IN THE MATTER OF	*	**BEFORE THE**
MITCHELL SILVERMAN, D.C.	*	**MARYLAND STATE BOARD OF**
Respondent	*	**CHIROPRACTIC EXAMINERS**
License Number: S01450	*	**Case Number: 01-41C**

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CONSENT ORDER

On April 15, 2003, the Maryland Board of Chiropractic Examiners ("Board") charged MITCHELL SILVERMAN, D.C. (the "Respondent"), D.O.B. 05/18/65, License No. S01450, under the Maryland Chiropractic Act (the "Act"), Md. Health Occ. ("H.O.") Code Ann. § 3-101 *et seq.* (2000).

As a result of negotiations between the Respondent, represented by his attorney, Paul Weber, Esquire, Kimberly S. Cammarata, Assistant Attorney General, and the Board, the parties agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order, with the terms and conditions set forth below.

FINDINGS OF FACT

1. At all times relevant hereto, the Respondent was and is licensed to practice Chiropractic in the State of Maryland. The Respondent owns and operates the Head, Neck & Back Pain Center at 1703 East Joppa Road, Baltimore, Maryland 21234. The Respondent was initially licensed in the State of Maryland on June 20, 1989, being issued License number S01450. The Respondent has staff members assisting him in his practice.

2. On or about September, 2001, the Board received a complaint regarding the billing practices of the Respondent; an investigation ensued.

3. The Respondent uses a "travel card", which is a sheet of paper on which the Respondent, using a circled number, notes what treatment he is providing and also uses these codes for billing purposes. The travel card also had a short space for inscribing SOAP[1] notes. While the space is available for the inscription of SOAP notes, the Respondent seldom documented using the SOAP format.

PATIENT A[2]

4. Patient A, a then nineteen (19) year old female, presented to the Respondent on 10/18/00 for an evaluation and treatment of middle and low back pain. The Respondent obtained a limited health history and examined the patient but did not adequately record additional information about the limited history provided by the patient or obtain[3] additional personal or family health history. The Respondent did not adequately record the results of the lumbosacral, neurological, circulatory, musculoskeletal, and palpatory examinations.

5. On 10/19/00, the Respondent began treatment of Patient A. The Respondent saw Patient A on twelve (12) occasions from 10/18/00 – 11/20/00. The Respondent documented each visit on the travel card. The Respondent did not document treatment in a SOAP format, but rather noted only the patient complaint and circled a code for the treatment provided. The Respondent; however, did not document what areas were treated. The Respondent did not document his findings, an assessment of care, or a plan for that visit or future visits.

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[1] SOAP is an acronym that is defined as follows: S=subjective complaints of the patient; O=objective observation by the practitioner; A=assessment or physical examination/diagnosis; P=plan of treatment.

[2] In order to protect patient privacy and the confidentiality of health care records, patient names are not used in this Consent Order.

[3] In each instance and with each patient, the Respondent asserts that he did obtain the necessary information but failed to record it. Professional standards require that information be recorded if obtained; if the information is not recorded, it was not done.

Patient B

6. Patient B, a then twenty-five (25) year old male, presented to the Respondent on 6/2/00 for an evaluation and treatment of low back pain. The Respondent obtained a limited health history and examined the patient, but did not record additional information about the limited history provided by the patient or obtain additional personal or family health history.

7. The Respondent did not obtain and/or did not record vital signs, perform a systems review or a complete patient examination including neurological, circulatory, musculoskeletal or palpatory.

8. The Respondent diagnosed instability of the lumbosacral or sacral iliac joint, restricted motion and myofascitis. The Respondent recommended chiropractic manipulation to the lumbar region and physical therapy, including ultrasound, electrical muscle stimulation and traction. The Respondent also noted bio-freeze as an adjunct to the outlined treatment. The Respondent recommended treatment three times per week.

9. The Respondent documented each treatment visit on the travel card. The Respondent did not document treatment in a SOAP format, but noted only the patient complaint and circled a code for the treatment provided. The Respondent, however, did not document what areas were treated. The Respondent did not document his findings, an assessment of care, or a plan for that visit or future visits.

10. The Respondent documented that he performed and billed for chiropractic manipulative treatment to five (5) regions, but failed to document the chiropractic basis for treating five (5) regions.

PATIENT C

11. Patient C, a then forty-six (46) year old female, presented to the Respondent on 6/11/99 for evaluation and treatment of left sided neck pain, left-sided mid-back pain and headaches. The Respondent obtained a limited health history and examined the patient but did not obtain and/or did not record additional information about the limited history provided by the patient or obtain additional personal or family health history.

12. The Respondent did not obtain and/or did not record vital signs, perform a systems review or conduct an adequate complete patient examination including neurological, circulatory, musculoskeletal or palpatory.

13. The Respondent diagnosed sprain/strain of the neck and thoracic area, cephalgia and myofascitis. The Respondent recommended chiropractic manipulation to the cervical and thoracic regions and physical therapy; including electrical muscle stimulation and traction.

14. The Respondent documented each treatment visit on the travel card. The Respondent did not document treatment in a SOAP format, but noted only the patient complaint and circled a code for the treatment provided. The Respondent, however, did not document what areas were treated. The Respondent did not document his findings, an assessment of care, or a plan for that visit or future visits.

15. The Respondent documented that he performed and billed for chiropractic manipulative treatment to five (5) regions, but failed to document the chiropractic basis for treating five (5) regions.

PATIENT D

16. Patient D, a then forty-seven (47) year old female, presented to the Respondent on 5/24/99 for evaluation and treatment of low back pain. The Respondent obtained a limited health history and examined the patient, but did not obtain and/or did not record additional information about the limited history provided by the patient or obtain additional personal or family health history. The file does not contain a patient information sheet, a patient history sheet, or any other information gathering tool for this initial visit. Patient D had been seen in the office prior to this visit on numerous occasions for a variety of complaints. The Respondent noted on the travel card that he performed a low back examination, but did not indicate what the examination consisted of. The Respondent did not obtain and/or did not record vital signs, perform a systems review or conduct a complete patient examination including neurological, circulatory, musculoskeletal or palpatory.

17. The Respondent saw Patient D on nineteen (19) occasions from 05/24/99 – 07/09/99. The Respondent documented each visit on the travel card. The Respondent did not document treatment in a SOAP format, but noted only the patient complaint and circled a code for the treatment provided. The Respondent; however, did not document what areas were treated. The Respondent did not document his findings, an assessment of care, or a plan for that visit or future visits.

18. Patient D, after ceasing treatment on 07/09/99, was re-evaluated by the Respondent on 01/13/01. Patient D presented to the Respondent on 01/13/01 with complaints of recurrent back pain. The Respondent obtained a limited health history and examined the patient, but did not obtain and/or did not record additional information regarding this history or obtain additional personal or family health history. The file does not contain a patient

information sheet, a patient history sheet, or any other information gathering tool for this initial visit. The Respondent noted on the travel card that he performed a low back examination, but did not indicate what the examination consisted. The Respondent did not obtain and/or did not record vital signs, perform a systems review or a conduct comprehensive patient examination including neurological, circulatory, musculoskeletal or palpatory.

19. On date of the re-evaluation visit, the Respondent began treatment of Patient D again. The Respondent documented each visit on the travel card. The Respondent did not document treatment in a SOAP format, but noted only the patient complaint and circled a code for the treatment provided. The Respondent, however, did not document what areas were treated. The Respondent did not document his findings, an assessment of care, or a plan for that visit or future visits.

PATIENT E

20. Patient E, a then forty-six (46) year old male, presented to the Respondent on 4/26/99 for an evaluation and treatment of chronic, right-sided, low back pain. The Respondent obtained a limited health history and examined the patient but did not obtain and/or did not record additional information about the limited history provided by the patient or obtain additional personal or family health history.

21. The Respondent did not obtain and/or did not record vital signs. The record does not include a sheet to document examinations performed or results thereof, but a form for treatment approval from MAMSI indicated that the Respondent performed a systems review and conducted a complete patient examination including neurological, circulatory, musculoskeletal or palpatory.

22. The Respondent diagnosed instability of the lumbosacral or sacral iliac joint -- right-sided, restricted motion and myositis. The Respondent recommended chiropractic manipulation to the lumbar region and physical therapy, including ultrasound, electrical muscle stimulation and traction.

23. The Respondent documented each visit on the travel card. The Respondent did not document treatment in a SOAP format, but noted only the patient complaint and circled a code for the treatment provided. The Respondent, however, did not document what areas were treated. The Respondent did not document his findings, an assessment of care, or a plan for that visit or future visits.

24. The Respondent documented that he performed and billed for chiropractic manipulative treatment to five (5) regions, but failed to document the chiropractic basis for treating five (5) regions.

25. Patient E presented to the Respondent again on 12/26/00 for an evaluation and treatment of recurrent, chronic, right-sided, low back pain. The Respondent obtained a limited health history and examined the patient, but did not obtain and/or did not record any additional information regarding Patient E's history or obtain additional personal or family health history. The Respondent did not obtain and/or did not record vital signs, perform a systems review or conduct a complete patient examination including neurological, circulatory, musculoskeletal or palpatory.

26. The Respondent made no notation of any changes in Patient E's previous diagnosis. The Respondent made no notations of recommended treatment. The Respondent documented each visit on the travel card. The Respondent did not document treatment in a SOAP format, but noted only the patient complaint and circled a code for the treatment

provided. The Respondent, however, did not document what areas were treated. The Respondent did not document his findings, an assessment of care, or a plan for that visit or future visits.

27. The Respondent documented that he performed and billed for chiropractic manipulative treatment to five (5) regions but, failed to document the chiropractic basis for treating five (5) regions.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board finds that the Respondent has violated the Maryland Chiropractic Act (the "Act"), Md. Health Occ. ("H.O.") Code Ann. § 3-101 *et seq.* (2000).

The pertinent provisions of the Act under § 3-313 provide the following:

> 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:
>
> (19) Violates any rule or regulation adopted by the Board.

The pertinent provisions of the regulations provide the following:

COMAR 10.43.15. Record Keeping.

.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 or alter 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.

.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.

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law, and agreement of the parties, it is this _____ day of November 2003, by a majority of the quorum of the Maryland State Board of Chiropractic Examiners hereby:

ORDERED that the Respondent is placed on **PROBATION** for Eighteen (18) Months, subject to the following conditions:

1. The Respondent shall enroll in and successfully complete a course in record keeping, which must be pre-approved by the Board. The Respondent shall submit a written request for approval to the Board and submit written verification to the Board of his enrollment in and proof of having successfully completed the course;

2. The Respondent shall enroll in and successfully complete a course in CPT Coding and/or a billing course which covers coding, which must be pre-approved by the Board. The Respondent shall submit a written request for approval to the Board and submit written verification to the Board of his enrollment in and proof of having successfully completed the course;

3. The Respondent will be subject to random, unannounced reviews of his patient records by a Board appointed practice reviewer; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with his reviewer, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order; and it is further

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

ORDERED that should the Respondent fail to practice in accordance with the laws and regulations governing the practice of chiropractic in Maryland, as reported by the Practice Reviewer or as otherwise reported and/or otherwise fails to fully comply with the terms and conditions of this Consent Order hereby imposed, it shall be deemed a Violation of Probation and of this Consent Order and the Respondent may be subject to additional charges and discipline by the Board of Chiropractic Examiners; and it is further

ORDERED that Eighteen (18) Months from the date of this Consent Order, the Respondent may petition the Board for termination of his probationary status without any conditions or restrictions whatsoever. If the Respondent has satisfactorily complied with all conditions of probation, including the full Eighteen (18) Month period of probation, and there are no outstanding complaints regarding the Respondent, the Board shall terminate the probation; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. State Gov't Code Ann ' 10-611 et seq. (1999).

12/11/03
Date

E. Brian Ashton, D.C.
President
State Board of Chiropractic Examiners

CONSENT

I, Mitchell Silverman, D.C., License No. S01450, by signing this Consent agree to be bound by the terms and conditions of the foregoing Consent Order. I acknowledge that I have read this Consent Order and that I have consulted with my attorney, Paul Weber, in the course of the Board's proceedings in relation to this Consent Order.

I further acknowledge that, by signing this Consent Order, I admit to the findings of fact and conclusions of law as detailed herein and submit to its terms and conditions. I acknowledge that if the case were to proceed to hearing the State would prove the facts delineated herein by a preponderance of the evidence. I further acknowledge that the Board has entered into this Consent Order in lieu of proceeding forward with the Charges. By signing

this Consent Order, I waive my right to contest the terms and findings herein and all challenges legal or otherwise to the proceedings before the Board.

I acknowledge the enforceability of this Consent Order as if it were made after a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other procedural protections to which I am entitled by law. I also recognize that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing and am also waiving any other legal remedies I may have regarding resolution of the Charges. I sign this Consent Order voluntarily, understanding its terms, meaning, and effect.

11-25-03
Date

Mitchell Silverman, D.C.

Approved by:
Paul Weber, Esquire

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 25th day of November, 2003, before me, Notary Public of the State and City/County aforesaid, personally appeared Mitchell Silverman, D.C., and made oath in due form of law that the foregoing Consent was his voluntary act and deed.

AS WITNESSETH my hand and Notarial seal.

My Commission expires: 2/1/04

Jayne M. Pampuro
Notary Public