Board of Chiropractic Examiners

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Enforcement Committee Meeting

March 13, 2015

BOARD of CHIROPRACTIC EXAMINERS
STATE OF CALIFORNIA

State of California
Edmund G. Brown Jr., Governor

NOTICE OF TELECONFERENCE
ENFORCEMENT COMMITTEE MEETING
March 13, 2015
12:30 p.m.

One or more Committee Members will participate in this meeting at the teleconference sites listed below. Each teleconference location is accessible to the public and the public will be given an opportunity to address the Enforcement Committee at each teleconference location. The public teleconference sites for this meeting are as follows:

Teleconference Meeting Locations:

Sergio Azzolino, DC	Heather Dehn, D.C.	Frank Ruffino
1545 Broadway St., Suite 1a	4616 El Camino Ave., Suite B	901 P Street, Suite 142-A
San Francisco, CA 94109	Sacramento, CA 95821	Sacramento, CA 95814
(415) 563-3800	(916) 488-0202	(916) 263-5355

AGENDA

1. **Call to Order**

2. **Approval of Minutes**
   January 27, 2015

3. **Discussion and Possible Action on Criteria and Standards for Expert Consultant Selection. [2014-2107 Strategic Plan]**

4. **Discussion and Possible Action on Proposed Language Regarding Maintenance of Patient Records/Amendments to Title 16, California Code of Regulations Sections 312.2 and 318**

5. **Scheduling Future Enforcement Committee Meetings for 2015**

6. **Public Comment**
   Note: The Committee may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125 & 11125.7(a).] Public comment is encouraged; however, if time constraints mandate, comments may be limited at the discretion of the Chair.

7. **Future Agenda Items**

8. **Adjournment**

T (916) 263-5355
F (916) 327-0039
TT/TDD (800) 735-2929
Consumer Complaint Hotline
(866) 543-1311

Board of Chiropractic Examiners
901 P Street, Suite 142A
Sacramento, California 95814
www.chiro.ca.gov

ENFORCEMENT COMMITTEE

Sergio Azzolino, D.C., Chair
Heather Dehn, D.C.
Frank Ruffino

Meetings of the Board of Chiropractic Examiners' Committee are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. Public comments will be taken on agenda items at the time the specific item is raised. The Board's Committee may take action on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. For verification of the meeting, call (916) 263-5355 or access the Board's Web Site at www.chiro.ca.gov.

The meeting facilities are accessible to individuals with physical disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Marlene Valencia at (916) 263-5355 ext. 5363 or e-mail marlene.valencia@dca.ca.gov or send a written request to the Board of Chiropractic Examiners, 901 P Street, Suite 142A, Sacramento, CA 95814. Providing your request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation.

Board of Chiropractic Examiners
MEETING MINUTES
Enforcement Committee
January 27, 2015
3:00 p.m.
State of California
901 P Street, Suite 142-A
Sacramento, CA 95814

Committee Members Present
Sergio Azzolino, D.C., Chair
Heather Dehn, D.C.

Staff Present
Robert Puleo, Executive Officer
Sandra Walker, Compliance Manager
Dixie Van Allen, Associate Governmental Program Analyst
Kristy Schieldge, Attorney III
Marlene Valencia, Associate Governmental Program Analyst
Christina Bell, Associate Governmental Program Analyst

Public Present
Penny Cunha, California Chiropractic Association (CCA)
Cris Forsyth, California Chiropractic Association (CCA)

Call to Order
Dr. Azzolino called the meeting to order at 3:01 p.m.

Roll Call
Dr. Dehn called the roll. Dr. Azzolino and Dr. Dehn were present. Mr. Ruffino was not able to participate in the meeting due to an Agenda error regarding his meeting location.

Approval of October 28, 2014 Minutes

MOTION: DR. DEHN MOVED TO APPROVE THE MINUTES
SECOND: DR. AZZOLINO SECONDED THE MOTION
DR. AZZOLINO ADDRESSED THE VOTE FOR FAVOR OF ADOPTION
DR. AZZOLINO STATED "YES"
DR. DEHN STATED "YES"
VOTE: 2-0
MOTION CARRIED

Discussion and Possible Action on Advertising a Chiropractic Specialty

At the Committee's request, Staff Counsel Ms. Schieldge provided a memorandum summary, the Medical Board's Regulation (California Code of Regulations Title 16 Section 1363.5) and copies of the legal cases involving the Dental Board: Bingham v. Hamilton, Potts v. Hamilton and Potts v. Zettel.

Dr. Azzolino, Dr. Dehn, and Ms. Schieldge had lengthy discussion about the case litigation involving the Dental Board's attempt to regulate advertising specialties. Dr. Azzolino expressed concern that we are seeing increased advertising of neuropathy, diabetes, or variety of conditions that licensees claim to be specialists for when they really don't have the training. He feels that this is harmful to the patient and also harmful to the profession. Dr. Azzolino inquired why the Medical Board is exempt (unlike Dental Board) from such practices and is able to engage in the practice of regulating specialties.

Ms. Schieldge discussed important litigation involving the Medical Board and Dental Board related to specialty advertising. In the American Academy of Pain Management v. Joseph case, the court upheld the Medical Board's authority to regulate specialty advertising pursuant Business and Professions Code Section 651(h)(5)(B). Section 651(h)(5)(B) forbids California-licensed physicians from advertising that they are certified by a medical specialty board unless that board is either recognized by the American Board of Medical Specialties (ABMS) or the Medical Board as having certification requirements that are equivalent to those of ABMS recognized specialty boards. This case determined there is a long established understanding within the medical profession about the precise meaning of "board certified". Within the case context, "board certified" means only a doctor who has been certified by a board that is a member of the ABMS in one of the 23 areas of medical specialization recognized by the ABMS. The court held that advertisement using the term board certified to denote a credential from a non-ABMS recognized specialty board is inherently misleading.

The Potts v. Hamilton case ruled as to whether dentists are permitted to advertise their credentials earned from specialty organizations or boards such as the American Academy of Implant Dentistry (AAID) and American Board of Oral Implantology / Implant Dentistry (ABOI/ID). These boards award specialty credentials to their members who fulfill certain practice, education, and testing requirements. The Dental Board specifically prohibited AAID members from calling themselves specialists in their advertising. The AAID members sued, alleging this violated their right to free speech. Section 651(h)(5)(A) governed false and misleading advertising and outlined the conditions under which a dentist advertises as a specialist. Section 651 permitted, among other things, a dentist to advertise a specialty if: (i) he or she has completed a specialty education program or is a member of a national specialty board approved by the American Dental Association (ADA), or, (ii) in the absence of ADA accreditation, he or she has attained membership in or been credentialed by an accrediting organization that is recognized by the board as a "bona fide" organization for that area of dental practice. The Court eventually ruled in favor of the dentists.

Ms. Schieldge noted that while advertising is a First Amendment right, if an advertisement is inherently misleading to the public, it is not protected by the First Amendment.

Dr. Azzolino asked whether the Board can list information about the specialties on its website. Ms. Schieldge stated the Board can explore disclaimers and disclosures as opposed to banning advertisement of specialties. For instance, she stated disclaimers may be worded as.... "if consumers are interested in finding out if chiropractors have specialized training or experience in a specific area, they may wish to confirm this with the specialty boards..." The chiropractor would be required to disclose the educational requirements met for their credentials. Ms. Schieldge agrees with the concern and interest in protecting consumers by using appropriate disclaimers and disclosures relevant to education and training so that the consumer can make an informed decision about a licensee.

Discussion and Possible Action on Proposed Language Regarding Maintenance of Patient Records/Amendment to Title 16, California Code of Regulation (CCR) Sections 312.2 and 318

Proposed draft language for Patient Records and Retention Requirements was discussed at length. **(Please Note: The prior committee draft was erroneously numbered as CCR Section 318.1. However the draft content was relevant and correct for the review that occurred on this topic).** The committee requested revisions to the draft content and determined those revisions can be incorporated into the current CCR Section 318 by renumbering it. Proposed language for CCR Section 318 will be brought back to the next committee meeting for further review and discussion.

The topics of Proof of Service, Custodian of Records and the Affordable Care Act (ACA) were additionally discussed as they relate to records or retention requirements.

Related to Proof of Service, Ms. Schieldge mentioned that it is an option to send First Class Mail with Proof of Service. Dr. Azzolino stated that Proof of Service is too cumbersome, due to the volume of patients and suggested a recommendation for a modified voice mail recording or website announcement about records location.

There was lengthy discussion regarding Custodian of Records. Dr. Azzolino stated that the Custodian of Records should be the chiropractic practice where treatment was provided, unless the patient starts treating elsewhere. Dr. Dehn stated that it depends on the agreement of the group of doctors as to who is the Custodian of Records. The committee members also agree that there are many scenarios that could arise regarding this subject. Ms. Schieldge stated that the Board's regulations do say "each licensed chiropractor shall maintain records..." so there has to be an identifiable licensee who is responsible.

Ms. Schieldge recommended that the Board decide who is responsible for notifying patients about the records location, and when the notification should occur.

Dr. Azzolino stated that we should spend some time reviewing the ACA. Ms. Schieldge stated that she had not yet researched if the ACA had included new record retention requirements for minors or even adults. She also stated that the statute of limitations for civil actions was listed in the Code of Civil Procedure Section 340.5. Ms. Schieldge also stated she would be happy to hear if the CCA has other information on this issue. Ms. Cunha from CCA offered the Board staff a copy of the CCA Medical Records Kit document for members.

Dr. Azzolino recommended that Ms. Walker do a check with Malpractice Carrier(s), specifically about the medical records retention period for minors.

Ms. Schieldge recommended that the words "personal representative" and/or "conservator" be added to CCR Section 312.2 because they are being added to CCR Section 318.

Dr. Dehn asked for clarity with reference to patient signature and electronic capabilities. Ms. Schieldge stated she will check the Electronic Signature Act from Secretary of State for this information.

The Committee reviewed and discussed the handout containing Helpful Hints about practice closure. About three to four changes were recommended. A revised handout will be brought back to the next committee meeting.

Discussion of Developing Qualifications and Proficiency Standards for Expert Consultants with the Enforcement & Scope of Practice Committee to Define Criteria and Standards for Expert Consultant Selection. [2014-2017 Strategic Plan]

Dr. Azzolino asked for the upcoming Expert training to be scheduled.

Mr. Puleo explained that a training session for Expert Consultants has not yet been scheduled due to the pending revisions on the Expert application. After review and discussion, one additional revision was requested in Section 3, to finalize the Expert application.

Public Comment
None

Future Agenda Items
None

Adjournment
Dr. Azzolino adjourned the meeting at 4:34 p.m.

BOARD of CHIROPRACTIC EXAMINERS
STATE OF CALIFORNIA

APPLICATION FOR EXPERT CONSULTANT

BOARD OF CHIROPRACTIC EXAMINERS
901 P Street, Suite 142A
Sacramento, California 95814
916-263-5355

Complete each section and attach your curriculum vitae/resume. If you need additional space you may attach a separate sheet. **PLEASE TYPE OR PRINT LEGIBLY**

SECTION 1 –APPLICANT INFORMATION

NAME: **(Last, First, Middle)**	**CHIROPRACTIC LICENSE NO.:**
BUSINESS ADDRESS:	
CITY: **STATE:**	**ZIP Code:**
TELEPHONE NUMBERS (include area code) **Office:** **Mobile:** **FAX:**	**EMAIL ADDRESS:** **WEBSITE ADDRESS(ES):**

CURRENT EMPLOYMENT INFORMATION

EMPLOYER:	
ADDRESS:	
CITY **STATE**	**ZIP Code**
TELEPHONE NUMBERS (include area code) **Office:** **FAX:**	**EMAIL ADDRESS:**
POSITION:	**HOW LONG?:**

COLLEGE EDUCATION

COLLEGE/UNIVERSITY:	
CITY **STATE**	**ZIP Code**
DEGREE EARNED:	**YEAR COMPLETED:**

PROFESSIONAL EDUCATION

CHIROPRACTIC COLLEGE:	
CITY **STATE**	**ZIP Code**
DEGREE:	**DATE COMPLETED:**

SECTION 2 –PROFESSIONAL QUALIFICATIONS

Year of Initial Licensure: Current Status of License (i.e., active; inactive):	Are you actively treating patients? YES ☐ NO ☐ What percentage of time, per month?

Have you ever been employed by or provided services to the Board? YES ☐ NO ☐
If so, when and what services did you provide?

Are you board-certified or board-eligible in any of the chiropractic diplomate programs? YES ☐ NO ☐

If yes, attach a copy of each certification or eligibility.

Have you, at any time in the past two years, worked for an insurance carrier, self-insured plan, third party administrator, or chiropractic claims review company? YES ☐ NO ☐

If yes, attach a description of the services you provided and your employment relationship with the above-mentioned entities.

Are you a State of California Qualified Medical Evaluator?
YES ☐ -QME Cert No.: _____ NO ☐
If yes, attach a copy of the certificate.

SECTION 3 –COURT EXPERT WITNESS EXPERIENCE and KNOWLEDGE

Have you testified in court as an Expert witness as a Doctor of Chiropractic?
YES ☐ I have this experience No ☒ I do NOT have this experience

If yes, how many total years have you testified as a Chiropractic Expert witness? _____

Within the last 3 years:
How many times have you testified as a Chiropractic Expert witness? _____
How often? _____

What was the approximate date of your last Chiropractic Expert court testimony: _____

You may describe your court experience on a separate attachment if necessary.

Do you have knowledge and experience with presenting testimony in court or arbitrations as an expert in medical and legal proceedings?

- ☐ I have extensive knowledge and experience *
- ☐ I have some knowledge and experience
- ☐ I have minimal knowledge and experience
- ☐ I have no knowledge and experience

***If you have checked the boxes indicating extensive knowledge and experience, provide explanation on a separate sheet**

Do you have knowledge of and ability to interpret current laws and regulations in Expert testimony?

- ☐ I have extensive knowledge and experience *
- ☐ I have some knowledge and experience
- ☐ I have minimal knowledge and experience
- ☐ I have no knowledge and experience

***If you have checked the boxes indicating extensive knowledge and experience, provide explanation on a separate sheet**

SECTION 4 –KNOWLEDGE AND EXPERIENCE

For each phrase listed below, please mark the statement that most accurately represents the depth of your knowledge and experience in the field of Chiropractic:

A. Knowledge and skill in case review of medical records (including x-rays) for the purpose of medical and legal proceedings.
- ☐ I have extensive knowledge and experience *
- ☐ I have some knowledge and experience
- ☐ I have minimal knowledge and experience
- ☐ I have no knowledge and experience

B. Knowledge of and ability to interpret current chiropractic laws and regulations, including standard of care.
- ☐ I have extensive knowledge and ability *
- ☐ I have some knowledge and ability
- ☐ I have minimal knowledge and ability
- ☐ I have no knowledge and ability

C. Knowledge and experience rendering opinion or summary of findings regarding treatment utilization or questionable billing issues.
- ☐ I have extensive knowledge and experience *
- ☐ I have some knowledge and experience
- ☐ I have minimal knowledge and experience
- ☐ I have no knowledge and experience

D. Knowledge and experience in performing case management / peer review evaluations regarding the professional conduct of licensees as required by chiropractic related law.
- ☐ I have extensive knowledge and experience *
- ☐ I have some knowledge and experience
- ☐ I have minimal knowledge and experience
- ☐ I have no knowledge and experience

E. Knowledge and experience in reviewing chiropractic laws and regulations and rendering written opinions relating to the review of chiropractic related laws and regulations.
- ☐ I have extensive knowledge and experience *
- ☐ I have some knowledge and experience
- ☐ I have minimal knowledge and experience
- ☐ I have no knowledge and experience

***If you have checked the boxes indicating extensive knowledge and experience, provide explanation on a separate sheet.**

SECTION 5 –ACADEMIC APPOINTMENTS

Have you ever held any academic appointments at any college or university? YES ☐ NO ☐

If yes, attach a description of each appointment and your job duties.

SECTION 6 –PUBLICATIONS

Please list all published articles and texts which you have written:

_____

_____

_____

_____

Have you developed or assisted in the development of chiropractic statutes, regulations, and/or guidelines?
YES ☐ NO ☐ If yes, attach a description of each experience.

SECTION 7 –DISCIPLINARY INFORMATION

Have you ever been involved in a malpractice lawsuit or arbitration proceeding related to your treatment of a patient? YES ☐ NO ☐
If yes, attach an explanation on a separate attachment, for each lawsuit or arbitration complaint.

Are there currently any medical malpractice lawsuits or arbitration claims pending against you?
YES ☐ NO ☐
If yes, attach an explanation on a separate attachment, for each lawsuit or arbitration complaint.

Has your professional liability insurance coverage ever been denied, limited, or cancelled by the action of any insurance company? YES ☐ NO ☐
If yes, attach an explanation on a separate attachment, for each occurrence.

Be sure to answer all questions. If you answer "yes" to any of the following, attach an explanation on a separate piece of paper.

(A) Has your chiropractic license (in this state or another state) or any health related professional licensing or disciplinary body in any state, territory or foreign jurisdiction, or any branch of the military, denied, limited, placed on probation, restricted, suspended, cancelled or revoked any professional license, certificate, or registration granted to you, or imposed a fine, reprimand, or taken any other action against you?
YES ☐ NO ☐

(B) Has your participation in any private, state, or federal health insurance program ever been the subject of disciplinary action? YES ☐ NO ☐

(C) Has any other type of professional sanction, discipline, or other adverse action ever been taken against you? YES ☐ NO ☐

(D) Have you ever been the subject of an investigation by any private, state, or federal health insurance program? YES ☐ NO ☐

(E) Have you ever been convicted of a misdemeanor or felony or are you currently under indictment for any alleged criminal activities? YES ☐ NO ☐

(F) Have you ever been the subject of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct? YES ☐ NO ☐

(G) Have you ever voluntarily surrendered a professional license, staff privileges or consented to a limitation of the same pending a review or investigation? YES ☐ NO ☐

(H) Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective and objective professional services? YES ☐ NO ☐

SECTION 8 –PERSONAL SUMMARY/WRITING SAMPLE

Attach a 1-page typed document, answering the following question (include an overview of your qualifications, including experience and training):

Why do you want to be an expert witness for the California Board of Chiropractic Examiners?

If available, provide a sample copy of your most recent Med/Legal or Expert Consultant report written by you. Be sure to redact all personal and confidential information. ☐ - A sample report is unavailable

SECTION 9 –REFERENCES

List two professional references who can verify your knowledge and ability to perform the necessary functions of an Expert for the Board:		
Name: (Last, First)		Relationship:
Company		Telephone No.:
Address:		
City:	State:	ZIP Code:
Name: (Last, First)		Relationship:
Company		Telephone No.:
Address:		
City:	State:	ZIP Code:

SECTION 10 –AFFADAVIT

Please Read and Initial each Paragraph

I hereby certify that I have not knowingly withheld any information that might adversely affect my appointment as an expert reviewer and the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. _____

I hereby authorize the Board to thoroughly investigate all of the information I have provided on this application, including attachments, as well as my references, work record, education and other matters related to my suitability for appointment as an expert and, further, authorize the references I have listed to disclose to the Board any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the Board, my current and former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure. _____

I hereby certify under penalty of perjury under the laws of the State of California that all statements, answers and representations in this application, including all attachments, are true and accurate.

Signature of Applicant: _____ **Date:** _____

State of California
Board of Chiropractic Examiners

Guidebook for Expert Consultants

September 2014

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Section I

INTRODUCTION

The State Board of Chiropractic Examiners (Board) is an administrative agency created by the Chiropractic Initiative Act of 1922. The Board's paramount responsibility is to protect California consumers from the fraudulent, negligent, or incompetent practice of chiropractic care. Among its many duties, the Board investigates and disciplines chiropractors for unprofessional conduct to protect the public from incompetent, negligent, dishonest or impaired chiropractors. Your role as an expert consultant is extremely important in identifying whether a deviation from the chiropractic standard of care or unprofessional conduct has occurred and in serving as an expert consultant at any hearing that may result from your expert assessment.

These guidelines introduce you to the administrative disciplinary process and define the Board's expectations of the expert review you have been asked to provide, your responsibilities, your legal protection, your compensation, and your testimony if necessary.

As an expert consultant, which is the first stage of this process for yourself and perhaps the only stage (besides attendance at mandatory Expert training), you will be provided with the complaint, patient records, and certain other information, including any interviews with patients, subsequent treating chiropractors or other licensed health care providers, other witnesses, and any statements of the chiropractor who is the subject of the investigation. You will NOT be provided a copy of any report prepared by another Board expert consultant to avoid the appearance of tainting your evaluation. You will be asked on the basis of your review of the documentation provided to render your professional assessment of the care rendered by the subject chiropractor to the patient or patients involved and other conduct relating to the practice of chiropractic.

You are neither asked, nor should you try, to determine what discipline should be imposed upon the subject chiropractor. Your opinion must be based solely upon the information provided to you by the Board; however, whenever possible you should refer to chiropractic texts and other authoritative reference materials that help define accepted standards. Your opinion should be based upon your knowledge of the standard of care or compliance with professional conduct standards, based upon your education, training, and experience and not upon the manner in which you personally practice chiropractic care.

If you have prior knowledge of the subject chiropractor or if you feel you cannot be objective in your assessment for any other reason, please immediately contact the Board representative who sent you the materials. Also, if you are in need of any additional documents or the records provided to you appear incomplete, please contact the Board representative who will attempt to resolve the issue.

In some cases, you will be required to testify in person as to your opinions in administrative hearings held before an administrative law judge and be subject to

cross-examination by the respondent regarding your opinions. In these instances, you will be considered an expert witness and will be required to make time to meet with the Deputy Attorney General (DAG) assigned to prosecute the matter in advance of the hearing to prepare for the hearing.

The Board appreciates your cooperation in lending your expertise and experience to accomplish this important work. The Board recognizes that you play a vital role and your objective performance will reflect well on the Board and the profession.

Section II

CRITERIA/COMPETENCY REQUIREMENTS FOR EXPERT CONSULTANTS

Effective September 2014, Board Expert Consultants must certify or declare under penalty of perjury on the Expert Consultant application for appointment that he or she:

A. Has not been employed by any insurance company or chiropractic review service within two (2) years prior to their appointment or use as a Board expert.

B. Has experience providing written review and evaluation of the professional competence, standard of patient care, or conduct of licensees in relationship to the requirements of law and regulations.

C. Has an active California license in good standing with no statement of issues or prior or pending disciplinary actions, which may deem or impact that license status as revoked, restricted, interim suspended, suspended, or probationary in nature from the state licensing board.

D. Has possessed an active California license for a minimum of five (5) years.

E. Has not sustained a misdemeanor or felony conviction related to the practice of chiropractic, including crimes of fraud or moral turpitude.

F. Has experience providing Expert witness testimony in court.

G. Will not use their status as an Expert to promote themselves in advertisements.

H. Will not use the Board as a reference, or in any way indicate that they are endorsed by the Board.

I. Will not state nor imply that they are an employee or representative of the Board other than when they are testifying as a witness on a case for which they are acting in the capacity of an expert.

Section III
DEFINITIONS

The following terms are used throughout this guide and have specific legal meaning:

"Negligence" is the failure to exercise the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful chiropractors would possess and use in similar circumstances.[1]

If a chiropractor is a specialist, then "negligence" is the failure to exercise the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful chiropractic specialists (in the same specialty) would possess and use in similar circumstances.[2]

Under California law, a "single act of negligence" does not constitute grounds for discipline of a professional license, however, "repeated acts of negligence" does constitute grounds for discipline of a professional license.

"Standard of Care" and "Standard of Practice" are terms used in evaluating the negligence of a chiropractor. The term "standard of care" and "standard of practice" are used interchangeably, however, for purpose of this document and your report, please use the term "standard of care." The standard of care requires that the chiropractor exercise that degree of skill, knowledge, and care ordinarily possessed by members of his or her profession under similar circumstances.[3]

"Gross Negligence" an extreme departure from the ordinary standard of care.[4]

"Incompetence" means an absence of qualification, ability or fitness to perform a prescribed duty or function. Incompetence is distinguishable from negligence in that one may be competent or capable of performing a given duty but was negligent in performing that duty.

Thus, a single act of negligence may be attributable to remissness in discharging known duties, rather than incompetence respecting the proper performance.[5]

"Scope of Practice" refers to the range of services that can be provided by a chiropractor under the Chiropractic Initiative Act. The scope of practice is found in Sections 7 and 16 of the Initiative Act, Section 302 and 306 of the regulations, and in several California court decisions.

"Administrative Procedure Act" is the California law that governs all Board disciplinary cases against a chiropractor.

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1 California Civil Jury Instructions CACI 501, 2003.
2 California Civil Jury Instructions CACI 502, 2003.
3 Barris v. County of Los Angeles, 20 Cal.4th 101, 83 Cal.Rptr.2d 145 (1999).
4 Kearl, v. Board of Medical Quality Assurance, 189 Cal.App3d 1040 (1986); City of Santa Barbara v. Superior Court, 41 Cal.4th 747, 62 Cal.Rptr3d 527 (2007).
5 Kearl.

"Administrative Law Judge" or "ALJ" presides at all administrative hearings before the Board.

"Deputy Attorney General" or "DAG" is the attorney that represents the Board's Executive Officer who is the "complainant" in all disciplinary cases. DAGs are employed by the California Attorney Generals Office.

Section IV

GUIDELINES FOR EXPERT CONSULTANTS

FREQUENTLY ASKED QUESTIONS

1. Will I have to testify?

Possibly. If the case is submitted for disciplinary action and a stipulated agreement is not reached, you will be called upon to provide expert testimony before an ALJ. However, the majority of cases are settled before a hearing is held.

2. How much will I be paid?

The expert is paid $100 per hour for record review and a maximum of $600 per half day and $1200 per full day of testimony at an administrative hearing. You will also be compensated for other expenses you may incur, (i.e., parking, postage or travel, if applicable) in accordance with state law (effective July 1, 2008).

3. How soon will I be paid?

Generally speaking you should receive payment for your services within 4 to 6 weeks following receipt of your billing for services rendered. Incomplete forms will delay payment so be sure to provide your taxpayer identification number and signature. It is also important to complete the Payee Data Record form that is required by the IRS and return it with the statement.

4. Can I be sued for expressing my opinion and if I am sued who will represent me?

Yes. However, **Civil Code section 43.8** provides immunity from civil liability for expert consultants. If you are sued, either the Attorney Generals Office or outside counsel in the event of the conflict with the Attorney Generals Office will represent you.

5. Should I do research?

Yes, you should consult chiropractic texts and other authoritative reference materials that help define accepted standards and are encouraged to do so. However, it is important that you do not attempt to conduct your own investigation of the facts in the case.

6. How soon do I need to complete the review and provide an opinion?

The Board expects reports to be completed within 30 days of assignment; however, this may vary depending on the volume and complexity of the case. In a complicated case involving multiple patients, your review could extend beyond our 30-day time frame in which you are expected to notify the Board representative. Keep in mind that the chiropractor you are reviewing will continue to see patients until a determination is made by the Board. If this chiropractor poses a danger to patients, it is vital that you provide your opinion expeditiously so that the Board can move rapidly to protect the public.

7. Who will see my report?

The Subject chiropractor will be provided with a copy of your report as a part of legal discovery if an accusation is filed. In addition, if the case goes to a hearing, your report may be introduced into evidence.

8. Can you give me a copy of a sample report?

Yes, please see Section VII.

9. What is the difference between negligence and gross negligence?

See Definitions Section for full explanation.

INSTRUCTIONS

A. Ensure that records, reports and materials provided for your review are kept confidential and secure.

B. Review the case and determine if there is any reason you cannot provide an opinion because of a professional or personal relationship with any subject, witness, or patient.

C. If for any reason you determine that you cannot complete the review or provide an opinion, please let us know immediately and the case will be reassigned.

D. Keep track of dates and hours spent reviewing.

E. Do not mark on the copy of the records provided to you.

F. Do not contact the Subject or patients.

G. Do not discuss the case with outside third parties. You may use an office assistant or transcriptionist to assist you in the preparation of your report.

H. Do not perform any investigation on your own, i.e., attempting to obtain additional records or interviewing participants in the case. If you feel the file is incomplete, please contact the enforcement staff at the Board.

I. Do not offer any recommendation about the appropriate disciplinary action for the Subject.

J. Do not make a copy of the records.

K. Do not destroy any of the materials provided to you.

L. Remember to date and sign your opinion.

M. Enclose a current curriculum vitae with your report. Fourteen (14) days before the hearing, if a hearing is scheduled, you need to send an updated curriculum vitae to the DAG assigned to the case.

N. When your review is completed, please return your report along with the documents unmarked and in bate-stamped order, confidentiality and conflict of interest agreement, statement for services, and current curriculum vitae. It is necessary for you to retain the report until the case is final in the event you need to review it for either a meeting with the DAG or in preparation for a hearing.

O. If you have questions or concerns, contact the Board's enforcement manager or Executive Officer.

IMMUNITY FROM LIABILITY and LEGAL REPRESENTATION

Civil Code Section 43.8 states, in pertinent part:

". . . . there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person on account of the communication of information in the possession of such person to any hospital, hospital medical staff, . . . professional licensing board or division, committee or panel of such licensing board, the Senior Assistant Attorney General of the Health Quality Enforcement Section appointed under section 12529 of the Government Code, peer review committee, . . . when such communication is intended to aid in the evaluations of the qualifications, fitness, character . . . of a practitioner of the healing arts . . . . "

This statutory provision provides for immunity from civil liability for expert consultants and expert witnesses acting within the scope of their duties in evaluating and testifying in cases before the Board. Should any problems arise in this area or if you are served a lawsuit related to your participation in this process, you should immediately contact Board staff. Failure to do so may result in a default decision being taken against you.

Section 306.2 of the regulations provides that the Board through the Attorney Generals

Office shall provide legal representation under specified conditions. This section reads:

"If a person, not a regular employee of the board, is hired or is under contract to provide expertise or to perform investigations for the Board of Chiropractic Examiners in the evaluation of the conduct of a licensee or administration of a board examination, and such person is named as a defendant in a civil action directly resulting from opinions rendered, statements made, investigations conducted or testimony given, the board shall provide for representation required to defend the defendant in that civil action. The board shall not be liable for any judgment rendered against that person. The Attorney General shall be utilized in those civil actions."

CONFIDENTIALITY AND CONFLICT OF INTEREST

As an expert consultant to the Board, you must safeguard the confidentiality of the records delivered to you for review and protect the identity of the patients, complainants and chiropractors involved. If you have prior knowledge of the subject chiropractor or if you feel you cannot be objective in your assessment for any other reason, please immediately contact the Board representative who sent you the materials. You will be given materials to review, including relevant patient records and investigative materials. You are obligated not to divulge any information contained in these materials to other parties. The obligation to preserve confidentiality also extends to any assistant you may utilize in the preparation of your report. You will be required to sign a confidentiality and conflict of interest agreement form on each case you review.

INVESTIGATIONS AND THE DISCIPLINARY PROCESS

The Board is responsible for investigating and bringing disciplinary action against the professional licenses of chiropractors suspected of violations of the Chiropractic Initiative Act of California, the California Code of Regulations, and other applicable laws and regulations.

The Board's hearings are conducted in accordance with the Administrative Procedure Act **(Government Code § 11150 et seq.)**. Its investigations are conducted pursuant to **Government Code sections 11180 though 11191**.

The Board, through the Executive Officer and investigative staff, identifies and takes appropriate action against chiropractors who commit unprofessional conduct, including acts or omissions evidencing repeated negligence, gross negligence, or incompetence, practicing under the influence of drugs or alcohol, practicing while mentally or physically impaired affecting competence, fraudulently billing patients or health insurance companies, clearly excessive treatment or use of diagnostic procedures, altering or creating false records, sexual misconduct, criminal acts and other conduct that endangers the health, welfare, or safety of the public.

The Board Members are not involved in the investigatory, expert review, or decision as to whether an accusation should be filed.

Consequently, you should NEVER contact any Board Member regarding any aspect of any case even after you have completed your opinion.

The purpose of the disciplinary process is not to punish as in the criminal justice system but to protect California consumers by ensuring that quality chiropractic care is provided by licensed chiropractors.

Standard investigations in quality of care cases include obtaining all relevant patient records, conducting interviews with witnesses, including the affected patient or patients, and obtaining any additional information. In insurance fraud cases, billing records and insurance claims are obtained. At times, information is found that goes far beyond the original complaint. After the documentary and interview evidence is obtained, the case is reviewed by the Board to determine if an evaluation by an expert consultant is necessary. If so, Board staff sends the case to an expert consultant who is qualified to render an opinion as to whether a departure from the standard of care occurred.

After the expert consultant submits his or her report, the Board makes a determination if the matter should be submitted to the Attorney General's Office to determine whether sufficient evidence exists to file an accusation against the subject chiropractor for unprofessional conduct.

If it is determined that sufficient evidence exists, an accusation is prepared and served upon the subject chiropractor, and he or she is given the opportunity to contest the charges.

In a majority of cases, the case is settled between the parties. However, if the case is not settled, a hearing is held before an Administrative Law Judge (ALJ) of the Office of Administrative Hearings. The hearing may last from one day to several weeks, depending upon the complexity of the case and the defense. Both sides may call expert witnesses to support their views. This makes it incumbent upon the expert consultant to ensure the utmost care is taken when reviewing cases. The ALJ hears evidence against and for the subject chiropractor and renders a proposed written decision that is submitted to the Board Members for adoption as its decision in the matter. If the Board members adopt the proposed decision, it becomes final; if the Board members do not adopt the proposed decision, the administrative record is ordered including the transcript from the hearing, the exhibits, and other documents. The Board members then decide the case themselves based upon the administrative record and the disciplinary guidelines. The Subject chiropractor may petition for reconsideration if dissatisfied with the decision or proceed to take a writ of mandate to the appropriate Superior Court contesting the decision.

STAGES OF EXPERT REVIEW

A. Investigative Review

After the investigator assigned to a case has completed his or her investigation, the case is reviewed by a Board reviewer who then makes a recommendation as to whether or not a full expert evaluation is warranted. If the Executive Officer agrees that an expert evaluation is necessary, that is where you come into the process.

You, the expert consultant at this point, will be contacted by the Board and will be

asked to review the case. Information will be provided to you that should be sufficient for you to determine whether you will be able to devote the necessary time to the matter and prepare an expert report in a timely manner. If you agree to review the case, you will be provided with the case file that includes all necessary documents, statements, and other evidence to render your opinion. Your review should include an assessment of all relevant aspects of chiropractic care with strict attention to information provided in the file. If you should require any other information or something is not clear, you should contact the Board's representative, and every effort will be made to provide you with the information necessary.

You must remember that at this stage, the review is primarily concerned with whether the facts as presented constitute unprofessional conduct. You are not asked to be an advocate for the Board, the chiropractor, or the patient. Your evaluation should be objective, well reasoned and impartial because it is the primary factor in deciding whether the case is submitted for disciplinary action.

The Board is not interested in using your services to advocate a position, make an example of a licensee or punish a licensee. The Board only wants you to provide an objective evaluation so that it can determine if public protection warrants the filing of disciplinary charges. Your evaluation may also result in the issuance of a lesser enforcement action such as a citation.

B. Hearing Testimony

Once the case is submitted for disciplinary action, and an accusation is filed, you may be called upon to provide expert testimony, should the case go to a hearing. The majority of cases are settled before a hearing is held.

If a case is set for hearing, the Deputy Attorney General (DAG) assigned to prosecute the case will meet with you, perhaps several times, to review your expert opinion. You will be asked to educate the DAG in the details of your opinion and to assist in the presentation of that opinion in the clearest and most concise manner possible. You may also be asked to assist in reviewing the opinions of the opposing experts and in preparing cross-examination questions for them.

During the hearing, you will be called as the Board's expert witness to testify concerning your opinion and the reasons for your opinion. You will be asked questions by the DAG and by the subject chiropractor or his or her attorney if the chiropractor is represented by counsel. The total time taken for your testimony at the hearing varies with the complexity of the case. The subject chiropractor will have been provided with copies of any written opinions you have submitted during the investigative stage of the case. You should always provide truthful testimony even if it is contrary to the interests of the Board. You may also be asked to evaluate the opinions expressed by respondent's expert at hearing because oftentimes respondents' experts fail to prepare a written opinion.

REGULATION SECTION 317 "UNPROFESSIONAL CONDUCT"

The following are the primary laws that are used when an expert consultant is evaluating a case. However, you should be familiar as an expert in the field with all applicable laws relating to the practice of chiropractic.

Section 317 referred to above under "Quality of Care" includes other acts that constitute unprofessional conduct. This section reads:

The Board shall take action against any holder of a license who is guilty of unprofessional conduct which has been brought to its attention, or whose license has been procured by fraud or misrepresentation or issued by mistake.

Unprofessional conduct includes, but is not limited to, the following:

(a) Gross negligence;
(b) Repeated negligent acts;
(c) Incompetence;
(d) The administration of treatment or the use of diagnostic procedures which are clearly excessive as determined by the customary practice and standards of the local community of licensees;
(e) Any conduct which has endangered or is likely to endanger the health, welfare, or safety of the public;
(f) The administration to oneself, of any controlled substance, or the use of any dangerous drug or alcoholic beverages to the extent or in a manner as to be dangerous or injurious to oneself, or to any other person or to the public, or to the extent that the use impairs the ability of the person to conduct with safety to the public the practice authorized by the license;
(g) Conviction of a crime which is substantially related to the qualifications, functions or duties of a chiropractor;
(h) Conviction of any offense, whether felony or misdemeanor, involving moral turpitude, dishonesty, physical violence or corruption. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if such conviction was of an offense involving moral turpitude, dishonesty, physical violence or corruption. A plea or verdict of guilty, or a plea of nolo contendre is deemed to be a conviction within the meaning of the board's disciplinary provisions, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code. The board may order a license to be suspended or revoked, or may decline to issue a license upon the entering of a conviction or judgement in a criminal matter.
(i) The conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any dangerous drug or alcoholic beverage, or any combination of those substances
(j) The violation of any of the provisions of law regulating the dispensing or administration of narcotics, dangerous drugs, or controlled substance;
(k) The commission of any act involving moral turpitude, dishonesty, or corruption, whether the act is committed in the course of the individual's activities as a license holder, or otherwise;
(l) Knowingly making or signing any certificate or other document relating to the

practice of chiropractic which falsely represents the existence or nonexistence of a state of facts;

(m) Violating or attempting to violate, directly or indirectly, or assisting in or abetting in the violation of, or conspiring to violate any provision or term of the Act or the regulations adopted by the board thererunder;

(n) Making or giving any false statement or information in connection with the application for issuance of a license;

(o) Impersonating an applicant or acting as a proxy for an applicant in any examination required by the board for the issuance of a license or certificate;

(p) The use of advertising relating to chiropractic which violates section 17500 of the Business and Professions Code;

(q) The participation in any act of fraud or misrepresentation;

(r) Except as may be required by law, the unauthorized disclosure of any information about a patient revealed or discovered during the course of examination or treatment;

(s) The employment or use of persons known as cappers or steerers to obtain business;

(t) The offering, delivering, receiving or accepting of any rebate, refund, commission, preference, patronage, dividend, discount or other consideration as compensation or inducement for referring patients to any person;

(u) Participation in information or referral bureaus which do not comply with section 317.1 of the regulations.

(v) Entering into an agreement to waive, abrogate, or rebate the deductible and/or co-payment amounts of any insurance policy by forgiving any or all of any patient's obligation for payment thereunder, when used as an advertising and/or marketing procedure, unless the insurer is notified in writing of the fact of such waiver, abrogation, rebate, or forgiveness in each such instance. ***(Subdivision contains actual waiver language)***

(w) Not referring a patient to a physician and surgeon or other licensed health care provider who can provide the appropriate management of a patient's physical or mental condition, disease or injury within his or her scope of practice, if in the course of a diagnostic evaluation a chiropractor detects an abnormality that indicates that the patient has a physical or mental condition, disease, or injury that is not subject to appropriate management by chiropractic methods and techniques. This subsection shall not apply where the patient states that he or she is already under the care of such other physician and surgeon or other licensed health care provider who is providing the appropriate management for that physical or mental condition, disease, or injury within his or her scope of practice.

(x) The offer, advertisement, or substitution of a spinal manipulation for vaccination.

TYPES OF EVALUATION

Because there are many possible violations of the laws governing the practice of chiropractic, evaluations of cases vary with the subject matter of the possible unprofessional conduct. Listed are the major kinds of evaluations you may be asked to prepare.

1. Quality of Care

These cases involve the quality of care rendered to a patient or patients. The general question asked in this context is whether the subject chiropractor's treatment of the patient constituted gross negligence, repeated acts of negligence, or incompetence. Often, it is difficult to distinguish which of these definitions fits the treatment rendered and sometimes, the conduct described exhibits both incompetence and negligence or gross negligence for a given patient's treatment.

One departure from the standard of care is not considered unprofessional conduct unless it is an extreme departure. Your evaluation should state whether in your opinion it is negligence, repeated acts of negligence, gross negligence or incompetence. You may have situations where the subject's conduct constituted both negligence and incompetence. You should explain this in your report.

The determinations are often difficult to make, but that is why you are called upon to render your expert opinion. With your knowledge of the standards of care within the chiropractic community, especially in your area of expertise, we are asking you to render a professional opinion based upon your education, knowledge, experience, and training.

2. Sexual Misconduct

Section 316 of the regulations prohibits certain sexual acts both on the premises of a chiropractic business and with patients and other individuals. This section reads:

"(a) Every licensee is responsible for the conduct of employees or other persons subject to his supervision in his place of practice, and shall insure that all such conduct in his place of practice conforms to the law and to the regulations herein.

(b) Where a chiropractic license is used in connection with any premises, structure or facility, no sexual acts or erotic behavior involving patients, patrons or customers, including, but not necessarily limited to, sexual stimulation, masturbation or prostitution, shall be permitted on said premises, structure or facility.

(c) The commission of any act of sexual abuse, sexual misconduct, or sexual relations by a licensee with a patient, client, customer or employee is unprofessional conduct and cause for disciplinary action. This conduct is substantially related to the qualifications, functions, or duties of a chiropractic license.

This section shall not apply to sexual contact between a licensed chiropractor and his or her spouse or person in an equivalent domestic relationship when that chiropractor provides professional treatment."

In this area you are asked to assess, based upon the standard of care, whether a chiropractor's relationship or conduct with a patient constitutes unprofessional conduct based on California law and the facts presented in each case.

In evaluating these cases, you are not asked to evaluate the CREDIBILITY of the complaining witness or whether the alleged statements or actions actually occurred.

This will be determined at the hearing, if one is held. For purposes of your review, you are to assume that the complainant's account of the doctor's conduct is true.

While some actions clearly constitute sexual misconduct, there are cases in which you will need to consider whether the conduct was appropriate because the doctor used an acceptable diagnostic or treatment technique.

In these cases, your evaluation should address whether the diagnostic or treatment technique is appropriate and whether the doctor used the diagnostic or treatment technique in an appropriate manner with the patient.

3. Excessive Treatment Violations

California Code of Regulations Section 317 states that the "administration of treatment or the use of diagnostic procedures which are clearly excessive as determined by the customary practice and standards of the local community of licensees..." In this type of case, you are asked to state the standard of the local community of licensees concerning the number of chiropractic visits necessary to treat a certain condition and the kind and extent of diagnostic procedures necessary to diagnose the condition. Excessive treatment may also constitute gross negligence or repeated acts of negligence. The insurance industry does NOT set the standard of care, therefore whether or not an insurance company considered treatment to be excessive is irrelevant.

4. General Unprofessional Conduct

Section 317 states that a chiropractor may be disciplined for unprofessional conduct, which includes, BUT IS NOT LIMITED TO certain enumerated conduct. Any unprofessional conduct which is not set forth as such in the Chiropractic Initiative Act, governing regulations, or other statutes covering the practice is referred to as "general unprofessional conduct." General unprofessional conduct reflects conduct which demonstrates an unfitness to practice chiropractic that does not fit into other categories.

In a case entailing ethical violations, you are asked to set forth the standard of conduct for a chiropractor in the circumstances described, and perhaps the underlying ethical code, and then you are asked to describe in what manner the subject chiropractor violated that standard.

Section V

THE OPINION ITSELF

There are Sample Expert Reports appended to this booklet at Section VI. Please refer to those when writing your report, but remember they are guidelines only, and your case and the contents of your report will necessarily differ.

A. Contents

Your expert report should contain:

1) An accurate listing of the records and other documents sent to you –for review. Additionally, all of the documents provided for your review will be stamped with a sequential number ("Bates Stamped.) For example, if you receive a five-page investigation report and 50 pages of patient records, each one will contain a page number stamped at the bottom of the page starting from 1 to 55. You should refer to these numbers whenever you reference a document in your evaluation. This will assist the DAG who will later review your report. It will also ensure that your testimony before an administrative law judge will be organized and time-efficient.

2) The substance of the opinion, which should consist of the following for each patient, if there is more than one patient:

   a. Do a summary of the patient's case, including relevant patient history and presenting complaint. Describe the subject chiropractor's treatment, and any subsequent treatment. Summarize the facts of the treatment and the findings.

   b. State the standard of care for the treatment of such a patient. Remember to state the standard of care for the community of chiropractors, not just the way in which you personally would treat such a patient. The standard reflects what a reasonable chiropractor would do under the circumstances.

   c. Specifically describe any departures from the standard of care and explain why. Each finding of a departure from the standard of care should be specifically described.

   d. State your opinion as to whether the overall care of this patient constitutes no departure, a departure, an extreme departure, a lack of knowledge or ability, excessive treatment, excessive use of diagnostic procedures, sexual misconduct, and so on, or any combination. You must also state the basis for each opinion.

B. Violation vs. Mitigation

In writing your report, you are asked to summarize the treatment rendered and the findings of the subject chiropractor. In preparing your summary, you may have identified certain factors that could have hampered accurate treatment. Please remember that it is your obligation to state the standard of care and the departure therefrom.

Mitigation is defined as an abatement or diminution of penalty or punishment imposed by law. Although there are instances where mitigating circumstances are relevant to the imposition of any penalty, those factors will be considered by the trier of fact. Therefore, you are asked to refrain from commenting whether the subject chiropractor should or should not be punished because of certain mitigating or aggravating factors.

The actual discipline to be imposed on the chiropractor is the province of the trier of fact, and you are not expected to prescribe or recommend any discipline in the case.

C. Injury Is Not Essential

The primary focus in an expert review is whether there has been a departure from the standard of care of chiropractic, not whether the patient has been injured. Although the potential for injury because of the violation of the standard of care may be relevant to a determination of the degree of departure, actual injury is not required to establish unprofessional conduct. Also, just because there was no injury does not mean there was no departure from the standard of care. Conversely, injury to a patient in and of itself may not constitute violation of the standard of care.

D. Evaluation and Credibility

In many cases, the significant facts will not be in dispute. However in some cases, (such as sexual misconduct or allegation of assault) significant facts may be disputed. For example, the patient may state that something happened, while the subject may deny that it occurred. In those cases, your opinion should not include an assessment as to the subject and witnesses credibility, but if you render an opinion as to whether certain conduct constituted unprofessional conduct you should state in your report whose statement you relied to reach that conclusion.

E. Assess the Standard of Care as of the Time of the Violation.

The standard of care of chiropractic is constantly evolving, and so it is particularly important to be cognizant of the time that the violation occurred and assess the case in terms of the standard of care **AT THAT TIME**.

This does **not** mean, however, that if you were not in practice at the time of the violation, you are disqualified as an expert consultant. If you are aware of the standards at the time the violation occurred through your education, training and

experience, you may render an opinion on the case.

F. Objectivity

In performing your review, you should maintain objectivity, and view the assigned case without regard to any other legal activity that may surround it. In specific, you should ignore the existence, non-existence or magnitude of any civil judgments or settlements involving the case. Since you may not be reviewing the same documents that were used to support or refute a civil case, no attention should be paid to any past adjudicatory history. The expert consultant should focus on the patient records and other case records, not on the reports, depositions or other testimony of other expert witnesses. However, you may review deposition testimony of patients or non-expert witnesses.

Section VI

COMPENSATION

The Board staff will provide you with a form entitled "Expert Chiropractic Consultant Statement of Services" and a form entitled "Payee Data Record" for use in billing for services which you render to the Board as an expert consultant. You will be asked to fill out the Statement of Services form **COMPLETELY** for each case that you review and you may be required to fill out more than one Statement of Services form during the course of a case. Failure to fill out the form completely will delay your compensation. The Payee Data Record is only required to be completed annually.

A. Initial Evaluation

You will be compensated at the rate of $100 per hour for your evaluation and expert report. Please record the hours worked on the case for each DAY for your eventual billing.

The Board keeps its accounts by Fiscal Year, which begins July 1 through June 30. Please do not submit bills for two Fiscal Years on one form. Instead, use a separate form for each Fiscal Year.

B. Consultation with Deputy Attorney General

This includes any consultation, in person or by telephone, before the case is filed, during the pendency of the action, or in preparation for hearing. You will be compensated at the rate of $100 per hour.

C. Testimony at Hearing

You will be compensated at the rate of $600 for a half day of testimony and $1200 for a full day of testimony.

D. Miscellaneous Expenses

Expenses incurred in fulfilling the various requests may be itemized on a separate sheet of paper. Mileage and parking can be charged in connection with testimony at hearings. All expenses incurred in this category must be accompanied by a receipt, excluding mileage. In the event your testimony requires an overnight stay, the Board will make the appropriate arrangements for you.

Section VII

SAMPLE EXPERT OPINION(S)

The attached expert consultant report samples are what the Board expects from your expert review.

These are provided for purposes of reference as to format and expression only, and in no way reflects the decisions or opinions of the Board with reference to any of the fact situations cited. You may, in fact, agree or disagree with, or have no opinions about the opinion in substance.

TERMS TO BE AVOIDED IN REPORTS

Guilt or Innocence: The expert consultant's role is to determine whether, and in what manner, a chiropractor's actions depart from the standard of care, or demonstrate a lack of knowledge or ability.

Judgmental or subjective comments: Your report should objectively establish what behavior was expected and how the chiropractor failed to meet the expectation. Avoid terms such as *"this guy is clearly incompetent"* or *"no-one in his right mind would do..."*

Malpractice: Malpractice is a term which applies to civil law (i.e., suits between individuals). The Board functions under administrative law, and its cases deal with unprofessional conduct. Also, the expert consultant should not let any information regarding malpractice filings, settlements or judgments affect their review of a case. The standards of evidence and proof for civil cases are different than for administrative cases.

Penalties: It is not the role of the expert consultant to propose a penalty. This will be determined at hearing, based on detailed guidelines adopted by the Board and utilized by Administrative Law Judges.

Personalized comments: Avoid characterizing the actions of the chiropractor in personal terms: *"She was rude and unprofessional to the patient."* Instead, describe what the expected standard was, and how the chiropractor deviated from the standard.

Section VIII

SERVING AS AN EXPERT WITNESS

A. EXPERT WITNESS

You have been asked to testify at an *administrative hearing* against a chiropractor. You will be an *expert witness*. What this means is that because of your background, training and experience you can express opinions and make evaluations that a layperson could not make.

Prior to the hearing date, you will be contacted by the *Deputy Attorney General* (DAG) assigned to represent the Board and to present our case at the hearing. The DAG may arrange to meet with you to review the case, your written expert opinion, your qualifications to serve as an expert, and what you can expect at the hearing. The DAG also may ask you to review expert opinions provided by the respondent chiropractor or his or her attorney in the discovery phase of the case.

Discovery is when each side provides the other with all documents and other exhibits it will use, as well as the names of any witnesses it intends to call.

If the case is unusually complex or involves voluminous records, you may have to meet with the DAG more than once prior to the hearing.

B. THE HEARING

The hearing afforded a chiropractor who is charged by the Board, is known as an "administrative hearing," and is conducted under the Administrative Procedure Act (APA). While an APA hearing has some things in common with a criminal trial, it also has numerous differences. In general, APA hearings are less formal than trials. The hearing will be conducted by an Administrative Law Judge (ALJ) who works for an independent state agency, not for the Board. No jury is used in APA hearings. The attorneys (or the subject chiropractor, if he or she represents him or herself) can ask questions of witnesses for both sides (direct and cross-examination). The ALJ also may choose to ask a witness questions to clarify specific points.

As with a trial, the burden of proving the case rests with the Board, which brings the accusation against the subject chiropractor on behalf of the Board's Executive Officer who is the Complainant in these cases. In an APA hearing, the standard of proof that the Board must meet when an accusation is filed against a chiropractor is *"clear and convincing evidence to a reasonable certainty".* The standard that is used when a statement of issues (filed against an applicant) or citation is appealed is "preponderance of the evidence."

As with criminal trials, the Board presents its charges against the subject chiropractor first. The chiropractor or attorney can cross-examine each witness.

Then the chiropractor presents his or her defense, and the Board (DAG) has the opportunity to cross-examine. Each side has the opportunity to give an opening statement describing what they intend to prove and a closing statement summarizing what they have attempted to prove.

C. YOUR TESTIMONY

Before you can give evidence, you must establish your expertise at the hearing. This is done by the DAG asking you questions about your qualifications. This process is known as *voir dire.* You may be asked about the following, or about other matters relating to your qualifications:

1. Your license status and history.
2. Your education, chiropractic education and training.
3. Your experience.
4. Any private board certification or board eligibility you have achieved.
5. The extent of your experience as it relates to the types of chiropractic care or treatment at issue in this case.
6. Your professional affiliations, memberships, staff appointments and other associations.
7. Your publications.
8. Any other information that could shed light on your qualifications to be considered an expert.
9. You probably will be asked whether you know or have any kind of business or professional relationship with the subject chiropractor.

During direct and cross-examination, you probably will be asked questions about the documents and other "exhibits" you reviewed as you prepared your expert opinion report. You should be prepared to identify any publications or resources you referred to as part of your review. You also may be asked to describe the kinds and extent of experience you have in performing the chiropractic procedures or treatments involved in the case.

It is extremely important that you be able to describe what is the *standard of care in the chiropractic community* for the type of procedure involved in the case. The term "standard of practice" or "standard of care" is set by the community of licensed chiropractors based upon their training, education and experience. This standard may change over time with new advancements in chiropractic. It will be necessary for you, as an expert witness, to articulate what the current acceptable standard is in chiropractic for various diagnosis and treatment procedures. Focus on what the standard is. Also, use lay terms whenever possible, and explain unavoidable technical terms and acronyms.

Focus on how the treatment in a particular case departed from the standard of care.

You also may need to address a charge of incompetence based on use of outmoded procedures. In some instances, you may be faced with a lack or inadequacy of patient records upon which to assess the quality of the case the patient received. Your testimony may consist of pointing out that based on the patient chart, it is not possible to determine what tests, if any were ordered, what

instructions were given the patient, what in-office procedures were done, etc. You could be asked to explain the standard of care as it relates to documenting such information in the patient record.

Be prepared to discuss the degree to which the treatment departed from the standard of care. Was the treatment a departure or an extreme departure? For more information on this, see the Guidelines For Expert Consultants in Section IV.

Very often, the other side will attempt to discredit you, belittle your qualifications, or use other techniques to raise doubts about your testimony.

You should make every effort to remain objective and detached. Try not to become defensive or to lose your professional demeanor. Your role is as a teacher, not as an advocate for the Board.

D. AFTER THE HEARING CONCLUDES

When the hearing is completed, the ALJ will take the case under submission. He or she has 30 days to prepare a proposed decision (PD). The PD is sent to the Board, which then has 100 days to decide whether to accept the PD, reject it and substitute its own decision in the case, or modify and adopt the decision.

2015 PLANNING TIMELINE

BOARD EXPERT TRAINING

FOR LATE SPRING/EARLY SUMMER

KEY TASK	TARGET COMPLETION DATE(S)
APPROVE TRAINING DATES (OF JUNE 18 & JUNE 25, OR JULY 9*)	**BY MARCH 13, 2015**
APPROVE FINAL EXPERT APP/GUIDELINES	**BY MARCH 13, 2015**
SECURE MEETING SPACE @ DGS, or City/County Meeting Space	MARCH 14-19, 2015
SECURE TRAINERS (2-DAGs), 2-BD Member GUESTS, OTHER VIP	MARCH 2015
MAIL APPS TO ALL EXPERTS ON ROSTER & NEWEST APPLICANTS	ON/BY MARCH 23, 2015
GIVE WEBSITE, NEWSLETTER, AND SOCIAL MEDIA INFO TO STAFF (B.L.)	MARCH 23 THRU 27, 2015
RECEIVE ALL EXPERT APPS BY THIS DEADLINE/POSTMARK DATE	BY APRIL 30, 2015
PROCESS / SCREEN EXPERT APPS	ON MAY 1 THRU MAY 22, 2015
SEND EXPERT INVITE LETTERS (FOR NOR CAL date/ SO CAL date)	ON MAY 26 THRU MAY 29, 2015
FINALIZE TRAINING MATERIALS/HANDOUTS POWERPOINT INFO	BY JUNE 1, 2015
RECEIVE EXPERT RSVPS FOR TRAINING	FROM JUNE 1 THRU JUNE 12, 2015
***TRAINING DATES**	THURS JUNE 18 NOR CAL/EAST BAY
	THURS JUNE 25 SO CAL/LA
	THURS JULY 9 (OPTIONAL)
FINALIZE POST EXPERT TRAINING RELATED ACTIVITIES	BY JULY 30, 2015

DRAFT

Proposed Text

§ 318. Chiropractic Patient Records/Consumer Notice Requirements After Death or Incapacity of Chiropractor or the Termination or Re-location of Practice/Accountable Billings.

(a) Chiropractic Patient Records. Each licensed chiropractor or the unlicensed heir, trustee, executor, administrator, conservator or personal representative acting pursuant to Section 312.2 is required to maintain all active and inactive chiropractic patient records for five years from the date of the doctor's last treatment of the patient unless state or federal laws require a longer period of retention. Active chiropractic records are all chiropractic records of patients treated within the last 12 months. Chiropractic patient records shall be classified as inactive when there has elapsed a period of more than 12 months since the date of the last patient treatment.

All chiropractic patient records shall be available to any representative of the Board upon presentation of patient's written consent or a valid legal order. Active chiropractic patient records shall be immediately available to any representative of the Board at the chiropractic office where the patient has been or is being treated. Inactive chiropractic patient records shall be available upon ten days notice to any representative of the Board. The location of said inactive records shall be reported immediately upon request.

Active and inactive chiropractic patient records must include all of the following:

(1) Patient's full name, date of birth, and social security number (if available);

(2) Patient gender, height and weight. An estimated height and weight is acceptable where the physical condition of the patient prevents actual measurement;

(3) Patient history, complaint, diagnosis/analysis, and treatment must be signed by the primary treating doctor. Thereafter, any treatment rendered by any other doctor must be signed or initialed by said doctor;

(4) Signature of patient;

(5) Date of each and every patient visit;

(6) All chiropractic X-rays, or evidence of the transfer of said X-rays;

(7) Signed written informed consent as specified in Section 319.1.

(b) Within one (1) month from the date of termination of practice or the chiropractor's death or declared incompetency, the chiropractor who has terminated his or her practice, or the unlicensed heir, trustee, executor, administrator, conservator or personal representative of a deceased or incapacitated chiropractor, or the succeeding licensed chiropractor shall notify all active patients and the Board in writing of the termination of the licensed chiropractor's practice. This written notice to the Board shall also contain the location where the active chiropractic patient records can be found. Notice to the Board shall be provided on the form entitled "Notice of Termination of Practice and Transfer of Patient Records," (Form No. XX, New

9/14). Notice to active patients shall be provided via first class mail to the last known address. This notice shall be posted on the Board's website. Records shall be disposed of or destroyed in such a manner as to preserve the confidentiality of the information contained therein in accordance with Civil Code section 1798.81.

(c) A licensed chiropractor who relocates his or her practice and will no longer be available to his or her former patients shall follow the procedures listed in subsection (b). A licensed chiropractor who relocates to a practice site no more than 20 miles away from any previous practice site shall notify the Board of his or her change of address to the Board in accordance with Section and, either provide written notice of such relocation one month prior to relocating to all active patients by first-class mail, or shall follow the procedures listed in subsection (b) . If the patient was treated by more than one chiropractor, the patient is a patient of the practice.

(d) If a patient was younger than 18 years of age when last treated by a licensee, the chiropractic records of the patient shall be maintained until the patient reaches age 21 or for 5 years from the date of last treatment, whichever is longer.

(e) A licensed chiropractor who terminates his practice, places his or her license in an inactive status or the unlicensed heir, trustee, executor, administrator, conservator or personal representative acting pursuant to Section 312.2 or succeeding licensed chiropractor of a deceased or legally incompetent chiropractor shall refund any part of fees paid in advance that have not been earned within one month of the termination of practice or the transfer of the practice to a succeeding licensed chiropractor.

(~~b~~f) Accountable Billings. Each licensed chiropractor is required to ensure accurate billing of his or her chiropractic services whether or not such chiropractor is an employee of any business entity, whether corporate or individual, and whether or not billing for such services is accomplished by an individual or business entity other than the licensee. In the event an error occurs which results in an overbilling, the licensee must promptly make reimbursement of the overbilling whether or not the licensee is in any way compensated for such reimbursement by his employer, agent or any other individual or business entity responsible for such error. Failure by the licensee, within 30 days after discovery or notification of an error which resulted in an overbilling, to make full reimbursement constitutes unprofessional conduct.

Note: Authority cited: Section 1000-4(b), Business and Professions Code (Chiropractic Initiative Act of California (Stats. 1923, p. 1xxxviii)). Reference: Section 1000-4(b), Business and Professions Code (Chiropractic Initiative Act of California (Stats. 1923, p. 1xxxviii)).

§ 312.2. Ownership of Practice upon the Death or Incapacity of a Licensee.

In the event of the death of a chiropractic licensee, or the legal declaration of the mental incompetency of the licensee to practice, the unlicensed heirs, ~~or~~ trustees, executor, administrator, conservator or personal representative of the chiropractor must dispose of the practice within six (6) months. At all times during that period the practice must be supervised by a licensed chiropractor. The board will consider a petition to extend this period if it is submitted within four (4) months after the death or the declaration of incompetence of the licensee, including identification of any extenuating circumstances that will prevent compliance.

Note: Authority cited: Section 1000-4(b), Business and Professions Code. Reference: Sections 1000-7, 1000-10 and 1000-15, Business and Professions Code.

THE HIPAA PRIVACY AND SECURITY RULES

Frequently Asked Questions About the Disposal of Protected Health Information

U.S. Department of Health and Human Services • Office for Civil Rights

1. What do the HIPAA Privacy and Security Rules require of covered entities when they dispose of protected health information?

The HIPAA Privacy Rule requires that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information (PHI), in any form. See 45 CFR 164.530(c). This means that covered entities must implement reasonable safeguards to limit incidental, and avoid prohibited, uses and disclosures of PHI, including in connection with the disposal of such information. In addition, the HIPAA Security Rule requires that covered entities implement policies and procedures to address the final disposition of electronic PHI and/or the hardware or electronic media on which it is stored, as well as to implement procedures for removal of electronic PHI from electronic media before the media are made available for re-use. See 45 CFR 164.310(d)(2)(i) and (ii). Failing to implement reasonable safeguards to protect PHI in connection with disposal could result in impermissible disclosures of PHI.

Further, covered entities must ensure that their workforce members receive training on and follow the disposal policies and procedures of the covered entity, as necessary and appropriate for each workforce member. See 45 CFR 164.306(a)(4), 164.308(a)(5), and 164.530(b) and (i). Therefore, any workforce member involved in disposing of PHI, or who supervises others who dispose of PHI, must receive training on disposal. This includes any volunteers. See 45 CFR 160.103 (definition of "workforce").

Thus, covered entities are not permitted to simply abandon PHI or dispose of it in dumpsters or other containers that are accessible by the public or other unauthorized persons. However, the Privacy and Security Rules do not require a particular disposal method. Covered entities must review their own circumstances to determine what steps are reasonable to safeguard PHI through disposal, and develop and implement policies and procedures to carry out those steps. In determining what is reasonable, covered entities should assess potential risks to patient privacy, as well as consider such issues as the form, type, and amount of PHI to be disposed. For instance, the disposal of certain types of PHI such as name, social security number, driver's license number, debit or credit card number, diagnosis, treatment information, or other sensitive information may warrant more care due to the risk that inappropriate access to this information may result in identity theft, employment or other discrimination, or harm to an individual's reputation.

In general, examples of proper disposal methods may include, but are not limited to:

- For PHI in paper records, shredding, burning, pulping, or pulverizing the records so that PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed.
- Maintaining labeled prescription bottles and other PHI in opaque bags in a secure area and using a disposal vendor as a business associate to pick up and shred or otherwise destroy the PHI.

- For PHI on electronic media, clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing or exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains), or destroying the media (disintegration, pulverization, melting, incinerating, or shredding).

  For more information on proper disposal of electronic PHI, see the HHS HIPAA Security Series 3: Security Standards – Physical Safeguards. In addition, for practical information on how to handle sanitization of PHI throughout the information life cycle, readers may consult NIST SP 800-88, Guidelines for Media Sanitization.

Other methods of disposal also may be appropriate, depending on the circumstances. Covered entities are encouraged to consider the steps that other prudent health care and health information professionals are taking to protect patient privacy in connection with record disposal. In addition, if a covered entity is winding up a business, the covered entity may wish to consider giving patients the opportunity to pick up their records prior to any disposition by the covered entity (and note that many states may impose requirements on covered entities to retain and make available for a limited time, as appropriate, medical records after dissolution of a business).

2. May a covered entity dispose of protected health information in dumpsters accessible by the public?

No, unless the protected health information (PHI) has been rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed prior to it being placed in a dumpster. In general, a covered entity may not dispose of PHI in paper records, labeled prescription bottles, hospital identification bracelets, PHI on electronic media, or other forms of PHI in dumpsters, recycling bins, garbage cans, or other trash receptacles generally accessible by the public or other unauthorized persons. The HIPAA Privacy Rule requires that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of PHI, in any form, including in connection with the disposal of such information. See 45 CFR 164.530(c). In addition, the HIPAA Security Rule requires that covered entities implement policies and procedures to address the final disposition of electronic PHI and/or the hardware or electronic media on which it is stored. See 45 CFR 164.310(d)(2)(i). Depositing PHI in a trash receptacle generally accessible by the public or other unauthorized persons is not an appropriate privacy or security safeguard. Instead, covered entities must implement reasonable safeguards to limit incidental, and avoid prohibited, uses and disclosures of PHI. Failing to implement reasonable safeguards to protect PHI in connection with disposal could result in impermissible disclosures of PHI.

For example, depending on the circumstances, proper disposal methods may include (but are not limited to):

- Shredding or otherwise destroying PHI in paper records so that the PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed prior to it being placed in a dumpster or other trash receptacle.

- Maintaining PHI for disposal in a secure area and using a disposal vendor as a business associate to pick up and shred or otherwise destroy the PHI.

- In justifiable cases, based on the size and the type of the covered entity, and the nature of the PHI, depositing PHI in locked dumpsters that are accessible only by authorized persons, such as appropriate refuse workers.

- For PHI on electronic media, clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing or exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains), or destroying the media (disintegration, pulverization, melting, incinerating, or shredding).

  For more information on proper disposal of electronic PHI, see the HHS HIPAA Security Series 3: Security Standards – Physical Safeguards. In addition, for practical information on how to handle sanitization of PHI throughout the information life cycle, readers may consult NIST SP 800-88, Guidelines for Media Sanitization.

3. May a covered entity hire a business associate to dispose of protected health information?

Yes, a covered entity may, but is not required to, hire a business associate to appropriately dispose of protected health information (PHI) on its behalf. In doing so, the covered entity must enter into a contract or other agreement with the business associate that requires the business associate, among other things, to appropriately safeguard the PHI through disposal. See 45 CFR 164.308(b), 164.314(a), 164.502(e), and 164.504(e). Thus, for example, a covered entity may hire an outside vendor to pick up PHI in paper records or on electronic media from its premises, shred, burn, pulp, or pulverize the PHI, or purge or destroy the electronic media, and deposit the deconstructed material in a landfill or other appropriate area.

4. May a covered entity reuse or dispose of computers or other electronic media that store electronic protected health information?

Yes, but only if certain steps have been taken to remove the electronic protected health information (ePHI) stored on the computers or other media before its disposal or reuse, or if the media itself is destroyed before its disposal. The HIPAA Security Rule requires that covered entities implement policies and procedures to address the final disposition of ePHI and/or the hardware or electronic media on which it is stored, as well as to implement procedures for removal of ePHI from electronic media before the media are made available for reuse. See 45 CFR 164.310(d)(2)(i) and (ii). Depending on the circumstances, appropriate methods for removing ePHI from electronic media prior to reuse or disposal may be by clearing (using software or hardware products to overwrite media with non-sensitive data) or purging (degaussing or exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains) the information from the electronic media. If circumstances warrant the destruction of the electronic media prior to disposal, destruction methods may include disintegrating, pulverizing, melting, incinerating, or shredding the media. Covered entities may contract with business associates to perform these services for them.

For more information on proper disposal of ePHI and reuse of electronic media, see the HHS HIPAA Security Series 3: Security Standards – Physical Safeguards. In addition, for practical information on how to handle sanitization of PHI throughout the information life cycle, readers may consult NIST SP 800-88, Guidelines for Media Sanitization.

5. How should home health workers or other workforce members of a covered entity dispose of protected health information that they use off of the covered entity's premises?

The HIPAA Privacy Rule requires that covered entities develop and apply policies and procedures for appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information (PHI), including through final disposition. See 45 CFR 164.530(c). In addition, the HIPAA Security Rule requires that covered entities implement policies and procedures to address the final disposition of electronic PHI and/or the hardware or electronic media on which it is stored. See 45 CFR 164.310(d)(2)(i). The Rules are flexible and thus, do not specify particular types of disposal methods; however, covered entities must ensure that the disposal method reasonably protects against impermissible uses and disclosures of PHI and protects against reasonably anticipated threats or hazards to the security of electronic PHI. See 45 CFR 164.530(c)(2) and 164.306(a). Whatever the disposal method, a covered entity must ensure that appropriate workforce members, either working on the premises or off-site, receive training on and follow the disposal policies and procedures of the covered entity. See 45 CFR 164.530(b) and (i), as well as 164.306(a)(4) and 164.308(a)(5) with regard to electronic PHI. These policies and procedures could require, for example, that employees or other workforce members who use PHI off-site, including electronic PHI, return all PHI to the covered entity for appropriate disposal. Or, for example, if appropriate under the circumstances, a covered entity could give off-site workforce members the option of either properly shredding PHI in paper records themselves or returning the PHI to the covered entity for disposal. In cases where workforce members fail to comply with the covered entity's disposal policies and procedures, the covered entity must apply appropriate sanctions. See 45 CFR 164.530(e).

6. Does the HIPAA Privacy Rule require covered entities to keep patients' medical records for any period of time?

No, the HIPAA Privacy Rule does not include medical record retention requirements. Rather, State laws generally govern how long medical records are to be retained. However, the HIPAA Privacy Rule does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. See 45 CFR 164.530(c).

Frequently Asked Questions

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What a digital signature?

Under California law, a digital signature is defined as "an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature."

Government Code section 16.5 states a digital signature shall have the same force and effect as a manual signature if and only if:

1. It is unique to the person using it.
2. It is capable of verification.
3. It is under the sole control of the person using it.
4. It is linked to data in such a manner that if the data are changed, the digital signature is invalidated, and
5. It conforms to regulations adopted by the Secretary of State.

Government Code section 16.5 also states that the use or acceptance of a digital signature is at the option of the parties to the transaction and nothing in the law requires a public entity to use or accept the submission of a document containing a digital signature.

The **regulations** adopted by the Secretary of State define the types of technologies that are acceptable for creating digital signatures for use by public entities in California. They also provide guidance to public entities that want to use digital signatures for certain transactions.

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What are some potential applications of the technology?

Digital signatures can be used for many transactions that currently require a hand written signature. Potential uses include on-line college applications, filing state income tax forms, and submitting applications for business permits at the local level.

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Who is affected by California's digital signature regulations?

Government Code section 16.5 and the **regulations** adopted by the Secretary of State affect public entities in California, which are defined by the Government Code as the State, the Regents of the University of California, a county, city, district, public authority, public agency, and any other political subdivision or public corporation in the State.

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We want to use digital signatures to help us computerize our employees' filing of time-cards. Where do we start?

Government Code section 16.5 specifies that the use of digital signatures shall be at the option of the parties involved in the transaction. Before beginning a transition from paper documents to electronic ones, public entities must ensure that all the parties to the transaction are willing to use digital signatures.

These **regulations** allow public entities to utilize digital signatures that are created by one of two different technologies—"public key cryptography (PKC)" and "signature dynamics."

For a public entity to get started, the first step is to determine the amount of security necessary to conduct the transaction. Some issues to consider are:

- Are the documents containing signatures going to be transmitted over an "open" or a "closed" network?
- Does the signature on the document need to be verified?
- How much time and resources can be allocated to verification?
- Does the signature need to be compared to a manual signature on paper or can a digital certificate adequately provide one-stop verification?
- Will immediate verifiability reduce the potential of fraud?
- Will the documents containing digital signatures need to be reproduced for public access to the records?
- Will the documents containing digital signatures need to be utilized by another local, state or federal agency? If so, is the technology compatible with the other agency's needs?

Answering these and countless other questions can help public entities identify the appropriate technology to use for each application that includes a digital signature component.

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How should we choose between a public key cryptography (PKC) system and a signature dynamics system?

PKC signatures have a greater degree of verifiability than signature dynamics signatures. PKC allows for a third party verification of the signature, while signature dynamics signatures require additional steps (including handwriting analysis) to verify the signer of a document.

PKC signatures are designed to be immediately verifiable. Signatures using signature dynamics technology are designed to allow future verification of the signature (similar to a non-notarized, paper-based signature).

PKC signatures are affixed to documents using software enhancements to existing applications and web browsers. Signature dynamics signatures require additional hardware to create the signatures.

Signature dynamics signatures are easier for the average user to understand, but they do not provide the level of security that is inherent in PKC signatures, which are immediately verifiable with a third-party issued certificate.

Public entities should conduct an extensive review of their needs and match them to the appropriate technology approved for use in the Secretary of State's approved **regulations**.

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Why does California permit signatures created by signature dynamics to be used?

Although signature dynamics signatures require the lengthy process of handwriting analysis to achieve certain verification of a signature, they are still "capable of verification" as required by Government Code section 16.5. Additionally, some degree of certainty can also be obtained by a lay-comparison of manual handwritten signatures, which may already be on file within a particular agency.

If a public entity needs immediate absolute verification of a signature, then this technology may not be the best option for those transactions.

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Digital Signatures

California Code of Regulations

Title 2. Administration

Division 7. Secretary of State

Chapter 10. Digital Signatures

22000 Definitions.

22001 Digital Signatures Must Be Created By An Acceptable Technology.

22002 Criteria For Determining If A Digital Signature Technology Is Acceptable.

22003 List of Acceptable Technologies.

22004 Provisions For Adding New Technologies to the List of Acceptable Technologies.

22005 Issues to Be Addressed By Public Entities When Using Digital Signatures.

22000. Definitions.

(a) For purposes of this chapter, and unless the context expressly indicates otherwise:

(1) "Digitally-signed communication" is a message that has been processed by a computer in such a manner that ties the message to the individual that signed the message.

(2) "Message" means a digital representation of information intended to serve as a written communication with a public entity.

(3) "Person" means a human being or any organization capable of signing a document, either legally or as a matter of fact.

(4) "Public entity" means the public entity as defined by California Government Code Section 811.2.

(5) "Signer" means the person who signs a digitally signed communication with the use of an acceptable technology to uniquely link the message with the person sending it.

(6) "Technology" means the computer hardware and/or software-based method or process used to create digital signatures.

22001. Digital Signatures Must Be Created by an Acceptable Technology.

(a) For a digital signature to be valid for use by a public entity, it must be created by a technology that is acceptable for use by the State of California.

22002. Criteria for State to Determine if a Digital Signature Technology Is Acceptable for Use by Public Entities.

(a) An acceptable technology must be capable of creating signatures that conform to requirements set forth in California Government Code Section 16.5, specifically,

(1) It is unique to the person using it;

(2) It is capable of verification;

(3) It is under the sole control of the person using it;

(4) It is linked to data in such a manner that if the data are changed, the digital signature is invalidated;

(5) It conforms to Title 2, Division 7, Chapter 10 of the California Code of Regulations.

22003. List of Acceptable Technologies.

(a) The technology known as Public Key Cryptography is an acceptable technology for use by public entities in California, provided that the digital signature is created consistent with the provisions in Section 22003(a)1-5.

(1) Definitions - For purposes of Section 22003(a), and unless the context expressly indicates otherwise:

(A) "Acceptable Certification Authorities" means a certification authority that meets the requirements of either Section 22003(a)6(C) or Section 22003(a)6(D).

(B) "Approved List of Certification Authorities" means the list of Certification Authorities approved by the Secretary of State to issue certification for digital signature transactions involving public entities in California.

(C) "Asymmetric cryptosystem" means a computer algorithm or series of algorithms which utilize two different keys with the following characteristics:

(i) one key signs a given message;

(ii) one key verifies a given message; and,

(iii) the keys have the property that, knowing one key, it is computationally infeasible to discover the other key.

(D) "Certificate" means a computer-based record which:

(i) identifies the certification authority issuing it;

(ii) names or identifies its subscriber;

(iii) contains the subscriber's public key; and

(iv) is digitally signed by the certification authority issuing or amending it, and

(v) conforms to widely-used industry standards, including, but not limited to ISO x.509 and PGP certificate standards.

(E) "Certification Authority" means a person or entity that issues a certificate, or in the case of certain certification processes, certifies amendments to an existing certificate.

(F) "Key pair" means a private key and its corresponding public key in an asymmetric cryptosystem. The keys have the property that the public key can verify a digital signature that the private key creates.

(G) "Practice statement" means documentation of the practices, procedures and controls employed by a Certification Authority.

(H) "Private key" means the key of a key pair used to create a digital signature.

(I) "Proof of Identification" means the document or documents presented to a Certification Authority to establish the identity of a subscriber.

(J) "Public key" means the key of a key pair used to verify a digital signature.

(K) "Subscriber" means a person who:

(i) is the subject listed in a certificate;

(ii) accepts the certificate; and

(iii) holds a private key which corresponds to a public key listed in tha t certificate.

(2) California Government Code § 16.5 requires that a digital signature be 'unique to the person using it'. A public key-based digital signature may be considered unique to the person using it, if:

(A) The private key used to create the signature on the document is known only to the signer, and

(B) the digital signature is created when a person runs a message through a one-way function, creating a message digest, then encrypting the resulting message digest using an asymmetrical cryptosystem and the signer's private key, and,

(C) although not all digitally signed communications will require the signer to obtain a certificate, the signer is capable of being issued a certificate to certify that he or she controls the key pair used to create the signature, and

(D) it is computationally infeasible to derive the private key from knowledge of the public key.

(3) California Government Code § 16.5 requires that a digital signature be 'capable of verification'. A public-key based digital signature is capable of verification if:

(A) the acceptor of the digitally signed document can verify the document was digitally signed by using the signer's public key to decrypt the message; and

(B) if a certificate is a required component of a transaction with a public agency, the issuing Certification Authority, either through a certification practice statement or through the content of the certificate itself, must identify which, if any, form(s) of identification it required of the signer prior to issuing the certificate.

(4) California Government Code § 16.5 requires that the digital signature remain 'under the sole control of the person using it'. Whether a signature is accompanied by a certificate or not, the person who holds the key pair, or the subscriber identified in the certificate, assumes a duty to exercise reasonable care to retain control of the private key and prevent its disclosure

to any person not authorized to create the subscriber's digital signature pursuant to Evidence Code Section 669.

(5) The digital signature must be linked to the message of the document in such a way that if the data are changed, the digital signature is invalidated.

(6) Acceptable Certification Authorities

(A) The California Secretary of State shall maintain an "Approved List of Certificate Authorities" authorized to issue certificates for digitally signed communication with public entities in California.

(B) Public entities shall only accept certificates from Certification Authorities that appear on the "Approved List of Certification Authorities" authorized to issue certificates by the California Secretary of State.

(C) The Secretary of State shall place Certification Authorities on the "Approved List of Certification Authorities" after the Certification Authority provides the Secretary of State with a copy of an unqualified performance audit performed in accordance with standards set in the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards No. 70 (S.A.S. 70) "Reports on the Processing of Service Transactions by Service Organizations" (1992) to ensure that the Certification Authorities' practices and policies are consistent with the Certifications Authority's stated control objectives. The AICPA Statement on Auditing Standards No. 70 (1992) is hereby incorporated by reference.

(i) Certification Authorities that have been in operation for one year or less shall undergo a SAS 70 Type One audit - A Report of Policies and Procedures Placed in Operation, receiving an unqualified opinion.

(ii) Certification Authorities that have been in operation for longer than one year shall undergo a SAS 70 Type Two audit - A Report Of Policies And Procedures Placed In Operation And Test Of Operating Effectiveness, receiving an unqualified opinion.

(iii) To remain on the "Approved List of Certification Authorities" a Certification Authority must provide proof of compliance with Section 20003(a)(6)(C)(ii) to the Secretary of State every two years after initially being placed on the list.

(D) In lieu of completing the auditing requirement in Section 22003(a)(6)(C), Certification Authorities may be placed on the "Approved List of Certification Authorities" upon providing the Secretary of State with proof of accreditation that has been conferred by a national or international accreditation body that the Secretary of State has determined utilizes accreditation criteria that are consistent with the requirements of Section 22003(a)(1)-(5).

(i) Certification Authorities shall be removed from the "Approved List of Acceptable Certifications Authorities" unless they provide current proof of accreditation to the Secretary of State at least once per year.

(ii) If the Secretary of State is informed that a Certification Authority has had its accreditation revoked, the Certification Authority shall be removed from the "Approved List of Certification Authorities" immediately.

(b) The technology known as "Signature Dynamics" is an acceptable technology for use by public entities in California, provided that the signature is created consistent with the provisions in Section 22003(b)(1)-(5).

(1) Definitions - For the purposes of Section 22003(b), and unless the context expressly indicates otherwise:

(A) "Handwriting Measurements" means the metrics of the shapes, speeds and/or other distinguishing features of a signature as the person writes it by hand with a pen or stylus on a flat surface.

(B) "Signature Digest" is the resulting bit-string produced when a signature is tied to a document using Signature Dynamics.

(C) "Expert" means a person with demonstrable skill and knowledge based on training and experience who would qualify as an expert pursuant to California Evidence Code s720.

(D) "Signature Dynamics" means measuring the way a person writes his or her signature by hand on a flat surface and binding the measurements to a message through the use of cryptographic techniques.

(2) California Government Code § 16.5 requires that a digital signatures be 'unique to the person using it.' A signature digest produced by Signature Dynamics technology may be considered unique to the person using it, if:

(A) the signature digest records the handwriting measurements of the person signing the document using signature dynamics technology, and

(B) the signature digest is cryptographically bound to the handwriting measurements, and

(C) after the signature digest has been bound to the handwriting measurements, it is computationally infeasible to separate the handwriting measurements and bind them to a different signature digest.

(3) California Government Code § 16.5 requires that a digital signature be capable of verification. A signature digest produced by signature dynamics technology is capable of verification if:

(A) the acceptor of the digitally signed message obtains the handwriting measurements for purposes of comparison, and

(B) if signature verification is a required component of a transaction with a public entity, the handwriting measurements can allow an expert handwriting and document examiner to assess the authenticity of a signature.

(4) California Government Code § 16.5 requires that a digital signature remain 'under the sole control of the person using it'. A signature digest is under the sole control of the person using it if:

(A) the signature digest captures the handwriting measurements and cryptographically binds them to the message directed by the signer and to no other message, and

(B) the signature digest makes it computationally infeasible for the handwriting measurements to be bound to any other message.

(5) The signature digest produced by signature dynamics technology must be linked to the message in such a way that if the data in the message are changed, the signature digest is invalidated.

22004. Provisions for Adding New Technologies to the List of Acceptable Technologies.

(a) Any individual or company can, by providing a written request that includes a full explanation of a proposed technology which meets the requirements of Section 22002, petition the California Secretary of State to review the technology. If the Secretary of State determines that the technology is acceptable for use with the state, the Secretary of State shall adopt regulation(s), pursuant to the Administrative Procedure Act, which would add the proposed technology to the list of acceptable technologies in Section 22003.

(b) The Secretary of State has 180 calendar days from the date the request is received to review the petition and inform the petitioner, in writing, whether the technology is accepted or rejected. If the petition is rejected, the Secretary of State shall provide the petitioner with the reasons for the rejection.

(1) If the proposed technology is rejected, the petitioner can appeal the decision through the Administrative Procedures Act (Government Code Section 11500 et seq).

22005. Criteria for Public Entities To Use in Accepting Digital Signatures.

(a) Prior to accepting a digital signature, public entities shall ensure that the level of security used to identify the signer of a document is sufficient for the transaction being conducted.

(b) Prior to accepting a digital signature, public entities shall ensure that the level of security used to transmit the signature is sufficient for the transaction being conducted.

(c) If a certificate is a required component of a digital signature transaction, public entities shall ensure that the certificate format used by the signer is sufficient for the security and interoperability needs of the public entity.

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BOARD of CHIROPRACTIC EXAMINERS
STATE OF CALIFORNIA

State of California
Edmund G. Brown Jr., Governor

GUIDELINES FOR WHEN A CHIROPRACTIC PRACTICE CLOSES

The following provides guidance to chiropractors regarding the closure of or departure from a chiropractic practice. For rules and regulations regarding the closing of a practice, please visit our website under "Rules and Regulations"; specifically sections 312.2 and 318 for details and further information.

It is the Board's position that due care should be exercised when closing or departing from a chiropractic practice, whether it is temporary or permanent. Not only does this ensure a smooth transition from the current chiropractor to the new chiropractor, but it also reduces the liability of "patient abandonment." Therefore, to ensure this occurs with a minimum of disruption in continuity of care, the chiropractor terminating the chiropractor-patient relationship should notify patients sufficiently in advance.

It is the patient's decision from whom to receive chiropractic care. Therefore, it is the responsibility of all chiropractors and other parties who may be involved to ensure that:

- Website Notification- The D.C.'s website may reflect status of the practice, where patient records can be located and who to contact for information and/or chiropractic care. It is suggested the website stay active for at least 6 months.
- Voicemail-The D.C.'s main phone number should stay active for at least 6 months advising callers of the status of the practice, where patient records can be located and who to contact for information and/or chiropractic care.
- Electronic Mail (E-mail)- An e-mail notification may be sent out to any patients the practice holds an email address for. The e-mail should reflect status of the practice, where patient records can be located and who to contact for information and/or chiropractic care.
- Local Newspaper- An announcement in the local newspaper may be taken out to inform patients of the status of the practice, where patient records can be located and who to contact for information and/or chiropractic care.

Unlicensed individuals are not allowed to perform the services of a chiropractor; including owning and operating a chiropractic practice (CCR 312.1 & 312)

T (916) 263-5355
F (916) 327-0039
TT/TDD (800) 735-2929
Consumer Complaint Hotline
(866) 543-1311

Board of Chiropractic Examiners
901 P Street, Suite 142A
Sacramento, California 95814
www.chiro.ca.gov

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals*

Summary of statutory or regulatory provision by entity.

State	Medical Doctors	Hospitals
Alabama	As long as may be necessary to treat the patient and for medical legal purposes. Ala. Admin. Code r. 545-X-4-.08 (2007).(1)	5 years. Ala. Admin. Code § 420-5-7.10 (adopting 42 C.F.R. § 482.24).
Alaska	N/A	**Adult patients** 7 years following the discharge of the patient. **Minor patients (under 19)** 7 years following discharge or until patient reaches the age of 21, whichever is longer. Alaska Stat. § 18.20.085(a) (2008).
Arizona	**Adult patients** 6 years after the last date of services from the provider. **Minor patients** 6 years after the last date of services from the provider, or until patient reaches the age of 21 whichever is longer. Ariz. Rev. Stat. § 12-2297 (2008).	**Adult patients** 6 years after the last date of services from the provider. **Minor patients** 6 years after the last date of services from the provider, or until patient reaches the age of 21 whichever is longer. Ariz. Rev. Stat. § 12-2297 (2008).
Arkansas	N/A	**Adult patients** 10 years after the last discharge, but master patient index data must be kept permanently. **Minor patients** Complete medical records must be retained 2 years after the age of majority (i.e., until patient turns 20). 016 24 Code Ark. Rules and Regs. 007 § 14(19) (2008).
California	N/A(1)	**Adult patients** 7 years following discharge of the patient. **Minor patients** 7 years following discharge or 1 year after the patient reaches the age of 18 (i.e., until patient turns 19) whichever is longer. Cal. Code Regs. tit. 22, § 70751(c) (2008).
Colorado	N/A(1)	**Adult patients** 10 years after the most recent patient care usage. **Minor patients** 10 years after the patient reaches the age of majority (i.e., until patient turns 28). 6 Colo. Code Regs. § 1011-1, chap. IV, 8.102 (2008).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Connecticut	7 years from the last date of treatment, or, upon the death of the patient, for 3 years. Conn. Agencies Regs. § 19a-14-42 (2008).	10 years after the patient has been discharged. Conn. Agencies Regs. §§ 19-13-D3(d)(6) (2008).
Delaware	7 years from the last entry date on the patient's record. Del. Code Ann. tit. 24, §§ 1761 and 1702 (2008).	N/A
District of Columbia	**Adult patients** 3 years after last seeing the patient. **Minor patients** 3 years after last seeing the patient or 3 years after patient reaches the age of 18 (i.e., until patient turns 21). D.C. Mun. Regs. tit. 17, § 4612.1 (2008).	10 years following the date of discharge of the patient. D.C. Mun. Regs. tit. 22, § 2216 (2008).
Florida	5 years from the last patient contact. Fla. Admin. Code Ann. 64B8-10.002(3) (2008).	Public hospitals: 7 years after the last entry. Florida Department of State, General Records Schedule GS4 for Public Hospitals, Health Care Facilities and Medical Providers, (2007), http://dlis.dos.state.fl.us/barm/genschedules/GS04.pdf (accessed September 12, 2008).
Georgia	10 years from the date the record item was created. See Ga. Code Ann. § 31-33-2(a)(1)(A) and (B)(i) (2008).	**Adult patients** 5 years after the date of discharge. **Minor patients** 5 years past the age of majority (i.e., until patient turns 23). See Ga. Code Ann. §§ 31-33-2(a)(1)(B)(ii) (2008); 31-7-2 (2008) (granting the department regulatory authority over hospitals) and Ga. Comp. R. & Regs. 290-9-7-.18 (2008).
Guam	N/A	N/A

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Hawaii	**Adult patients** Full medical records: 7 years after last data entry. Basic information (i.e., patient's name, birth date, diagnoses, drugs prescribed, x-ray interpretations): 25 years after the last record entry. **Minor patients** Full medical records: 7 years after the patient reaches the age of majority (i.e., until patient turns 25). Basic information: 25 years after the minor reaches the age of majority (i.e., until patient turns 43). Haw. Rev. Stat. § 622-58 (2008).	**Adult patients** Full medical records: 7 years after last data entry. Basic information (i.e., patient's name, birth date, diagnoses, drugs prescribed, x-ray interpretations): 25 years after the last record entry. **Minor patients** Full medical records: 7 years after the minor reaches the age of majority (i.e., until patient turns 25). Basic information: 25 years after the minor reaches the age of majority (i.e., until patient turns 43). Haw. Rev. Stat. § 622-58 (2008).
Idaho	N/A	Clinical laboratory test records and reports: 5 years after the date of the test. Idaho Code Ann. § 39-1394 (2008).
Illinois	N/A	10 years. See 210 Ill. Comp. Stat. 85/6.17(c) (2008).
Indiana	7 years. Burns Ind. Code Ann. § 16-39-7-1 (2008).	7 years. Burns Ind. Code Ann. § 16-39-7-1 (2008).
Iowa	**Adult patients** 7 years from the last date of service. **Minor patients** 1 year after the minor attains the age of majority (*i.e.*, until patient turns 19). See Iowa Admin. Code r. 653-13.7(8) (2008); Iowa Code § 614.8 (2008).	N/A
Kansas	10 years from when professional service was provided. Kan. Admin. Regs. § 100-24-2 (a) (2008).	**Adult patients** Full records: 10 years after the last discharge of the patient. **Minor patients** Full records: 10 years or 1 year beyond the date that the patient reaches the age of majority (i.e., until patient turns 19) whichever is longer. Summary of destroyed records for both adults and minors—25 years. Kan. Admin. Regs. § 28-34-9a (d)(1) (2008).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Kentucky	N/A	**Adult patients** 5 years from date of discharge. **Minor patients** 5 years from date of discharge or 3 years after the patient reaches the age of majority (i.e., until patient turns 21) whichever is longer. 902 Ky. Admin. Regs. 20:016 (2007).
Louisiana	6 years from the date a patient is last treated. La. Rev. Stat. Ann. § 40:1299.96(A)(3)(a) (2008).	10 years from the date a patient is discharged. La. Rev. Stat. Ann. § 40:2144(F)(1) (2008).
Maine	N/A	**Adult patients** 7 years. **Minor patients** 6 years past the age of majority (i.e., until patient turns 24). See 10-144 Me. Code R. Ch. 112, § XII.B.1 (2008). Patient logs and written x-ray reports—permanently. 10-144 Me. Code R. Ch. 112, § XV.C.5 (2008).
Maryland	**Adult patients** 5 years after the record or report was made. **Minor patients** 5 years after the report or record was made or until the patient reaches the age of majority plus 3 years (i.e., until patient turns 21), whichever date is later. MD. Code Ann., Health–Gen. §§ 4-403(a)–(c) (2008).	**Adult patients** 5 years after the record or report was made. **Minor patients** 5 years after the report or record was made or until the patient reaches the age of majority plus 3 years (i.e., until patient turns 21), whichever date is later. MD. Code Ann., Health–Gen. §§ 4-403(a)–(c) (2008).
Massachusetts	**Adult patients** 7 years from the date of the last patient encounter. **Minor patients** 7 years from date of last patient encounter or until the patient reaches the age of 9, whichever is longer. 243 Mass. Code Regs. 2.07(13)(a) (2008).	30 years after the discharge or the final treatment of the patient. Mass. Gen. Laws ch. 111, § 70 (2008).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Michigan	7 years from the date of service. Mich. Comp. Laws § 333.16213 (2008).	7 years from the date of service Mich. Comp. Laws § 333.20175 (2008).
Minnesota	N/A	Most medical records: Permanently (in microfilm). Miscellaneous documents: **Adult patients** 7 years. **Minor patients** 7 years following the age of majority (i.e., until the patient turns 25). Minn. Stat. § 145.32 (2007) and Minn. R. 4642.1000 (2007).
Mississippi	N/A	**Adult patients** Discharged in sound mind: 10 years. Discharged at death: 7 years.[2] **Minor patients** For the period of minority plus 7 years.[3] Miss. Code Ann. § 41-9-69(1) (2008).
Missouri	7 years from the date the last professional service was provided. Mo. Rev. Stat. § 334.097(2) (2008).	**Adult patients** 10 years. **Minor patients** 10 years or until patient's 23rd birthday, whichever occurs later. Mo. Code Reg. tit. 19, § 30-094(15) (2008).
Montana	N/A[1]	**Adult patients** Entire medical record—10 years following the date of a patient's discharge or death. **Minor patients** Entire medical record—10 years following the date the patient either attains the age of majority (i.e., until patient is 28) or dies, whichever is earlier. Core medical record must be maintained at least an additional 10 years beyond the periods provided above. Mont. Admin. R. 37.106.402(1) and (4) (2007).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Nebraska	N/A	**Adult patients** 10 years following a patient's discharge. **Minor patients (under 19)** 10 years or until 3 years after the patient reaches age of majority (i.e., until patient turns 22), whichever is longer. Neb. Admin. Code 175 § 9-006.07A5 (2008).
Nevada	5 years after receipt or production of health care record. Nev. Rev. Stat. § 629.051 (2007).	5 years after receipt or production of health care record. Nev. Rev. Stat. § 629.051 (2007).
New Hampshire	7 years from the date of the patient's last contact with the physician, unless the patient has requested that the records be transferred to another health care provider. N.H. Code Admin. R. Ann. Med 501.02(f)(8) (2008).	**Adult patients** 7 years after a patient's discharge. **Minor patients** 7 years or until the minor reaches age 19, whichever is longer. N.H. Code Admin. R. Ann. He-P 802.06(h) (1994).[4]
New Jersey	7 years from the date of the most recent entry. N.J. Admin. Code § 13:35-6.5(b) (2008).	**Adult patients** 10 years following the most recent discharge. **Minor patients** 10 years following the most recent discharge or until the patient is 23 years of age, whichever is longer. **Discharge summary sheets (all)** 20 years after discharge. N.J. Stat. Ann. § 26:8-5 (2008).
New Mexico	**Adult patients** 2 years beyond what is required by state insurance laws and by Medicare and Medicaid requirements. **Minor patients** 2 years beyond the date the patient is 18 (i.e., until the patient turns 20). N.M. Code R. §.16.10.17.10 (C) (2008).	**Adult patients** 10 years following the last treatment date of the patient. **Minor patients** Age of majority plus 1 year (i.e., until the patient turns 19). N.M. Stat. Ann. § 14-6-2 (2008); N.M. Code R. § 7.7.2.30 (2008).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
New York	**Adult patients** 6 years. **Minor patients** 6 years and until 1 year after the minor reaches the age of 18 (i.e., until the patient turns 19). N.Y. Education § 6530 (2008) (providing retention requirements in the definitions for professional misconduct of physicians).	**Adult patients** 6 years from the date of discharge. **Minor patients** 6 years from the date of discharge or 3 years after the patient reaches 18 years (i.e., until patient turns 21), whichever is longer. **Deceased patients** At least 6 years after death. N.Y. Comp. Codes R. & Regs. tit. 10, § 405.10(a)(4) (2008).
North Carolina	N/A	**Adult patients** 11 years following discharge. **Minor patients** Until the patient's 30th birthday. 10 A N.C. Admin. Code 13B.3903(a), (b) (2008).
North Dakota	N/A	**Adult patients** 10 years after the last treatment date. **Minor patients** 10 years after the last treatment date or until the patient's 21st birthday, whichever is later. N.D. Admin. Code 33-07-01.1-20(1)(b) (2007).
Ohio	N/A	N/A
Oklahoma	N/A	**Adult patients** 5 years beyond the date the patient was last seen. **Minor patients** 3 years past the age of majority (i.e., until the patient turns 21). **Deceased patients** 3 years beyond the date of death. Okla. Admin. Code § 310:667-19-14 (2008).
Oregon	N/A[1]	10 years after the date of last discharge. Master patient index—permanently. Or. Admin. R. 333-505-0050(9) and (15) (2008).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Pennsylvania	**Adult patients** At least 7 years following the date of the last medical service. **Minor patients** 7 years following the date of the last medical service or 1 year after the patient reaches age 21 (i.e., until patient turns 22), whichever is the longer period. 49 Pa. Code § 16.95(e) (2008).	**Adult patients** 7 years following discharge. **Minor patients** 7 years after the patient attains majority[5] or as long as adult records would be maintained. 28 Pa. Code § 115.23 (2008).
Puerto Rico	N/A	N/A[6]
Rhode Island	5 years unless otherwise required by law or regulation. R.I. Code R.14-140-031, § 11.3 (2008).	**Adult patients** 5 years following discharge of the patient. R.I. Code R. 14 090 007 § 27.10 (2008). **Minor patients** 5 years after patient reaches the age of 18 years (i.e., until patient turns 23). R.I. Code R. 14 090 007 § 27.10.1 (2008).
South Carolina	**Adult patients** 10 years from the date of last treatment. **Minor patients** 13 years from the date of last treatment. S.C. Code Ann. § 44-115-120 (2007).	**Adult patients** 10 years. **Minor patients** Until the minor reaches age 18 and the "period of election" expires, which is usually 1 year after the minor reaches the age of majority (i.e., usually until patient turns 19). S.C. Code Ann. Regs. 61-16 § 601.7(A) (2007). See S.C. Code Ann. § 15-3-545 (2007).[7]
South Dakota	When records have become inactive or for which the whereabouts of the patient are unknown to the physician. S.D. Codified Laws § 36-4-38 (2008).	**Adult patients** 10 years from the actual visit date of service or resident care. **Minor patients** 10 years from the actual visit date of service or resident care or until the minor reaches age of majority plus 2 years (i.e., until patient turns 20), whichever is later. See S.D. Admin. R. 44:04:09:08 (2008).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Tennessee	**Adult patients** 10 years from the provider's last professional contact with the patient. **Minor patients** 10 years from the provider's last professional contact with the patient or 1 year after the minor reaches the age of majority (i.e., until patient turns 19), whichever is longer. Tenn. Comp. R. & Regs. 0880-2-.15 (2008).	**Adult patients** 10 years following the discharge of the patient or the patient's death during the patient's period of treatment within the hospital. Tenn. Code Ann. § 68-11-305(a)(1) (2008). **Minor patients** 10 years following discharge or for the period of minority plus at least one year (i.e., until patient turns 19), whichever is longer. Tenn. Code Ann. § 68-11-305(a)(2) (2008).
Texas	**Adult patients** 7 years from the date of the last treatment. **Minor patients** 7 years after the date of the last treatment or until the patient reaches age 21, whichever date is later. 22 Tex. Admin. Code § 165.1(b) (2008).[8]	**Adult patients** 10 years after the patient was last treated in the hospital. **Minor patients** 10 years after the patient was last treated in the hospital or until the patient reaches age 20, whichever date is later. Tex. Health & Safety Code Ann. § 241.103 (2007); 25 Tex. Admin. Code § 133.41(j)(8) (2008).[8]
Utah	N/A	**Adult patients** 7 years. **Minor patients** 7 years or until the minor reaches the age of 18 plus 4 years (i.e., patient turns 22), whichever is longer. Utah Admin. Code r. 432-100-33(4)(c) (2008).
Vermont	N/A[1]	10 years. Vt. Stat. Ann. tit. 18, § 1905(8) (2007).
Virginia	**Adult patients** 6 years after the last patient contact. **Minor patients** 6 years after the last patient contact or until the patient reaches age 18 (or becomes emancipated), whichever time period is longer. 18 Va. Admin. Code § 85-20-26(D) (2008).	**Adult patients** 5 years following patient's discharge. **Minor patients** 5 years after patient has reached the age of 18 (i.e., until the patient reaches age 23). 12 Va. Admin. Code § 5-410-370 (2008).

(continued)

Table A-7. State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals* (continued)

State	Medical Doctors	Hospitals
Washington	N/A	**Adult patients** 10 years following the patient's most recent hospital discharge. **Minor patients** 10 years following the patient's most recent hospital discharge or 3 years after the patient reaches the age of 18 (i.e., until the patient turns 21) whichever is longer. Wash. Rev. Code § 70.41.190 (2008).[9]
West Virginia	N/A	N/A
Wisconsin	5 years from the date of the last entry in the record. Wis. Admin. Code Med. § 21.03 (2008).	5 years. Wis. Admin. Code Health & Family Services §§ 124.14(2)(c), 124.18(1)(e) (2008).
Wyoming	N/A	N/A[9]

* = All years are minimum periods (e.g., "at least" 7 years). Chart does not address retention of original x-rays or tracings, which may be subject to other requirements.

Minor = Person under 18 years old unless otherwise noted.

N/A = No statute or regulation found.

Notes: [1] No statutory or regulatory requirement but state medical board or medical association recommends as follows:

Alabama: At least 10 years. *See* "Medical Records," available on the website of the Medical Association of the State of Alabama (MASA) at: http://www.masalink.org/uploadedFiles/Practice_Management/policy_Medicalrecords.pdf (accessed September 15, 2008).

California: Indefinitely, if possible. See CMA ON-CALL: The California Medical Association's Information-On-Demand Service, available at http://www.thedocuteam.com/docs/retention_medicalrecords.pdf (accessed August 14, 2008).

Colorado: Adult patients 7 years after the last date of treatment and the records of minor patients 7 years after the last date of treatment or 7 years after the patient reaches the age of 18, whichever is later. See Colorado Board of Medical Examiners, Policy 40-7: "Guidelines Pertaining to the Release and Retention of Medical Records." Available at: http://www.dora.state.co.us/Medical/policies/40-07.pdf (accessed September 16, 2008).

Montana: Seven years from the date of last contact with the patient. Birth and immunization records: Until the patient's 25th birthday. See Montana Board of Medical Examiners, Statement on Physician Obligation to Retain Medical Records (2004), available at http://www.mt.gov/dli/bsd/license/bsd_boards/med_board/pdf/patient_medrec.pdf (accessed July 17, 2008).

Oregon: In accordance with Oregon's statute of limitations, at least 10 years after the patient's last contact with the physician. If space permits, indefinitely for all living patients. See Oregon Medical Board, available at http://www.oregon.gov/OMB (accessed August 8, 2008).

Vermont: Patient's lifetime if possible. Minors' records: at least until the child reaches age 21 and decedent's records at least 3 years after the patient's death. *See Vermont Guide to Health Care Law*, available at http://www.vtmd.org/ (accessed September 16, 2008).

[2] If a patient dies in the hospital or within 30 days of discharge and is survived by one or more minors who are or claim to be entitled to damages for the patient's wrongful death, the hospital must retain the patient's hospital record until the youngest minor reaches age 28. Miss. Code Ann. § 41-9-69(1) (2008).

[3] A person under the age of 21 is generally considered a "minor" in Mississippi. However, for purposes of consenting to health care, an "adult" is a person age 18 or older. See Miss. Code Ann. §§ 1-3-27 and 41-41-203(a) (2008).

[4] Hospital licensure rules have expired, but, as of June 2008, they were still in current use by the state Bureau of Licensing & Certification, which licenses health care facilities.

[5] The age of majority in Pennsylvania is 21. *See* 1 Pa. Cons. Stat. § 1991 (2008). However, minors over 18 may consent to health services in their own right. See 35 Pa. Cons. Stat. § 10101 (2008).

[6] Based only on statutes, not on regulations, which currently are published only in Spanish.

[7] The period of election is the time during which a person may elect to bring a law suit for malpractice that occurred while the patient was a minor, generally a maximum of 1 year after the minor reaches the age of majority. See S.C. Code Ann. § 15-3-545 (2007).

[8] The physician may not destroy medical records that relate to any civil, criminal, or administrative proceedings unless the physician knows the proceeding has been finally resolved. 22 Tex. Admin. Code § 165.1(b) (2008); Tex. Health & Safety Code Ann. § 241.103 (2007); 25 Tex. Admin. Code § 133.41(j)(8) (2008).

[9] Must maintain a record of a patient's health care information: for at least 1 year following receipt of authorization to disclose that health care information; and during the pendency of a request for examination, copying, correction, or amendment of that health care information. Wash. Rev. Code § 70.02.160 (2008); Wyo. Stat. Ann. § 35-2-615 (2008).

2015 Remaining Public Board Meetings

MEETING DATE	LOCATION
April 16, 2015	Southern California
July 30, 2015	San Francisco
October 27, 2015	Southern California

2015 Remaining Enforcement Committee Meetings

MEETING DATE	LOCATION/TELECONFERENCE