STATE OF VERMONT
BOARD OF CHIROPRACTIC

In re: Louis M. Huppert } Docket No. CH 03~~0~~1002

Decision on
UNPROFESSIONAL CONDUCT CHARGES

Board Members Participating:
Sean Mahoney, DC
Denise Natale, DC
Charles Foster, DC
Anne Valliere
Emma Pudvah

Appearances:
for Petitioner, State of Vermont: Edward G. Adrian
for Respondent: John D. Monahan

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Board of Chiropractic held a hearing in the above matter on February 1, 2005 at 26 Terrace Street in Montpelier, Vermont.

The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence.

Background

The State alleges in its specification of charges that Dr. Huppert kept notes of treatment for patients L.S. and her daughter A.W., but that the notes did not support the duration of care given. The State's specification of charges recites several instances where it alleges the patient notes for L.G. and A.W. do not meet expected standards. The State charges that Dr. Huppert's use of E&M codes was not substantiated by his notes in two instances. It charges that Dr. Huppert failed to refer L.G. for additional testing or a second opinion when improvement in her condition was not seen. The State finally alleges that Dr. Huppert improperly delayed referring L.G. to a neurologist for two years after onset of weakness. The State alleges that the failures alleged above violated Board Rules and Vermont Statutes and constituted failure to keep proper records, the use of undue influence over L.G., willfully falsifying records, failure to practice competently, all which the State contends, showing unfitness to practice.

Dr. Huppert in his testimony and through counsel conceded that his "documentation needs to improve," and that he had displayed "poor record keeping." He denied the other allegations stating that the treatment given was reasonable and necessary, and that his decision not to refer L.G. for alternative treatment was a reasonable exercise of professional judgment.

Findings of Fact

Based upon substantial credible evidence, the Board finds as follows:

1 Dr. Huppert is licensed by and subject to the disciplinary authority of this Board. 26 V.S.A. § 521, 527, 529, and 541, the board's administrative rules, and 3 V.S.A. § 129(a).

2. Dr. Huppert's license 006-0000839 is valid through September 30, 2006.

3. On October 22, 1998 L.G. and her four year old daughter A.W. were involved in an minor automobile accident.

4. On October 22, 1998 L.G. went to Dr. Huppert for treatment for neck and back pain.

5. Dr. Huppert treated L.G. for neck and back pain.

6. Dr. Huppert learned that L.G.'s daughter, A.W., had also been involved in the accident. He believed that the accident occurred in a manner which caused the child restraint seat A.W. occupied to become displaced in the accident. He suggested that L.G. bring her daughter in to check on her status. A.W. was four years old at the time.

7. Dr. Huppert treated patient A.W. for neck and back pain.

8. Much of the testimony during the hearing concerned the adequacy of Dr. Huppert's records. Dr. Huppert admitted that his record keeping at the time in question left much to be desired.

9. Regarding matters not included in his records, Dr. Huppert provided reasonable explanations for many of the questions raised by the prosecutor during his examination of the doctor.

10. The State alleged that on October 23, 1998, for A.W. "decreased range of motion" was checked off of the "travel card," and that no measurements or estimates of deficiencies were noted. This allegation, if true, does not constitute a treatment error, as it was only one day after the injury when accurate measurements were not possible.

11 Dr. Huppert relied on his memory of his patient L.G. to answer some questions for which his records for L.G. were vague or without entries. An example of this was how L.G. felt after receiving treatments. His records do not document improvements Dr. Huppert said she felt. His records did not contain post-treatment assessments.

12. Dr. Huppert's records of patient L.G. indicated that she made no progress in reduction of her neck pain during the initial four month period of treatment. His explanation of her condition showed that she did improve after treatment, but returned to the office for her next visit, once again experiencing an elevated level of pain, the same level of pain she had when she arrived for previous visits. Dr. Huppert attributed the recurrence of pain to L.G.'s active life style. L.G. did not disagree.

13. Regarding his records and the forms he uses, Dr. Huppert admitted that he understood that "almost everybody outside of myself that has looked at this form has needed some explanation."

14. During Dr. Huppert's testimony some of the inadequacies of his record keeping became

apparent.

15. During his testimony some file entries were found on random pieces of paper inserted into the file.
16. During his testimony, Dr. Huppert found a document he wished to refer to, tucked between other documents in the file.
17. One file entry testified to was out of sequence because it had been written on a loose piece of paper and not discovered for some time after the treatment date.
18. State's Exhibit 2, "travel cards" for patient L.G., lacked entries for objective findings for 13 office visits. If, as Dr. Huppert testified, he performed treatments when he saw L.G., noting objective findings to justify the treatment is necessary. This did not occur.
19. Dr. Huppert's records do not consistently provide a reviewer with sufficient information to say whether the frequency of appointments or course of treatment followed was justified.
20. L.G. saw Dr. Huppert because she trusted him. She came for initial treatment after the accident. After a period of no treatment, she returned to him when her injury "flared up."
21. The State alleged that Dr. Huppert willfully made false reports using improper insurance billing codes. The State offered no evidence as to which codes should have been used at the times in question. The prosecution did not point to any evidence to show that Dr. Huppert in any way attempted to receive, or actually obtained payment to which he was not entitled. Dr. Huppert's testimony, at best, showed possible errors in code use.
22. Regarding the State's allegation that Dr. Huppert should have referred L.G. for treatment by an alternative source: Doctor Huppert's records do not consistently provide enough information for the Board to determine if a referral for alternative treatment was necessary.
23 Dr. Huppert's testimony provided, in some instances, the only evidence showing that L.G.'s condition was being thoroughly monitored.
24. Dr. Huppert admitted that during the period of time in question, matters personal to him took precedence over record keeping for his patients. "My record keeping was a secondary consideration at that point." He denied that his patient treatment, as opposed to his record keeping, was in any way less than adequate.
25. Between October 26, 1998 and January 29, 1999, L.G.'s pain level, according to his "travel card" for her, was a 9 out of a 10 pain scale. Dr. Huppert made no notation indicating why L.G. did not appear to be progressing. In his testimony he provided an explanation for the duration of her symptoms.
26. The State in its specification of charges stated that L.G. was treated for back pain continuously between October 1998 and December 2001.
27. L.G.'s testimony, which was consistent with Dr. Huppert's, showed, and the Board finds, that L.G. saw Dr. Huppert *periodically*, not continuously, between those dates. He treated her for only 10 months, off and on, during that time.
28. When L.G. needed treatment, that is when her condition regressed, she saw Dr. Huppert. When the physical demands of her work or life caused flare ups needing treatment, she went back to Dr. Huppert.
29. Between November 27, 1998 and December 16, 1998 the "travel card" (the document used to keep most of his file entries) did not indicate if there was decreased range of motion, tenderness or spasms. Despite this, Dr. Huppert continued to manipulate the

neck and low back. He did this even though there was no documentation showing the presence of a subluxation.

30. The State alleged that on December 16, 1998, Dr. Huppert made a diagnosis change on an insurance claim form without any record of a reassessment on that date. Dr. Huppert's explanation of the change showed that he did do an evaluation of L.G. each time she was seen, and that his diagnosis evolved and was more of a "refinement," as her symptoms stabilized and her condition became more evident. He characterized his chart entries as the more accurate description of her status, all part of a working diagnosis. He admitted that he did not include the code showing that L.G. had been in an accident until well after the first few L.G. visits.
31. Dr. Huppert did not note on the "travel card" why the diagnosis change was made to the insurance claim form.
32. Better attention to detail in his record keeping would have clarified the previous point.
33. Dr. Huppert testified that he could not remember if some of L.G.'s symptoms were intermittent or not. This is a good example of the effects of incomplete record keeping
34. From January 25, 1999 through March 16, 1999, the second side of a "travel card" was left completely blank. What was going on in Dr. Huppert's personal life, he admitted, affected his record keeping. This is another clear example of inadequate record keeping.
35. L.G. reported that her hands felt weak. Dr. Huppert's records showed that no deep tendon reflexes or vibratory or pinwheel sensory testing was performed. Dr. Huppert said that this was not "necessarily true." "I'll admit that there is less than complete information available in this case." He then spoke about what he generally does in cases like this. He was able to say only that he "probably" did not do deep tendon reflexes. Dr. Huppert could not state, without speculating based on his usual practice, whether he had done those tests. This is another clear example of inadequate record keeping.
36. From January 25, 1999 through August 21, 2000, there was no documentation of spasms, tenderness, decreased motion, nor any indication of what was subluxated.
37. On January 4, 2002, Respondent noted that L.G. presented with "swollen and irritated soft tissues." However, there is no documentation in the record to support the swelling of tissues.
38. L.G.'s visit frequency of treatment was not justified by the records.
39. Dr. Huppert's testimony provided an explanation for why L.G. was seen when she was and why treatment frequency varied.
40. The State offered no evidence showing that Dr. Huppert performed unnecessary treatments on L.G.
41. The Board cannot find that treatments L.G. received from Dr. Huppert were unnecessary.
42. L.G. testified that she went to Dr. Huppert when her condition made it necessary for her to see him. From time to time she wanted to see how she would do on her own without treatment. He warned her about over-activity and its possible adverse effects.
43. L.G. did not testify about undue influence, or imply that she had been unduly influenced to receive treatment. On the contrary, her testimony showed that she received treatment when her complaints justified it.
44. Dr. Huppert's testimony indicated that L.G. received an acceptable frequency of treatment from Dr. Huppert. The State offered no evidence from which to find otherwise. The treatment given was not unnecessary.

45. Dr. Huppert did not exercise undue influence over L.G. to compel her to obtain treatment with him.
46. Doctor Huppert did not receive payment for much of the treatment rendered to L.G.
47. From October 23, 1998 through January 20, 1999, Dr. Huppert checked off on the form showing that A.W. had neck pain, but the level of pain was not documented. No supporting documentation of the presence of subluxation was provided; only check marks were used to indicate subluxations.
48. On A.W.'s twelfth visit, "exacerbation" was checked, following four previous visits where "no change" had been indicated. Respondent's records do not indicate what caused the exacerbation.
49. From January 25, 1999 through December 24, 2001, "satisfactory progress" was checked off on all of A.W.'s visit dates. The Respondent did not make any notation as to what parameters were being evaluated to determine progress. No pain scales were documented during this time and from February 1999 through December 24, 2001, including entries for September 13, 2001, December 14, 2001 and December 17, 2001, no evaluation of spasms were graded, performed or checked off.
50. Dr. Huppert's records for L.G. between December 2001 and January, 2002 are similarly deficient.
51 Dr. Huppert's records do not consistently provide support for the duration of care that he rendered to patient L.G.
52. Dr. Huppert's records do not consistently provide support for the duration of care to patient A.W.
53. The State alleged that on October 22, 1998, the Respondent's use of E&M Code "99204" for both L.G. and A.W. was not justified or substantiated by the records. The State offered no evidence on the proper use of E&M Code 99204. The absence of such evidence precludes any inference of impropriety.

The State alleged that throughout the entire billing of L.G.'s and A.W.'s insurance carrier, the Respondent used the 972 series. The 972 series is one which the State claimed is maintained only for use by medical doctors when they perform manipulative services and which carries a higher reimbursement rate from insurance carriers than the chiropractic 989 series. The State offered no evidence to substantiate this charge, and no explanation of billing codes, such as which ones were in use at any time in question. The State provided no testimony regarding possible differences in reimbursement rates for chiropractors or medical doctors. This absence of evidence precludes any inference of impropriety.

The State alleged that Dr. Huppert did not refer L.G. or A.W. for additional testing or a second opinion when they showed no improvement. The testimony of L.G. and of Dr. Huppert showed that L.G. ***did not appear*** for treatment continuously. She did receive frequent treatment in the first months after the car accident. She did make progress with some of her symptoms, while others stubbornly persisted.

The decision of whether to refer L.G. to alternative treatment after the first few weeks of treatment required professional discretion based on clinical evidence.

57. The Board cannot find that deciding to not refer L.G. for alternative treatment is beyond the range and proper use of discretion that a chiropractor treating a patient with these symptoms would use. His decision to not refer here does not fall below expected

standards of conduct.

58. Doctor Huppert testified without contradiction that the treatments he performed on L.G. did permit her to leave his office with a reduction in pain and complaints. That L.G. appeared for subsequent appointments complaining of pain can be attributed to the nature of her injury and the physical demands her body was subjected to in the normal course of her busy life.

59. The Board cannot find that Dr. Huppert performed any unneeded treatment on L.G. or A.W.

Conclusions of Law

Dr. Huppert did not consistently keep written chiropractic records justifying a course of treatment for L.G. 26 V.S.A. § 541(b)(5), Board rule 6.1. Keeping appropriate records provides subsequent health care providers and others with the information needed to understand the client's condition and to evaluate the treatment the patient receives.

2. The Board notes that Rule 6.1 became effective on June 1, 2001. The statutory requirement that records meet certain minimum standards precedes the rule. Prior decisions of this Board, for example, In re: Jennifer B. Peet, D.C. (November 2001) imposed a sanction for insufficient record keeping which occurred before June 1, 2001. In that case the Board noted that, "The general standard of care for chiropractic record keeping is, (a) that written patient records should be kept, (b) that the written records should be legible, (c) that the chiropractor has an ethical responsibility to keep written patient records, and (d) that the written patient records, should provide a subsequent treating chiropractor or other third party the ability to understand the patient's care and outcome."

3. The Board concludes that Dr. Huppert's record keeping before June 1, 2001 could not violate rule 6.1. His records between October 1998 and June 2001 do, however, violate 26 V.S.A. § 541(5). Records kept after June 1, 2001 violate the rule as well as the statute.

4. Dr. Huppert's health insurance claim forms indicate inconsistencies in code use and reveal a degree of inattention to consistency.

5 Dr. Huppert did not exercise undue influence on L.G. or take improper advantage of her for financial gain.

6. The State has not proved that any reports or records were willfully falsified. There may have been inconsistencies on billing codes, but there was no evidence from which the Board could conclude that coding inconsistencies rose to the level of willfully making false records constituting unprofessional conduct. The charge of violation of 3 V.S.A. § 129a(a)(7) was not proved. Inconsistencies in billing codes do show inadequate attention to record keeping requirements.

7. The State has not proved by a preponderance of the evidence that Dr. Huppert provided

unnecessary treatment to either L.G. or A.W.

8. There is no evidence from the which the Board can find that any of the treatment rendered to L.G. or A.W. deviated in any way from the expected level of competence.

9. The decision to refer a patient to another treatment provider depends on many variables. Given the symptoms presented by L.G. and the progress she made in some areas, reasonable minds and competent practitioners could reach varying conclusions on whether a referral was necessary at any particular time in her treatment. Some competent chiropractors might have referred L.G. when Dr. Huppert did not. Other competent practitioners might not have referred her for alternate treatment. The Board cannot say that Dr. Huppert's decision not to refer her to another alternate provider violated standards of competence.

10. Dr. Huppert is not unfit to practice chiropractic. 26 V.S.A. § 541(b)(10).

ORDER

The State has met its burden of proof on the charge of failure to keep written chiropractic records justifying a course of treatment. **Dr. Huppert's record keeping violates 26 V.S.A. 541(B)(5) and Board Rule 6.1 (Minimum Record Keeping Standards), and 3 V.S.A.§ 129a(b)(2).** Remedial sanctions for this violation appear below.

On the Charge of Exercising Undue Influence on, or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner which exploits a person for the financial gain of the practitioner, 3 V.S.A. § 129a(a)(11), the State has not met its burden of proof. That count is **dismissed.** Treatment Dr. Huppert rendered appears to be reasonable and necessary.

On the charge of willfully making or filing false reports or records, 3 V.S.A. § 129a(b)(2), the State has not met its burden of proof. That charge is **dismissed.**

The inadequacies of Dr. Huppert's record keeping do not show that he is unfit to practice. 26 V.S.A. § 541(B)(14). The charge of conduct which evidences unfitness to practice is **dismissed.**

Sanctions

1) Dr. Huppert's license shall be conditioned for a minimum of two years. At that time he may petition the Board for removal of the conditions set forth below. The Board may remove the conditions if it is satisfied that they have been met in full and that further continuation of the conditions is not required.

2) Dr. Huppert shall, as a condition of continued licensure, successfully complete two courses: a minimum of 6 hours dedicated to record keeping, and a minimum of 6 hours

dedicated to coding and billing. Each course must be approved by the Board and be taken within six months of the date of this order. Courses taken up to one year before the date of this order may, in the discretion of the Board, be approved by the Board toward this requirement.

3) Dr. Huppert shall be subject to random case file audits which shall occur quarterly. The audits shall be performed by a Vermont licensed chiropractor pre-approved by the Board. The audit will be for the purpose of determining compliance with Vermont statutes and rules requirements. All reports shall be sent to the Board for its review. If an audit report is inadequate, the Board will reject it and require a substitute audit. The first audit shall occur and results sent to the Board no more than ninety (90) days following the entry of this order. Each audit shall consist of examining approximately 20 percent of Dr. Huppert's current and active files, or 10 files, which ever is more. Current and active files are meant to include patients who have had, or will have, a present and continuing course of care in the chiropractic practice of Dr. Huppert during the time this condition is in effect. The audit shall not include patients who have not visited Dr. Huppert's practice for more than six months before the date of this order. The audit shall include looking for complete notes for each visit sufficient to allow monitoring of a course of treatment which would permit another doctor to understand and utilize the notes for care of the same patient. The office will provide audit forms to be used and a sample of an acceptable audit report which can be used as a model.

The licensed Chiropractor performing the audits shall be available to meet with the Board, or the Board's designee, upon request.

Dr. Huppert shall take any steps, and make corrections and/or changes as suggested by the auditor in a timely manner.

Dr. Huppert shall bear all costs associated with this Order.

Violation of any of the conditions of this order shall be grounds for further action by the Board.

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Chiropractic. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, 26 Terrace Street, Drawer 09, Montpelier, Vermont 05609-1106 within 30 days of the entry of this order.

If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

Vermont Board of Chiropractic

By: Sean P. Mahoney DC
Sean Mahoney, DC, Chair

Dated: 2/28/05

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 3/4/05 +

STATE OF VERMONT
BOARD OF CHIROPRACTIC

IN RE:	)	
LOUIS M. HUPPERT	)	**Docket No. CH 03-1002**
License No: 006-0000839	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Louis M. Huppert, D.C.:

Board Authority

1. The Vermont Board of Chiropractic has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Chiropractic Physicians pursuant to 3 V.S.A. §§129, 129a; 26 V.S.A. §§521, 527, 529, 541 and; the Board of Chiropractic Laws and Rules ("BCLR"); and the Office of Professional Regulation's Rules.

2. Failure to comply with the provisions of state statutes or rules governing the practice of the profession is unprofessional conduct upon which the Board can base disciplinary action. 3 V.S.A. §129a(a)(3).

3. Failure to keep written chiropractic records justifying a course of treatment for a patient, including patient histories, examination results and test results records is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. §541(b)(5).

4. Chiropractic records shall be legibly maintained and shall contain sufficient information to identify the patient; support the diagnosis/assessment; substantiate the treatment; and document the course and results of treatment accurately by including, at a minimum, patient histories, examination results, test results, records of substances dispensed, administered, or recommended, reports of consultations and hospitalizations, and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient. Initial and follow-up services (daily records) shall consist of documentation of current status and treatment rendered. All patient records shall include patient history; condition presented or wellness care, or both; and examination findings, including x-rays when clinically indicated. BCLR 6.1.

5. Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner which exploits a person for the financial gain of the practitioner or a third party is

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unprofessional conduct upon which the Board can impose disciplinary action. 3 V.S.A. §129a(a)(11).

6. Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper reports or records is unprofessional conduct upon which the Board can base disciplinary action. 3 V.S.A. §129a(a)(7).

7. Failing to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct. Failure to practice competently includes failure to conform to the essential standards of acceptable and prevailing practice. 3 V.S.A. §129a(b)(2).

8. In the course of practice, failure to use and exercise that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent chiropractor engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred. 26 V.S.A. §541(b)(14).

9. Conduct which evidences unfitness to practice chiropractic is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. §541(b)(10).

Facts

10. Respondent, Louis M. Huppert, is a Chiropractic Physician holding license number 006-0000839 issued by the State of Vermont. Respondent's license was originally issued on June 30, 1989 and Respondent's license has a current expiration date of September 30, 2004.

11. At all times relevant, Respondent maintained a chiropractic practice in Norwich, Vermont.

12. On or about October 22, 1998, L.G. and her four year old daughter, A.W., began receiving treatment from the Respondent for pain caused by a minor automobile accident.

13. L.G. was treated by the Respondent for neck and back pain continuously until approximately March of 2002. A.W. was also treated by the Respondent for neck and back pain until approximately December of 2001. The Respondent's documentation for both L.G. and A.W. does not support the duration of care.

14. At all times relevant, Respondent's notes for L.G. were inadequate to justify the course of treatment. Specifically,:

i. On October 23, 1998, decreased cervicothoracic and lumbar range of motion was checked off of the travel card, however no measurements or estimates of deficiencies were noted. Tenderness and spasms were checked off without indicating rating of spasms. Muscle weakness was checked off

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without any notation as to which muscles were weak or how weak they were. Progress affected by ADLs was checked off without indicating which ADLs were bothersome.

ii. From October 26, 1998 through January 29, 1999, L.G.'s pain level remained at a 9 out of a 10 pain scale without any notation by Respondent as to why L.G. was not progressing.

iii. From November 27, 1998 through December 16, 1998, the travel card did not indicate if there was decreased range of motion, tenderness or spasms, however, the Respondent continued to manipulate the neck and low back without documentation as to the presence of a subluxation.

iv. On December 16, 1998, the Respondent made a diagnosis change without any record of a reassessment on that date.

v. On January 25, 1999, the Respondent noted "weak B/L" in the subjective area and checked this off daily until March 29, 1999. No deep tendon reflexes or vibratory or pinwheel sensory testing was noted despite the fact that this was a new symptom.

vi. From January 25, 1999 through March 16, 1999, the second side of the travel card was left completely blank. This side of the travel card contains information for "tenderness", "spasms", "decreased range of motion", "positive test", "postural evaluation" "progress affected by", whether or not there was a change in the patient's condition and more.

vii. From January 25, 1999 through August 21, 2000, there was no documentation of spasms, tenderness, decreased motion, nor any indication of what was subluxated.

viii. On January 4, 2002, Respondent noted that L.G. presented with "swollen and irritated soft tissues". However, there is no documentation in the record to support the swelling of tissues.

ix. During week eight of treatment, L.G.'s visit frequency went from once per week to twice per week without any documentation as for the need for the increase in visit frequency.

x. During week twelve, L.G.'s visit frequency went from once per week to three times per week without any documentation as for the need for the increase in visit frequency.

xi. During week fifteen, L.G.'s visit frequency went from twice per week to four times per week without any documentation as for the need for the increase in visit frequency.

15. At all times relevant, Respondent's notes for A.W. were not adequate to justify the course of treatment. Specifically,:

i. From October 22, 1999 through December 24, 2001, no re-exams were done to determine progress and no exacerbating factors were noted to rationalize prolonged treatment.

iii. On October 23, 1998, decreased range of motion was checked off of the travel card, however no measurements or estimates of deficiencies were noted.

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iii. From October 23, 1998 through January 20, 1999, neck pain was checked off on each visit, but the level of pain was not documented. No supporting documentation of the presence of subluxation was provided; only check marks were used to indicate subluxations.
iv. On visit twelve, "exacerbation" was checked, following four previous visits with "no change". Respondent's records do not indicate what the issue with the exacerbation was.
v. From January 25, 1999 through December 24, 2001, "satisfactory progress" was checked off on all visit dates. The Respondent did not make any notation as to what parameters were being evaluated to determine progress. No pain scales were documented during this time and from February 1999 through December 24, 2001, no evaluation of spasms were graded, performed or checked off.

15. Throughout L.G.'s and A.W.'s care, the Respondent's use of E&M Codes was not substantiated by his notes. Specifically, the Respondent used improper E&M Codes as follows:

i. On October 22, 1998, the Respondent's use of E&M Code 99204 for both L.G. and A.W. was not justified or substantiated by the records.
ii. Throughout the entire billing of L.G.'s and A.W.'s insurance carrier, the Respondent used the 972 series, which is maintained only for use by medical doctors when they perform manipulative services and which carries a higher reimbursement rate from insurance carriers than the chiropractic 989 series.

16. Additionally, the Respondent did not refer L.G. or A.W. for additional testing or a second opinion when improvement was not being seen. L.G.'s pain scale remained at 9 out of 10 in the cervical region until January 29, 1999, when it dropped to an 8 out of 10. L.G.'s pain scale remained at 9 out of 10 in the neck region until February 26, 1999, which was eighteen weeks into treatment.

17. In December 1998, complete range of motion studies and computerized muscle testing studies were performed on L.G. On January 25, 1999, Respondent noted that L.G. had been experiencing new sudden weakness in her right hand, however the Respondent did not refer L.G. to a neurologist until January of 2002, approximately two years form the onset of the weakness.

Charges

18. The above acts and/or omissions constitute unprofessional conduct pursuant to, and also violate:

a. 3 V.S.A. §129a(a)(3) (Failure to comply with the provisions of state statutes or rules governing the practice of the profession);

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b. 26 V.S.A. §541(b)(5) (Failure to keep written chiropractic records justifying a course of treatment for a patient, including patient histories, examination results and test results records);

c. BCLR 6.1 (Minimum Record Keeping Standards);

d. 3 V.S.A. §129a(a)(11) (Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner which exploits a person for the financial gain of the practitioner or a third party);

e. 3 V.S.A. §129a(a)(7) (Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper reports or records);

f. 3 V.S.A. §129a(b)(2) (Failing to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct. Failure to practice competently includes failure to conform to the essential standards of acceptable and prevailing practice);

g. 26 V.S.A. §541(b)(14) (In the course of practice, failure to use and exercise that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent chiropractor engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred);

h. 26 V.S.A. §541(b)(10) (Conduct which evidences unfitness to practice chiropractic).

WHEREFORE, the license of Louis M. Huppert should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

Dated this 13th day of May, 2004 at Montpelier, Vermont.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

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