLUSION

The  
Chiropractic  
experts #1 job  
is to identify  
Standard of  
Care.



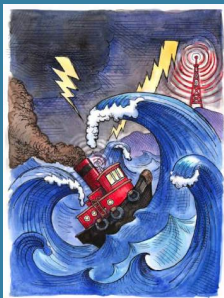
# STANDARD OF CARE

“That level of skill, knowledge and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent chiropractors in the same or similar circumstances at the time in question.”



## CONCLUSION

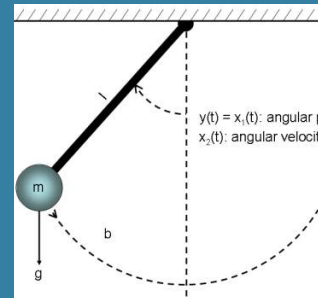
The expert should have an understanding of “reasonably prudent” and the relationship to customary practices.



TJ Hooper  
Radio



Helling  
Glaucoma



Hall  
Minimally Competent



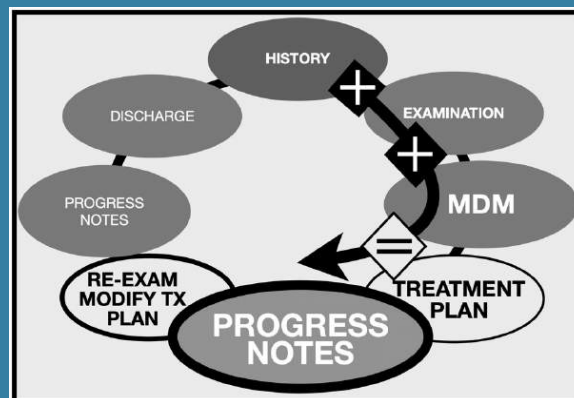
## CONCLUSION

In addition to readily defining SoC (testimony), the expert must be able to explain their method of arriving at Standard of Care for the specific complaint. This includes citing sources and relevance.



CPG's

## CONCLUSION



Documentation substantiates Proper Patient Management. The degree to which the medical record meets documentation standards is reflective of PPM and goes a long way to determining violation.

## CONCLUSION

**Professional Boundary issues can be challenging for experts to opine due to the greater degree of subjectivity.**

## CONCLUSION



Experts who know the impact of the Power Differential and Dual Relationship and understand the Risk Factors associated with the practice of chiropractic can better assess the presence and degree of boundary violations.



## CONCLUSION

### The Four Laws of Boundary Violations

- #1 Everyone has a violation potential which is constantly changing.**
- #2 Perception is 9/10 of the law (if it looks bad it, it is bad).**
- #3 Protect yourself at all times.**
- #4 The Board (or College) decides what's right, not you.**



## Thank you!

Questions and contact :

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[Kasey@PBleducation.com](mailto:Kasey@PBleducation.com)