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BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against**:** **JOHN MICHAEL CASCI** **630 Mission St., Suite C** **South Pasadena, CA, 91030** **Chiropractor License No. DC 30704** Respondent.	Case No. AC 2024-2050 **ACCUSATION**

PARTIES

1. Kristin Walker (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Chiropractic Examiners, Department of Consumer Affairs.

2. On or about September 5, 2007, Board of Chiropractic Examiners issued Chiropractor License Number DC 30704 to John Michael Casci (Respondent). The Chiropractor License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2025, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Chiropractic Examiners (Board), under the authority of the following sections of the Chiropractic Act (Act).[1]

[1] The Chiropractic Act, an initiative measure approved by the electors on November 7, 1922, while not included in the Business and Professions Code by the legislature, is set out in (continued…)

4. Section 10 of the Act states, in pertinent part, that the Board may suspend or revoke a license to practice chiropractic or may place the license on probation for violations of the rules and regulations adopted by the Board or for any cause specified in the Chiropractic Initiative Act.

5. California Code of Regulations, title 16, section 372 states:

> "The suspension, expiration, or forfeiture by operation of law of a license issued by the board, or its suspension, or forfeiture by order of the board or by order of a court of law, or its surrender without the written consent of the board shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

STATUTES AND REGULATIONS

6. California Code of Regulations, title 16, section 317, states:

> 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.
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> Unprofessional conduct includes, but is not limited to, the following:
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> (a) Gross negligence;
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> (b) Repeated negligent acts;
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> (e) Any conduct which has endangered or is likely to endanger the health, welfare, or safety of the public;
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> . . .
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> (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.
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> . . .

West's Annotated California Codes as sections 1000-1 to 1000-19, and is included in Deering's California Codes as Appendix I, for convenient reference.

7. California Code of Regulations, title 16, section 318, states:

(a) Chiropractic Patient Records. Each licensed chiropractor 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) 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. . . .

8. California Code of Regulations, title 16, section 319.1, states, in pertinent part:

(a) A licensed doctor of chiropractic shall verbally and in writing inform each patient of the material risks of proposed care. “Material” shall be defined as a procedure inherently involving known risk of serious bodily harm. The chiropractor shall obtain the patient's written informed consent prior to initiating clinical care. The signed written consent shall become part of the patient's record.

(b) A violation of this section constitutes unprofessional conduct and may subject the licensee to disciplinary action.

COST RECOVERY

9. California Code of Regulations, title 16, section 317.5, subdivision (a), states, in pertinent part:

> In any order in resolution of a disciplinary proceeding before the Board of Chiropractic Examiners, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the Chiropractic Initiative Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

10. On January 25, 2018, after suffering from a headache, Patient CB sought treatment from Respondent, whom he knew through his child. Respondent provided heat packs, electrical stimulation and did two neck manipulations (one on the left and another on the right). Patient CB stood up and still had pain/tenderness. Respondent said "let's go for the C1" and Patient CB laid back down. Respondent then turned Patient CB's head to the left and down to the point where his chin was almost touching his chest. Before he could say anything, Respondent thrust forward and Patient CB heard a pop. When Patient CB opened his eyes, he immediately had double vision, started panicking and asked Respondent what was going on. Respondent appeared frazzled, turned off the lights, laid Patient CB down and got an ice pack for him. Patient CB felt nauseous, dizzy and weak. When Patient CB was attempting to leave, Respondent asked if he was OK to drive and Patient CB stated "I think so" and Respondent advised him to take Advil and stay hydrated.

11. Patient CB went home and got in bed and thought it was something he could sleep off. Respondent checked in on him that night and set up an appointment for Patient CB to return the next day. Patient CB didn't want Respondent to touch his neck, so Respondent used a clicker device up and down his neck. Patient CB felt really uncomfortable.

12. Two to three days later, while he was driving, Patient CB lost half of his vision and couldn't see the street signs so he pulled over. Later that day, he called an ENT friend who told him to go to the emergency room (ER). After a visit to the neurologist (that was recommended at the ER), he had a Magnetic Resonance Angiography (MRA) and a computed tomography (CT)

and the results showed a dissection of the vertebral artery and a pseudoaneurysm just inside the brain. Patient CB had surgery and a stint was placed in his brain.

13. After Respondent checked in on Patient CB and the patient advised him that the "news is not what I had hoped for. The aneurysm has grown in size, and the tear is inside the brain, they have decided I need surgery…" Respondent responded: "Oh my! I am sick to my stomach! Seriously. I know you know this but I was only trying to help. This is the same adjustment I do all the time, that's why I'm a little confused…."

14. Following receipt of a complaint against Respondent, the Board investigator interviewed Respondent and obtained Patient CB's records. The document titled, "Patient Ledger," lists services provided to Patient CB on the following dates: January 10, 2017, February 25, 2017, January 25, 2018 and January 26, 2018.

FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Chiropractic Records)

15. Respondent is subject to disciplinary action under Regulation 317, subdivision (m), and Regulation 318 (a) (3) in that he failed to properly document and maintain Patient CB's records. The circumstances are as follows:

a. January 10, 2017 (Lower Mid-Back and Low Back Pain):

(1) Examination: The new patient E/M service documentation consists of both handwritten and EHR entries. The pre-printed form with handwritten notes records appropriate testing for the patient's chief complaint of mid-back pain. However, the patient's height and weight are not recorded. A diagnosis of Thoracic Spine Strain/Sprain, Lumbar Spine Strain/Sprain and Myalgia is listed on this same form. Neither the intake form nor the examination forms make any mention of either neck pain or headache.

(2) Plan of Care: The medical record does not specify prescribed treatment (e.g., CMT, muscle stim, hydrotherapy, etc.). The medical record provides no indication of future care.

(3) Treatment Rendered: Although the Patient Ledger itemizes the CMT and multiple therapies, none of these procedures are documented in the medical record.

(4) Documentation is missing the provider's signature.

b. February 25, 2017 (Neck and Upper Back Pain and Headache): Because the patient presented with a complaint which was new and different from the initial assessment on January 10, 2017, an E/M service is indicated. Accordingly, documentation should include a history of the new complaint, appropriate examination and specific diagnosis. Respondent failed to record these elements in the medical record.

(1) Examination: The medical record for February 25, 2017 consists of a single page documented with an EHR system. The new patient E/M service documentation consists of both handwritten and EHR entries. The patient presents with a chief complaint of Neck and Upper Back Pain and Headache. These are new complaints and had not previously been reported by the patient. Dr. Casci records findings of pain, tenderness and spasm in the neck and upper back. With exception of these palpatory findings, no other examination results are recorded. Neither range of motion, orthopedic nor neurological test were performed.

(2) History: Other than the complaint itself, the medical record does not provide a history of this new condition.

(3) Plan of Care: The medical record does not specify prescribed treatment (e.g., CMT, muscle stim, hydrotherapy). The medical record provides no indication of future care.

(4) Diagnosis: Because this is a new complaint that has not been previously documented, it is appropriate to render a diagnosis specific to the condition(s). The medical record does not record a diagnosis for the new conditions.

(5) Treatment Rendered: The medical record documents CMT of the cervical and thoracic spine. The medical record documents the following modalities: Hot Pack, EMS unattended.

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c. January 25, 2018 (Neck and Upper Back Pain and Headache):

(1) Examination: The medical record for January 25, 2018 consists of two pages documented with an EHR system. Patient CB presented for care with a complaint of severe headache, neck pain and upper back pain. Because the patient had not been seen for eleven months, a complete E/M service is indicated. This includes an appropriate History, Examination and Medical Decision Making (Diagnosis and Plan of Care). Respondent failed to include important information in the History, perform an adequate examination and did not provide a diagnosis. The patient presents with a chief complaint of upper thoracic, right posterior trapezius, right side of neck, anterior head and right mid thoracic sharp, aching and tightness/stiffness discomfort. The patient reports right sided headache pain that started five days prior and is worsening. The examination records palpation findings and range of motion. No orthopedic or neurologic findings are documented. In light of the 11 month void since last treating the patient, a more thorough evaluation is indicated.

(2) History: The medical record provides a chronology of the headache pain as five days in duration with a worsening of the complaint. The documentation includes unintelligible and inconsistent statements, including "ability to participate with has worsened" and "showing improvement and meeting expectations" and "improving because he is reporting less discomfort…" The original patient intake form shows the patient has a family history of Heart Problems/Stroke. In light of this family history and the chief complaint of headache, the medical record should reflect a thorough inquiry/history by the provider. Documentation does not reflect an adequate history. In the recorded interview, Respondent provided the following information:

> "I'm on my way home, I only work ½ day on Thursdays. He texted me while I was driving. I called him and he said he had a headache, a really bad headache and could he come and see me? And I said, Well I'm on my way home right now, and he said it's really hurting. I turned around and we met at the office."

The above dialogue is not reflected in the medical record. Respondent failed to provide a description of the headache, including relaying the pain intensity.

(3) Plan of Care: A follow-up visit is indicated for Friday January 26, 2018.

(4) Diagnosis: Although the patient had prior complaints of neck pain, upper back pain and headaches, diagnoses for these conditions were never issued by Respondent. Consequently, diagnoses reflective of the current chief complaints should be present. The medical record does not record diagnoses for the chief complaints of January 25, 2018.

(5) Treatment Rendered: The medical record documents CMT of the cervical and thoracic spine. The medical record documents the following modalities: Hot Pack, EMS unattended. Regarding the adverse event following the cervical spine adjustment, Respondent documented the following: "[CB] stated he felt a vision issue related to the headache after treatment, but stated that before leaving the clinic he felt better with less neck pain, but still had the headache. The visual disturbance was relieved and not there. A follow up text was given later that evening and [CB] stated he felt much better." The medical record simply reports the AE as a "vision issue" and does not include details of double-vision (diplopia). The medical record does not include statements regarding nausea, dizziness nor weakness (ataxia). During an interview with Board investigator's Respondent contradicts the patient's reports of nausea, dizziness and weakness and stated "He never at all ever had any of those other things. It was just that brief eye disturbance."

Respondent demonstrated a pattern of failing to meet the standard of care regarding the appropriate evaluation and management of the conditions which his Patient CB presented. Complainant refers to and incorporates all the allegations contained in paragraphs 10-15, as though set forth fully herein.

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SECOND CAUSE FOR DISCIPLINE

(Failure to Manage An Emergency Situation)

16. Respondent is subject to disciplinary action under Regulation 317, subdivision, (a), (e), and (w), and Regulation 319.1 in that his failure to manage the emergency situation on January 25, 2018 constitutes unprofessional conduct, gross negligence, endangering the health of Patient CB and in not referring a patient to a physician. The combination of severe headache pain intensity, duration greater than 72 hours and family history of stroke are red-flags for cervical artery dissection. Respondent confirms that Patient CB suffered an adverse effect immediately following SMT of the cervical spine. Respondent does not report the visual disturbance as diplopia and did not report nausea, dizziness nor weakness. Although Respondent alleged in an interview that Patient CB denied being dizzy or nauseous, the medical record provides no documentation reflecting his alleged inquiry regarding dizziness, nausea, slurred speech nor altered gait. The SMT of the cervical spine rendered to Patient CB by Respondent on January 25, 2018 resulted in symptoms of diplopia, dizziness, nausea and weakness, indicative of Vertebral Artery Dissection and Stroke, an emergency situation requiring immediate medical care. Despite a clear clinical picture indicative of Vertebral Artery Dissection and Stroke, rather than follow standard of care and refer the patient to immediate emergency medical care, Respondent released the patient and advised rest, hydration and Advil. Complainant refers to and incorporates all the allegations contained in paragraphs 10-15, as though set forth fully herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Provide Informed Consent)

17. Respondent is subject to disciplinary action under Regulation 318, subdivision (a)(7) and Regulation 319.1, in that he failed to maintain an informed consent. In California, chiropractors are required to discuss material risks, which is explained both verbally and in writing. Documentation maintained by Respondent of the care rendered to Patient CB does not include Informed Consent, neither in writing nor chart entries memorializing a verbal explanation. Informed Consent was indicated on January 10, 2017 when the patient was first seen by Respondent with a chief complaint of lower thoracic pain and low back pain, none was

provided. Additional Informed Consent was indicated on February 25, 2017 when the patient was treated for complaints which were not present on January 10, 2017 (i.e., headache and neck pain), none was provided. Informed Consent was also indicated on January 25, 2018 and January 26, 2018 in light of the fact that none had been provided previously. Complainant refers to and incorporates all the allegations contained in paragraphs 10-16, as though set forth fully herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent is subject to disciplinary action under Regulation 317, subdivision (b), and Regulation 318 (a)(3) in that his treatment of Patient CB involved repeated negligent acts, including as follows:

a. Failure to document vitals (height and weight)

b. Failure to document a plan of care

c. Failure to document services rendered

d. Failure to sign the medical record (provider signature)

e. Failure to assess new complaints

f. Failure to diagnose new complaints

g. Failure to document an accurate and relevant history

h. Failure to document adverse events (nausea, dizziness, weakness)

i. Failure to maintain clear and decipherable documentation

Complainant refers to and incorporates all the allegations contained in paragraphs 10-17, as though set forth fully herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Chiropractic Examiners issue a decision:

1. Revoking or suspending Chiropractor License Number DC 30704, issued to John Michael Casci;

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2. Ordering John Michael Casci to pay the Board of Chiropractic Examiners the reasonable costs of the investigation and enforcement of this case, pursuant to Title 16, California Code of Regulations, section 317.5 and if placed on probation, the costs of probation monitoring; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: _____

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KRISTIN WALKER
Executive Officer
Board of Chiropractic Examiners
Department of Consumer Affairs
State of California
Complainant

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