Medical Board of California
Expert Reviewer Guidelines

Revised November 2023

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MISSION STATEMENT

The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professionals and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

OVERVIEW

The Medical Board of California (hereafter referred to as Board) is a state regulatory agency within the Department of Consumer Affairs.

The Board is responsible for investigations and discipline of physician licensees of the State of California. The primary purpose of the Board is to protect the public from incompetent, negligent, dishonest and/or impaired physicians. Your role as an objective expert reviewer is critical in identifying whether a departure from the accepted standard of care has occurred, thereby constituting unprofessional conduct.

This manual will describe the administrative disciplinary process for physician misconduct and define the Board's expectations with respect to your review.

As an expert reviewer, you will be provided medical records and other information concerning an investigation. This may include reports that contain interviews of patients, subsequent treating physicians, other witnesses, and the physician who is the subject of the investigation. You will be asked, on the basis of your review of the documentation provided, to render your impartial opinion of the care provided by the subject physician.

Your objective opinion must be based solely upon the information provided to you by the Board; however, you may refer to peer review journal articles, medical texts and other authoritative reference materials, which help to define the accepted standard of care. The opinion should be based upon your knowledge of the accepted standard of care, drawing from your education, training, experience and knowledge of the medical literature. **Because of laws protecting confidentiality, you may not discuss the case with anyone other than staff of the Board, the Division of Investigation, and the Office of the Attorney General. Please note that while you may discuss the case with staff of the Board, you may not discuss the case with any of the 15 Board Members, as they need to remain impartial.**

Submitting a case for expert review does not imply that there are departures from the standard of care. You are responsible for identifying the medical or ethical issues (if any) based upon the materials you reviewed. You will discuss the standard of care for each medical issue and articulate an analysis and explanation of your conclusions (either no departure, simple departure, extreme departure, and/or lack of knowledge).

Key Point
Submitting a case for expert review does not imply that there are departures from the standard of care.

If you know the subject physician, or other parties involved, or if you feel you cannot be objective in your review for any reason, please inform the investigator/analyst assigned to the case and do not accept the case for review. It is also very important to make sure that you have experience with the procedure or treatment at issue *during the period* of the alleged misconduct.

You will be expected to be available to Deputy Attorney General to answer questions and review opposing opinions or other mitigating evidence. You will be required to testify in administrative hearings held before an administrative law judge for those cases that progress to a hearing. In these instances, you will be considered an expert witness and will be required to meet with the Deputy Attorney General, assigned to prosecute the case, prior to the hearing. The purpose of the meeting is to prepare you for the hearing. In cases referred for criminal prosecution, you may be contacted by a Deputy District Attorney (DDA) or other criminal prosecutor and be required to testify in a criminal trial.

The Board greatly appreciates your willingness to serve as an expert reviewer. You play a vital role to the Board in its mission of public protection.

INVESTIGATIONS AND THE DISCIPLINARY PROCESS

The Role of the Board in Physician Discipline

The Board is responsible for investigating and bringing disciplinary action against the professional licenses of physicians and surgeons suspected of violating the Medical Practice Act **(Business and Professions Code §2000, et seq.)**.

Business and Professions Code §2001 establishes the Medical Board of California, which consists of 15 members, seven of whom are public members [non-physicians] and eight of whom are physicians. **Business and Professions Code §2004** defines the duties of the Board, which include:

- The enforcement of the disciplinary and criminal provisions of the Medical Practice Act;
- The administration and hearing of disciplinary actions;
- Carrying out disciplinary actions appropriate to findings made by the division or administrative law judge;
- Suspending, revoking, or otherwise limiting certificates after disciplinary actions;
- Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the Board.

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

The Board identifies and takes appropriate action against any licensee who is charged with unprofessional conduct.

Complaints against physicians

Business and Professions Code Section 109 and Business and Professions Code Section 325 require the Board to investigate complaints concerning its licensees. Complaints come to the Board from many sources. Under ***Business and Professions Code §800 et seq.***, civil judgments, settlements or arbitration awards against a licensee must be reported to the Board by insurers, self-insured governmental agencies, physicians and/or their attorneys, and employers; discipline by any professional peer review body (hospital, medical society, health care service plan) must be reported to the Board; written complaints submitted by patients or patients legal representatives alleging sexual misconduct or abuse must be reported by ambulatory surgical centers, health care facilities or clinics, or other entities, including but not limited to, postsecondary educational institutions; coroners must report any deaths that may be due to gross negligence by a physician; district attorneys must report felony criminal filings against a physician; and courts must transmit felony preliminary hearing transcripts involving a licensee. Many complaints are filed by patients, family members of patients or by other licensees concerned about the care rendered by another physician for a patient or patients.

Investigation of Complaints

Complaints regarding quality of care are received and reviewed in the Board's Central Complaint Unit (CCU) in Sacramento by a medical consultant in the same specialty in which the subject is practicing. The CCU medical consultant determines whether the quality of care issues presented in the complaint and supporting documents warrant investigation. If the CCU consultant believes the facts of a case support either repeated simple departures or one extreme departure from the standard of care, then the case is sent either to the Board's Complaint Investigation Office (CIO) or to the Department of Consumer Affairs (DCA), Health Quality Investigation Unit (HQIU).

Investigators, District Medical Consultants, Deputy Attorneys General, and Expert Reviewers

The following describes the roles of the main participants in the investigation and administrative prosecution process:

The Role of the Investigator

The Board utilizes both non-sworn and sworn peace officer investigators to investigate complaints of alleged violations of law by obtaining facts, documents, and other evidence. Non-sworn investigators, employed in the Board's CIO and sworn peace officer investigators employed by DCA's Division of Investigation, HQIU perform many similar functions. They obtain information by interviewing complainants, witnesses, and licensed health care professionals. They obtain documentation, such as medical records, witness statements, and court documents. They serve investigational subpoenas. Sworn peace officer investigators also conduct inspections and undercover operations, and are authorized by law to perform pharmacy audits, as well as write/serve search and arrest warrants (for criminal cases). All investigators memorialize their activities in an investigation report.

Investigators work closely with District Medical Consultants (DMC) in reviewing case materials and determining what additional records or information is needed and whether an expert review is necessary. Once an expert reviewer is selected by either the investigator, DMC, or Expert Procurement Unit (EPU) analyst, the assigned investigator/analyst is the contact person for the expert reviewer. The investigator/analyst tracks cases sent out for review to ensure they are completed within a 30-day time limit. If a report is not received within that time, the investigator/analyst will contact the expert reviewer to determine the reason for delay.

If a violation of the Medical Practice Act (laws governing the practice of medicine in California) is confirmed, the matter is referred to the Office of the Attorney General and assigned to a Deputy Attorney General (DAG). The DAG then drafts an accusation, which is a formal statement of charges. This document begins the legal process for the administrative action against the subject physician's license. Sworn peace officer investigators may also present certain cases to a District Attorney/City Attorney if there is sufficient evidence of a criminal violation. If the case is referred for either administrative or criminal action (or, occasionally, both), the investigator submits an investigation report with all evidence, including the expert report. If an administrative hearing or a criminal trial is conducted, the investigator works with the DAG and/or Deputy District Attorney (DDA). This includes case preparation, additional

investigation, if needed, and working with the DMC to secure additional expert reviews, if needed.

The Role of the District Medical Consultant (DMC)

The DMC assists investigators with the case investigation. This includes review of the complaint, medical and pharmacy records, insurance and billing records, and other documents in the case file where medical knowledge is needed. The DMC also assists the investigator with the subject interview.

After all of the evidence has been obtained, including an interview of the subject physician, the DMC and investigator determine whether the case should be sent for expert review. If the case requires an expert review, the DMC and investigator will provide input on the type of specialty expert needed and submit the case to the EPU where an analyst will be assigned to contact, screen and submit materials for the expert to review.

The DMC reviews the report prepared by the expert reviewer. When appropriate, he or she provides feedback to the reviewer to assist in future case reviews and reports. The DMC and the investigator also prepare an evaluation of the performance of the expert reviewer when the case is completed.

In some cases, the Board may order a physician to undergo either a physical or a mental examination by an expert reviewer. The DMC or investigator may contact you and ask you to perform such an examination and prepare a report.

The Role of the Deputy Attorney General (DAG)

The Office of the Attorney General (AG's office) is located within the state Department of Justice. Within the AG's office is the Health Quality Enforcement Section (HQE). This office handles administrative prosecutions against physician licenses. Cases where an expert has found an extreme departure from the standard of care, repeated simple departures, or other actionable violations of the Medical Practice Act are sent from the Board to HQE. A DAG may also seek and obtain a temporary license suspension order whenever an expert opines that a licensee's continued practice of medicine will endanger the public health, safety or welfare.

HQE DAGs carefully review evidence obtained during the investigation to determine whether it is sufficient to establish that a violation of law has occurred. This review includes a careful assessment of witness statements, medical records, and expert reviewer reports. In quality of care cases, DAGs sometimes contact the expert reviewer to discuss the technical medical issues addressed in the expert reviewer's report. Such contacts, which are generally conducted by telephone, are extremely important in helping the DAG understand the often-complex medical issues and clarify any possible ambiguity in the expert reviewer's report.

If an accusation is filed against a physician, the physician usually submits a notice of defense and requests discovery. Discovery is the provision of all evidence used to support the accusation, and always includes all investigative materials, including the expert reviewer's report. Most physicians request a hearing on the charges filed

against them and, in those cases, a hearing is scheduled with the Office of Administrative Hearings (OAH). The vast majority of these disciplinary cases are settled prior to the hearing with a stipulated agreement. Obviously, where a case is settled, expert reviewer involvement will be minimal. However, in those cases that do not settle and, instead, go forward to a full hearing, expert involvement will be critical to the successful prosecution of the case.

Typically, once a hearing has been scheduled with the OAH, the DAG will contact the expert to confirm availability for the hearing dates set in the case. Generally, expert testimony at the hearing will be required on one day only. However, in some instances, the expert may be called back to testify a second time in the same case as a rebuttal witness in order to rebut testimony offered by the licensee and/or his/her own expert witness(es).

Defense counsel often submit defense expert reports. The DAG, in turn, will often forward those defense expert reports to the expert for consideration and, most importantly, to determine whether the opinions expressed by defense experts in any way changes the expert's original expert opinion (s) given in the case.

In preparation for an upcoming hearing, the DAG will often contact the expert reviewer in order to schedule a face-to-face meeting to review the evidence in the case, the expert report, and opinions, as well as any possible defenses in the case. At the hearing, it is extremely important that the often-complex medical issues be presented in terms that are clear, concise and readily understandable to the Administrative Law Judge (ALJ) assigned to hear the case, as the ALJ is not a medical professional.

In most instances, expert testimony at the administrative hearing will end the expert's involvement in the case. Following issuance of a final decision by the Board, HQE DAGs will defend those decisions at both the superior court and appellate level. However, appeals are based on the record of the administrative hearing, including the transcripts and exhibits or other evidence. Witnesses are not called to testify in those proceedings.

The Role of the Expert Reviewer

The expert reviewer plays a crucial part in the investigation process by providing an objective, reasoned, and impartial evaluation of the case. **They are neither an advocate for the Board nor an advocate for the physician. Rather, the review is concerned primarily with whether there is a departure from the accepted standard of practice.**

An expert reviewer must safeguard both the confidentiality of the records, the identities of the patients, complainants and physicians involved. The expert reviewer is obligated not to divulge any information contained in any materials provided to other parties, at any time. Once the report is written, all case material must be returned to the Board/Division of Investigation. The obligation to preserve confidentiality also extends to any assistant whom the expert uses in the preparation of the report.

Key Point
Expert Reviewers must scrupulously protect the confidentiality of medical records, persons, and all other information related to a case review.

An important *caveat* regarding confidentiality relates to contacts from an attorney representing the subject physician or members of the media. At no time should a case be discussed, nor should any sort of acknowledgment be given that the case has been or is currently being investigated and/or reviewed. DO NOT agree to testify, on behalf of the complainant, in a civil matter regarding the review of the case. Any contact made by the media should be reported **and** referred to the Board's Public Information Officer at (916) 263-2389.

The Board keeps expert reports confidential to the greatest extent allowable under law.

The Board reimburses the expert reviewer for time spent preparing for hearing, meeting with the DAG, and reviewing additional documents and testifying. An additional Statement of Services will be provided to receive reimbursement for the additional hours worked. **The expert reviewer program analysts are the liaisons for coordinating any reimbursements, including travel arrangements, which may be required (hotel/airfare) and will be able to explain the state reimbursement rates for per diem.** Please do not make flight or hotel reservations without first speaking with an expert reviewer program analyst.

Civil Code §43.8 provides for immunity from civil liability for expert reviewers 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, the Board's Expert Reviewer Program must be contacted immediately.

In the event an Expert Reviewer Program Participant, acting on the Board's behalf, is named as a defendant in a lawsuit, **Business and Professions Code §2317** provides for the defense of the expert by the AG's office.

The AG's office will also represent you in connection with specialty board disciplinary proceedings related to your work as an expert for the Board, pursuant to Business and Professions Code section 2316.

TYPES OF EVALUATIONS

There are many possible violations of the Medical Practice Act. Listed below are some of the types of cases an expert may be asked to review.

Quality of Care

These cases involve the quality of medical care rendered to a patient or patients. Under **Business and Professions Code Sections 2234 (b), (c) and (d),** it is unprofessional conduct for a physician to commit gross negligence, repeated negligent acts, or incompetence in the practice of medicine. The question presented to you will be whether the physician's diagnosis and treatment of his/her patient constitutes: (1) no departure from the standard of care; (2) simple departure; (3) extreme departure; and/or (4) lack of knowledge. When conducting your review, it is vital you understand the different definitions for each of these terms. These will be addressed in further detail as you continue reading.

Sexual Misconduct

In evaluating allegations of sexual misconduct, you are to assume the allegations are true. You are not being asked to evaluate or comment on the credibility of the alleged victim or whether the alleged misconduct actually occurred. A determination as to whether the alleged misconduct can be proven will be made by the DAG when the investigation is reviewed or by the trier of fact at the hearing.

Key Point
A determination as to whether the alleged misconduct can be proven will be made by the DAG when the investigation is reviewed or by the trier of fact at the hearing.

If the issue involves a patient's account of what they feel to be an inappropriate exam, please make sure to describe in detail, in your standard of care section, what the appropriate physical exam should have entailed. Then comment on what the patient described and whether or not the exam itself met the standard of care.

In reviewing allegations regarding sexual misconduct, if you discover other departures dealing with the medical care provided, please address those issues in your opinion as well.

Under present law regulating physicians, any act of sexual abuse, misconduct or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for discipline. This does not apply to sexual contact between a physician and his or her spouse or a person in an equivalent domestic relationship when the physician provides medical treatment, other than psychotherapeutic treatment, to that person (**Business and Professions Code §726**). This section of law is an administrative violation.

Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be one, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, **unless** the physician and surgeon, psychotherapist, or

alcohol and drug counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor **recommended by a third party** physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation **(Business and Professions Code §729)**. This section of law is a criminal violation.

It is important to address whether or not the referral to another physician was done by an objective third party, not the subject physician.

Allegations are sometimes made that a physician has engaged in some form of sexual touching or contact with nursing staff, other physicians or some other subordinate staff person that may appear to be some form of sexual harassment. The conduct could also include verbal comments of a sexual nature or that conveys a sexual innuendo. In cases like this you are to assess whether the alleged conduct by the physician constitutes unprofessional conduct (**Business and Professions Code §2234**). Again, in making this assessment you are to assume the allegations are true.

Key Point
In evaluating allegations of sexual misconduct, you are to assume the allegations are true.

Drug Violations

Expert reviewers are referred a variety of cases alleging drug violations. These cases fall into three basic categories: excessive prescribing or treatment **(as defined in Business and Professions Code §725),** prescribing to an addict (**Business and Professions Code §2241)** or prescribing without an appropriate prior medical examination **(Business and Professions Code §2242)**.

Excessive Prescribing, under Business and Professions Code §725, often involves controlled substances. Generally, the assessment as to whether prescribing for a particular patient was excessive involves the nature of the medical complaint and the amount and frequency of the prescription of drugs. This can be a single drug, a class of drugs (such as opiates or amphetamines), or a pattern of prescribing large amounts of drugs without justification. An action under this section also can be sustained if the drug itself is not being given in excessive amounts, by ordinary standards, but is being knowingly given in excessive amounts for a given patient's condition. For instance, repeatedly prescribing a drug in the same amounts for a patient who has repeatedly attempted suicide using that drug constitutes excessive prescribing (among other potential violations, e.g., extreme departure from the standard of practice).

Prescribing controlled substances to a known addict for nonmedical purposes is illegal under Business and Professions Code §2241. Several provisions of the Health and Safety Code prohibit prescribing controlled substances to a known addict or a representative of an addict. Generally, controlled substances can be provided to addicts only in certain facilities such as prisons and state hospitals, or in licensed clinics established for the treatment of drug addiction. Even in those facilities, the controlled substances must be administered directly to the patient, not prescribed or dispensed for future use. For additional information, see **Health and Safety Code Section 11156, Health and Safety Code Section 11210, Health and Safety Code Section 11215, and Health and Safety Code Section 11217.**

Prescribing without Medical Indication, under Business and Professions Code §2242 indicates that it is unprofessional conduct to prescribe, dispense, or furnish dangerous drugs (prescription medications, including controlled substances) "without an appropriate prior examination and medical indication." This covers the situation where a physician simply prescribes a medication, usually a controlled substance, without any underlying pathology indicating a need for that medication. This also addresses the situation where a physician, knowing that a patient is addicted to a dangerous drug, continues to prescribe that drug. There are many instances when prescribing without medical indication and excessive prescribing overlap. In addition, there are instances when excessive prescribing of drugs or prescribing drugs without medical indication also constitutes an extreme departure, repeated departures from the standard of care, or lack of knowledge or skill, depending upon the evidence presented.

There is an exception for the prescribing of large amounts of controlled substances for documented cases of intractable, nonmalignant pain. In these cases, expert reviewers who are board-certified in the area of pain management are required.

Intractable Pain Treatment Act under Business and Professions Code §2241.5 provides that a physician may prescribe or administer controlled substances to a person in the course of treatment for pain, including, but not limited to, intractable pain. The patient must be evaluated by the treating physician and a specialist in the area deemed to be the source of the pain. However, the physician cannot prescribe or administer controlled substances in the treatment of known addicts, treatment that is non-therapeutic in nature or treatment that is not consistent with public health and welfare. He or she cannot violate the drug statutes governing the prescription of controlled substances and their documentation. For cases alleging that controlled substances were administered for intractable pain, the expert reviewer will be called upon to determine the reasonableness of the diagnosis of intractable pain and the compliance with the accepted standard of practice for the treatment of such pain.

When the Board requests an expert opinion in a pain management case, the investigator/ analyst must provide the selected expert reviewer with the case documents to be reviewed, as well as provide a link to the Guidelines for Prescribing Controlled Substances for Pain (https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf).

Guidelines for Prescribing Controlled Substances for Pain 2023 (Pain Management Guidelines, PMG)

The 2023 guidelines emphasize individualized care based on the patient's unique needs and comorbidities while reiterating the compelling need for physicians to clearly document the medical necessity and rationale for the treatment provided.

When reviewing cases, please reference only the appropriate and applicable PMG based upon treatment dates as follows:

- Treatment after July 1, 2023: Reference 2023 Pain Management Guidelines
- Treatment from November 2014 through June 30,2023: Reference 2014 Pain Management Guidelines
- Treatment before November 1, 2014: Reference 2007 Pain Management Guidelines

You may reference more than one PMG as applicable.

It is imperative that when reviewing cases involving pain management, your opinion addresses the following specific areas from the Board's PMG for the care rendered to each individual patient.

PMG: Patient Evaluation and Risk Stratification

This includes, but is not limited to:

- Completing a medical history and physical examination.
- Performing a psychological evaluation to assess risk of addictive disorders.
- Establishing a diagnosis and medical necessity.
- Exploring non-opioid therapeutic options.
- Evaluating both potential benefits and potential risks of opioid therapy.
- Being cognizant of aberrant or drug seeking behaviors.
- As a universal precaution, undertaking urine drug testing.
- Reviewing the CURES/Prescription Drug Monitoring Program (PDMP) report for the patient.

PMG: Consultation

The physician and surgeon should seek consultation with, or refer the patient to a pain, psychiatry, or an addiction or mental health specialist as needed. For example, a patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment, if available.

Physicians who prescribe long-term opioid therapy should be familiar with treatment options for opioid addiction (including those available in licensed opioid treatment programs and those offered by an appropriately credentialed and experienced physicians through office-based opioid treatment), to make appropriate referrals when needed.

In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

PMG: Treatment Plan and Objectives

When considering long-term use of opioids for chronic, non-cancer pain, the physician and the patient should develop treatment goals together. The goals of pain treatment include reasonably attainable improvement in pain and function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; and avoidance of unnecessary or excessive use of medications. Pain relief is important, but it is difficult to measure objectively. Therefore, it cannot be the primary indicator to assess the success of treatment. Effective pain relief improves functioning, whereas addiction decreases functionality. Effective means of achieving these goals vary widely, depending on the type and causes of the patient's pain, other concurrent issues, and the preferences of the physician and the patient.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, to provide clear-cut individualized objectives to guide the choice of the therapies. The treatment plan should contain information

supporting the selection of therapies, both pharmacologic (including medications other than opioids) and non-pharmacologic. It also should specify measurable goals and objectives that will evaluate treatment progress, such as relief of pain and improved physical and psychosocial function.

The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered. The treatment plan should also include an "exit strategy" for discontinuing opioid therapy in the event the tapering or termination of opioid therapy becomes necessary.

PMG: Patient Consent

The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, with persons designated by the patient or with the patient's conservator if the patient is without medical decision-making capacity. If opioids are prescribed, the patient (and possibly family members, if appropriate) should be counseled on safe ways to store and dispose of medications. For convenience, the patient consent and pain management agreement can be combined into one document.

Patient consent typically addresses:

- The potential risks and anticipated benefits of long-term opioid therapy.
- Potential side effects.
- The likelihood that some medications will cause tolerance and physical dependence to develop.
- The risk of drug interactions and over-sedation; respiratory depression; impaired motor skills; opioid misuse, dependence, addiction, and overdose.
- The limited evidence as to the benefit of long-term opioid therapy.

PMG: Pain Management Agreement

Use of a pain management agreement is recommended for patients:

- On short-acting opioids at the time of third visit within two months,
- On long-acting opioids, or,
- Expected to require more than three months of opioids.

PMG: Counseling Patients on Overdose Risk and Response

It is important to educate patients and family/caregivers about the danger signs of respiratory depression. Everyone in the household should know to summon medical help immediately if a person demonstrates symptoms of respiratory depression, and where appropriate, should be advised about the availability of naloxone.

PMG: Initiating Opioid Trial

Consider safer alternative treatments before initiating opioid therapy for chronic pain. Present opioid therapy to the patient as a therapeutic trial or test for a defined period of time (usually no more than 45 days) and with specific evaluation points.

PMG: Ongoing Patient Assessment

When a trial of an opioid medication is successful, and the physician and patient decide to continue opioid therapy, regular review and monitoring should be undertaken for the duration of treatment. Continuation, modification, or termination of controlled substances for pain should be contingent on the physician's evaluation of (1) evidence of the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as overdose or diversion.

PMG: Compliance Monitoring

Physicians who prescribe opioids or other controlled substances for pain should ensure the provisions of a pain management agreement are being heeded. Strategies for monitoring compliance may include CURES/PDMP report and drug testing. Effective October 2, 2018, a physician must query the CURES database and run a Patient Activity Report (PAR) on each patient the first time a patient is prescribed, ordered, or administered a Schedule II-IV controlled substance (unless an exemption exists in law).

PMG: Medical Records

The physician and surgeon should keep accurate and complete records documenting these items. Records should include the medical history and physical examination, and all laboratory results ordered by the physician; other evaluations and consultations; treatment plan objectives; informed consent; results of risk assessment, including results of screening instruments used; instructions to the patient, including discussions of risks and benefits with the patient and any significant others; results of CURES/PDMP data searches; treatments; medications (whether written, telephoned or electronic); pain management agreement; rationale for changes in the treatment plan or medications; and periodic reviews of the treatment plan.

PMG: Supervising Allied Health Professionals

Physicians who supervise physician assistants or nurse practitioners who prescribe opioids should be aware of the specific regulations and requirements governing them and those whom they supervise.

PMG: Compliance with Controlled Substances Laws

To prescribe controlled substances, the physician and surgeon must be appropriately licensed in California, have a valid controlled substances registration, and comply with federal and state regulations for issuing controlled substances prescriptions.

In rare instances, you may be asked to review cases in which there has been an allegation that the physician has failed to prescribe adequate doses of pain medication to address the condition of the patient.

There are other violations that involve drugs. Effective October 2, 2018, a physician must query the CURES database and run a Patient Activity Report (PAR) on each patient the first time a patient is prescribed, ordered, or administered a Schedule II-IV controlled substance (unless an exemption exists in law).

The next statutes describe other aspects of unprofessional conduct. Generally, these statutes do not require you to set forth the standard of care; however, your opinion may be needed to confirm that the allegations constitute unprofessional conduct. If these allegations are included as a part of your review, you will be provided copies of the law. Examples of these types of violations are:

Excessive use of Drugs or Alcohol **(Business and Professions Code §2239)**;

Intoxication While Treating Patients **(Business and Professions Code §2280)**.

Excessive Treatment Violations

Business and Professions Code §725 states it is unprofessional conduct for a physician to engage in repeated acts of clearly excessive prescribing or administering of treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities. In this type of case, you will be asked to state the accepted standard of practice concerning the number of physician visits necessary to treat a certain condition, the type and extent of diagnostic procedures necessary to diagnose the condition, or the type and extent of medical laboratory tests necessary to diagnose or treat a given medical condition. Then, you will be asked to determine whether the subject physician repeatedly violated these standards.

Statutes citing unprofessional conduct

There are several other Business and Professions Code sections that cite behavior that is considered "unprofessional conduct." Although sometimes the behavior appears to be obvious evidence of a violation, you may still be asked to opine whether the behavior constituted unprofessional conduct. Examples of these laws include:

§2236 – Conviction of a crime related to qualifications, functions, or duties of a physician and surgeon
§2240 – Report for death of patient
§2262 – Alteration of medical records
§2264 – Employment of unlicensed person
§2271 – False or misleading advertising

Regarding **Business and Professions Code §2236** (conviction of a crime), your opinion may be needed to relate the conviction to the qualifications, functions, or duties of a physician and surgeon. Here, it may be helpful to review and cross-reference ethical guidelines in arriving at a conclusion. Although a particular conviction may not directly be correlated to the practice of medicine, evaluate the behavior in terms of the code of ethics in existence at the time.

General Unprofessional Conduct

Business and Professions Code §2234 states that a physician may be disciplined for unprofessional conduct. Any act of unprofessional conduct, which is not specifically set forth as such in the Medical Practice Act or other statutes covering the practice of medicine, is referred to as "general unprofessional conduct." This kind of violation usually entails ethical violations such as dual relationships with patients, threatening a

witness in a case, failing to disclose pertinent financial information to a patient or other conduct that is prohibited by the general rules of ethics of physicians. Unprofessional conduct under **Business and Professions Code §2234** is conduct which breaches the rules or ethical code of the medical profession or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (Shea v. Board of Medical Examiners (1978) 81 Cal.App.3d 564, 575.)

In a case involving ethical violations, you will be asked to set forth the standard of conduct for a physician in the circumstances described, along with the underlying ethical code at the time of the act(s) in question. You must describe the manner in which the subject physician violated that standard.

Unlicensed practice/aiding and abetting unlicensed practice

Any person who practices or attempts to practice or who advertises or holds him/herself out as practicing any system or mode of treating the sick or afflicted or who diagnoses, treats, operates for or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other physical or mental condition without having at the time of so doing, a valid, unrevoked, or unsuspended certificate as provided in **Business and Professions Code §2052** or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense.

Business and Professions Code §2054 also adds that any person who uses in any sign, business card, or letterhead, or, in an advertisement, the words “doctor’ or “physician”, the letters “Dr.,” the initials “M.D.,” or any other terms or letters indicating or implying that he/she is a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, or that he or she is entitled to practice hereunder, or who represents or holds himself or herself out as a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon under this chapter is guilty of a misdemeanor.

Aiding and abetting the unlicensed practice of medicine

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct pursuant to **Business and Professions Code §2264**.

Mental or Physical evaluations

Experts may be asked to perform a mental or physical evaluation, pursuant to **Business and Professions Code §820**, whenever it appears that any person holding a license, certificate, or permit may be unable to practice his or her profession safely

because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the Board may order the licentiate to be examined by one or more physicians and surgeons or psychologists.

INSTRUCTIONS FOR COMPLETING YOUR REVIEW:

Before You Get Started

You should have already had a conversation with a DMC investigator or analyst to discuss your area of specialty and to ensure you are qualified in the area of medicine at issue and will be a good match to perform the review. The investigator/analyst should have gone through a checklist with you to ensure you and the case are an appropriate match.

As soon as you receive notification the electronic case is ready for you to review in the cloud-based system, please assess the case to determine if your training and clinical experience qualify you to provide an expert opinion. It is very important that you have had significant experience with the procedure or medical issue *during the exact time period* in question. The standard of care may change over time as new methods and research are developed. **Please contact the assigned investigator/analyst immediately if you have not had experience actually treating the condition or performing the procedure**. The Board has many cases that require review, so there will be future opportunities for you to perform this valuable service.

Please also determine if there is any reason you cannot provide an objective opinion because of a professional, business, and/or personal relationship with the subject physician or any witness in the case. **If you know the subject physician and/or any witnesses in the case, please immediately contact the assigned investigator/analyst and advise them of the nature of your relationship**. You will be advised whether you should continue with the review.

Key Point

Expert Reviewers should not participate in any review where there is the potential for conflict of interest. Failure to disclose a conflict of interest has serious consequences.

REVIEWING THE CASE

Before you begin reviewing the case, make sure you received everything listed on the investigator/analyst's cover letter. Audio recordings of subject interviews should be included, as well as any test results such as x-rays, ultrasounds, fetal monitoring strips, etc. As you complete your review, if you find the investigator/analyst did not procure information that is vital to forming your opinion (e.g., missing medical records, CT scans, test results; illegible records; information from witnesses; medical records from another provider) it is imperative that you contact the assigned investigator/analyst immediately and request the information needed. Please do not complete your report until the missing information is received. Preparing a report when information is missing will require you to complete an addendum report once the necessary information is obtained. This can be extremely detrimental to the case. Do not use your own CURES access. If a CURES report is needed, ask the investigator/analyst to run it for you. CURES reports should already be provided to you in the case materials, if applicable.

It is important to listen to the recording of the physician interview, even if a summary of the interview or a transcript of it exists.

Do not remove any pages from or make any marks or notations on the records provided to you. Ensure that records, reports and materials (including any audio recordings) are kept confidential and secure. Do not make any copies of the documents provided to you. You are required to return all materials to the investigator/analyst who submitted the case to you. If you print any documents from the cloud-based system to conduct your review, you must return them to the investigator/analyst who submitted the case to you for confidential destruction.

Do not attempt to contact any witnesses or conduct further investigation yourself. Keep all materials confidential and do not discuss the case with anyone other than Board staff. If you find potential problems with the care other medical providers have given, call the assigned investigator/analyst and let them know your concerns. Do not include that information in your report. Another case can be opened on the provider you have identified.

Track dates and hours spent reviewing. You are authorized a total of 10 hours at the beginning of your review, however, if you need more time, contact the assigned investigator/analyst. The important thing is to obtain authorization for more hours before you undertake them. Additional hours need to be approved in advance in order to avoid a delay in reimbursement.

You are allowed 30 days to complete your review and prepare the written opinion. In a complicated case, involving multiple patients, your review deadline may be extended, however this is usually agreed upon in advance. If you have not been given an extended deadline, and you anticipate your review will exceed 30 days, please provide status updates to the assigned investigator/analyst (by e-mail or voicemail message). Keep in mind that the physician under review will continue to see patients. If you feel a physician poses a danger to patients, it is vital that you inform the assigned investigator/analyst ***immediately***, and provide your opinion expeditiously, to protect the public.

Key Point

Your review is an important step in the investigative process and must be completed before the Board can make a final disposition. The timely submission of your report is vital to the resolution of the case.

PREPARING YOUR REPORT

Your expert report is the most important aspect of your review. Your report will be reviewed by the investigator/analyst and DAG assigned to the case to determine how the case will proceed. It is imperative that you strictly adhere to the provided report format. The following expert report format was designed to limit the need for addenda and provide an easy template for you to follow in preparing your report.

Key Point
The Board will rely on your report to determine if remediation or disciplinary action should be pursued. Your report should be clear, detailed, and followed the mandatory format.

It is critical to get the report correct the first time. Having to prepare an addendum to your report often detracts from an expert's credibility. The only exception would be if the Board sent you materials later to review and wanted you to prepare a brief addendum stating whether the additional materials change your original opinion. An example of this might be expert depositions that were not originally sent to you so that your initial opinion would not be biased.

Your expert report must be typed using an easily readable type style at least 12 (standard) font and submitted on your office letterhead. It should have headers containing the investigator/analyst's name, requesting office, case name and case number. The pages must be numbered. Your report must be signed and dated on the last page.

Please parenthetically explain any technical medical terminology or any medical abbreviation the first time they are used in a report so a layperson understands your opinion. For example, claudication (pain that occurs while walking and is relieved by rest) or SOB (shortness of breath).

The materials that are submitted to you will be numbered (Bates stamped). Please include the Bates page number for any information you reference during your opinion. This will make it easier for the DAG to cross-reference this information when reviewing your opinion. Most importantly, if it becomes necessary for you to testify, this will be invaluable in saving your time.

Please review the approved report format included in these guidelines and the sample reports online (https://www.mbc.ca.gov/Enforcement/Expert-Reviewer-Program.aspx) prior to preparing your report. This will ensure proper formatting and will help eliminate the need for any clarification or addenda.

It is important to note that there is no such thing as a "draft report." Do not e-mail or fax draft reports. It is important to proofread your report prior to submission. If you have any questions about the preparation of your report, please call the assigned investigator/analyst.

Please complete the Task Order/Expert Reviewer Checklist for each service you perform for the Board and submit the completed form with your statement of services (see following page for sample Statement of Services and Task Order form). The completed Task Order form is a supporting document to your statement of services

(bill). The Expert Reviewer Checklist section will assist you in confirming that all the necessary requirements of the expert report have been met.

MEDICAL BOARD OF CALIFORNIA
EXPERT REVIEWER PROGRAM
STATEMENT OF SERVICES

CONTRACT NUMBER: 00000 00000 00000 00000 00 | **INVOICE NUMBER:** MBC-

NAME: LAST | FIRST | MI

PAYMENT MAILING ADDRESS: | **CITY/STATE/ZIP CODE:**

DAY PHONE NUMBER: | **FAX NUMBER:** | **LICENSE NUMBER:**

BUSINESS STATUS: (check one)
☐ **Individual or Sole Proprietor** (enter Social security Number or Individual Tax Identification Number)
Provide Last 4 digits of SSN or ITIN: _____

For the following business status, a Federal Employer Identification Number (FEIN) is required:
☐ Partnership ☐ Corporation ☐ Estate or Trust
Provide Last 4 digits of FEIN: _____

IF A PARTNERSHIP, CORPORATION, OR ESTATE/TRUST, THE FOLLOWING INFORMATION IS ALSO REQUIRED:
Business Name: _____
(must match the name on contract)
Address: _____
City/State/Zip Code: _____
Phone Number: _____

Case Number: _____ **Case Name:** _____

☑ **Field Office:** _____ ☐ **Probation Unit:** _____ **Index** _____ **PCA** _____ **Object Code:** 5340540

EXPERT SERVICES

ACTIVITY CODES:

R	Record Review/Report Preparation - $150.00 per hour.
RPC	Case Review/Question Development for PC Exam - $150.00 per hour
PC	Professional Competency Exam - $150.00 per hour, up to $600.00.
AG	Conference/Consultation with Deputy Attorney General - $150.00 per hour.
DA/CA	Conference/Consultation with Deputy District Attorney or City Attorney-$150.00 per hour.
MC	Phone/Personal discussion with Medical Consultant or Investigator - $150.00 per hour.
MP	Mental and/or Physical Evaluation - pre-approved examiner's usual and customary fees for the face-to-face evaluations and tests; Board's usual rates for the other activities (review/report, consultations with DAG/investigative team/probation @150/hour; testimony @$200/hour).
T	Testimony at hearing - $200.00 per hour, up to $1600.00 per day.
TV	Travel time - $75.00 per hour
O	Other Expenses (describe in "Comments" section and attach receipts).

OTHER EXPENSES:
Mileage: _____ miles x $_____ (current rate) = $ 0.00
Lodging *: Date(s) _____ $_____
Meals *: Date(s) _____ $_____
Other *: (Describe in "Comments" section) $_____
SUBTOTAL $ 0.00
Receipts required

Date (Month/Day/Year)	Activity Code	Rate per Hour	Hours	Amount
		$		$ 0.00
		$		$ 0.00
		$		$ 0.00
		$		$ 0.00
		GRAND TOTAL *(Include subtotal from "Other Expenses")*		$ 0.00

CERTIFICATION OF EXPERT REVIEWER: I certify under penalty of perjury that the above is a true statement of expenses.

Signature _____ Date _____

FOR EXPERT REVIEWER PROGRAM USE	
Original Contract Amount	50,000.00
Current Contract Balance	
Invoice Amount	
Remaining Contract Balance	

COMMENTS

TO BE COMPLETED BY INVESTIGATOR/INSPECTOR:
Date Expert Report was Received: _____
☐ Case Review: [Indicate status of expert performance evaluation(s)]
☐ Evaluation attached ☐ Evaluation to follow ☐ Evaluation on-line/intranet
☐ Professional Competency Exam
☐ Evaluation: ☐ Mental ☐ Physical

SUPERVISOR'S APPROVAL: The Expert Reviewer Statement of Services has been reviewed and the services are approved.
Printed Name _____
Original Signature _____ Date _____

Allow 8-10 weeks for payment

TASK ORDER and EXPERT REVIEWER CHECKLIST

Contract Number: 00000000000000000000 **Task Order Number/Case Number:** _____

Task Order is incorporated by reference into the aforementioned Contract.

TASK ORDER

I, _____, (hereinafter "Contractor") enter into this Task Order, according to the terms and conditions of the said contract.

1. **TASK(S):** Check each box that applies.
   - ☐ The preparation of expert opinions on enforcement related matters, including technical subject matters, professional standards and any deviations therefrom, the quality and completeness of evidentiary material, and assistance in all phases of the judicial and administrative process including hearings and appeals, if required.
   - ☐ The evaluation of the mental or physical health of a licensee or an applicant for licensure.

   Provide description of the task(s) to be performed:
   _____
   _____
2. **CASE(S) COMPLETION DATE:** _____
3. **TOTAL NUMBER OF ALLOCABLE HOURS SHALL NOT EXCEED:** _____
4. **AUTHORIZATION FOR PAYMENT:** My services will be billed
   - ☐ At a rate of $ 150 per hour for record review/report, consultations with DAG/Investigative team/Probation.
   - ☐ Other: Mental and/or physical examination rate is a pre-approved examiner's usual and customary fees for the face-to-face evaluation and diagnostic tests; and the Board's rate of compensation for all other activities (as detailed above).
     testimony at hearing is $200 per hour up to $1600 per day;
     travel time at a rate of $75 per hour plus applicable travel expenses

   I understand that the Agency will allocate an approximate number of hours for each task or service to be provided under this Contract. If I need to exceed those hours, I agree to contact _____ (Representative) of the Agency in advance for authorization. I further understand and acknowledge that I will not be compensated for work performed without specific prior written authorization from the Agency.

5. **AGENCY ☐ AUTHORIZES / ☐ DOES NOT AUTHORIZE TRAVEL AND/OR PER DIEM FOR THE TASK(S) SPECIFIED IN SECTION #1.**

EXPERT REVIEWER CHECKLIST

- ☐ I have reviewed all the materials provided to me, including the audio recording and transcript of the physician interview.
- ☐ I have followed the format for the expert report by identifying a list of medical issues, and for each issue, I have included a standard of care, analysis, and conclusion section.
- ☐ In my conclusion section, I have only used the correct terms of **no departure, simple departure, extreme departure, and/or lack of knowledge.**
- ☐ I identified the medical literature or texts relied upon to form basis for standard of care, as a footnote or listed at end of report under heading "Literature Consulted" or "References."
- ☐ Any reference material cited in my opinion is attached.
- ☐ I have submitted my expert report on my letterhead; it is dated, paginated, proof read, and includes my signature.
- ☐ I have included a current copy of my curriculum vitae.
- ☐ I have included my completed Expert Statement of Services Form and have attached the necessary receipts for items such as transcription costs.

Board/Bureau/Program: MEDICAL BOARD OF CALIFORNIA

Task Ordered By: _____ Signature _____ Date: _____
(PRINT) Investigator (HQIU or MBC)/Probation/Deputy Attorney General

Contractor: _____ Signature _____ Date _____
(PRINT) Expert

When you have completed your report and task order/expert reviewer checklist, please contact the assigned investigator to arrange for the return of your report and case materials. Make sure you have also completed an Expert Statement of Services Form (billing form) and submit it with your expert report, completed task order/ expert reviewer checklist, and your current curriculum vitae. Double check to make sure you have included receipts for any expenses, i.e. transcription costs, travel expenses, etc. Keep a copy of your statement of services and receipts for your records.

MBC Form, Task Order and Expert Reviewer Checklist (Rev 2021)

IF THIS IS AN INVESTIGATION, THE INFORMATION CONTAINED HEREIN IS CONFIDENTIAL.

FORMATTING THE OPINION

There are Model Expert Opinions online (https://www.mbc.ca.gov/Enforcement/Expert-Reviewer-Program.aspx). Please refer to those when writing your opinion, but remember they are only examples.

Your expert opinion should contain the following headings:

- Materials Reviewed
- Summary of Case
- Medical Issues Identified
  - Standard of Care
  - Analysis
  - Conclusion

Materials Reviewed

- List all attachments and property items given to you for review.
- Listen to the audio recordings (of interview) provided to you before reaching an opinion or finalizing your report.

Summary of Case

- Create your own summary from the materials provided. Summarize the treatment in chronological order and in narrative format.
- Describe the treatment history of the patient with the subject practitioner. When did he/she start seeing the doctor, what for, what symptoms were being treated, and how.
- When referring in your report to a specific document/medical record in the materials provided to you, identify it in parenthesis; i.e. “Chest x-rays disclosed a 7mm coin lesion of the right lung (Attachment 4, page 9).”

Medical Issues Identified

- Identify the medical issues. Headings are very important.
- Number the medical issues. The medical issues will be broken down and discussed further in your opinion.
- Address all the medical issues.

Standard of Care

For each medical issue identified you will have a sub-heading of “Standard of Care.” Provide a detailed description of the standard of care for each medical issue. Be careful not to substitute your own practices (which may be beyond the standard) for the standard of care. Additional discussion regarding the standard of care can be found on page 30.

Analysis

For each medical issue identified you will have a sub-heading of “Analysis.” This will directly follow the standard of care section for the medical issue.

Here you will apply the facts of the case to the standard of practice. You will describe what the subject physician did or did not do relating to the standard of care. Please refer to page numbers of the medical records in parenthesis as you go.

Your analysis must be detailed, thorough and must support your conclusions and findings. Explain **why** the care provided (or not provided) to the patient is or is not a departure from the standard of care. Be specific.

Conclusion

For each medical issue identified you will have a sub-heading of “Conclusion.” This will directly follow the analysis section.

Describe the departures from the standard of care. You must only use the following terminologies: **no departure, simple departure, extreme departure, and/or lack of knowledge.**

Each departure must have a separate conclusion. Do not bundle departures. Generally, each separate act or omission by the subject physician should be treated as a separate departure. One of the biggest pitfalls of an expert report is mentioning several different areas where the subject departed from the standard of care and only having one conclusion. (Please do not write, for example, “I find four simple departures, but there are so many, they count as one extreme departure.”)

THE STANDARD OF CARE AND DEFINING DEPARTURES

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

In medicine, standards of care (also referred to as "standards of practice"), whether established by law or the medical community, are designed to protect patients from the **risk of harm**. The standard of care for general practitioners is defined as that level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question. Specialists, or physicians practicing outside their specialty, are held to the standard of skill, knowledge and care ordinarily possessed and exercised by other reasonably careful and prudent specialists in the same or similar circumstances at the time in question. For example, if a dermatologist decides to perform brain surgery, he/she will be held to the standard of care for the procedure performed (e.g., the reasonable prudent brain surgeon in the same or similar circumstances).

A physician's departure from the applicable standard of care is either negligence or gross negligence. **When determining whether a departure is a simple departure (negligence) or an extreme departure (gross negligence), the determining factor is the degree of departure from the applicable standard of care.**

"Negligence and gross negligence are relative terms. 'The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the danger becomes greater, the actor is required to exercise caution commensurate with it.'" (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal. App. 3d 184,198, citing Prosser, Law of Torts (4th ed. 1971) at p.180.)

Negligence is the failure to use that level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. A negligent act is often referred to as a "**simple departure**" from the standard of care.

Simple Departure
The failure to use that level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances.

Gross negligence, on the other hand, is defined as "the want of even scant care" or "an **extreme departure** from the standard of care." Gross negligence can be established under either definition, both are not required.

Extreme Departure
The want of even scant care.

Where, for example, the standard of care in the medical community requires a physician to take several steps in the detection, diagnosis and treatment of a patient presenting with possible breast cancer (e.g., complete history and physical, breast examination, mammogram, biopsy, surgical oncology consultation, all on a timely basis), a departure from that standard would, depending on the degree, constitute either a simple departure or an extreme departure from the standard of care. Likewise,

under section 2266 of the Medical Practice Act, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct." Here, the standard of practice applicable to medical records has been established by law. A physician's failure to maintain adequate and accurate medical records would (in addition to being a violation of section 2266) be a departure from this legislatively created standard of practice and, depending on the degree (e.g., partially illegible records, missing information, no records at all), constitute either a simple departure (negligence) or extreme departure (gross negligence).

If there are multiple negligent acts, it is important to explain whether they are related acts or, alternatively, separate and distinct acts. For example, an initial negligent diagnosis (e.g., failing to correctly diagnose a broken bone) followed by an act or omission medically appropriate for that negligent diagnosis (e.g., failing to place the patient in a cast) constitutes a single simple departure. However, if a physician failed to order appropriate lab tests on three separate occasions when they should have been ordered, each of those failures is a separate and distinct simple departure because, on each visit, the physician had an opportunity to treat the patient in accordance with the standard of care. Keep in mind that there may also be situations where on the same treatment visit, there may be multiple, separate and distinct simple departures from the standard of care. Please do not aggregate departures to increase the degree of departure. For example, multiple simple departures from the standard of care do not equal an extreme departure. Each departure maintains its own distinct basis and degree.

When determining whether a failure to practice in accordance with the standard of care constitutes either a simple or extreme departure, do not consider patient outcome. Rather, focus on how, why and the degree the care provided, or not provided, to the patient deviated from the standard of care, regardless of whether ultimately there was injury or death to the patient. Some cases with significant patient injury or death may involve only simple departures from the standard of care, while other cases where the patient suffered no harm or injury at all may involve extreme departures from the standard of care.

- Be sure to explain <u>why</u> the care provided, or not provided, to the patient is a departure from the standard of care. For example, do not just state your conclusion that the physician's care was a simple or extreme departure from the standard of care. State <u>why</u> and be <u>specific</u>. Your conclusion might be the doctor failed to order follow up laboratory tests and that is a _____ departure from the standard of care.
- Ambiguous terms, such as a "severe" or "significant" departure from the standard of care, may not be used. The terminology must be either simple or extreme departure from the standard of care.
- Each medical issue might have multiple areas to be discussed. Be sure to state your conclusions for each.

- Incompetence is generally defined as an absence of qualification, ability or fitness to perform a prescribed duty or function. Remember that the terms simple departure, extreme departure and lack of knowledge are not synonymous. Rather, a physician may possess the knowledge and ability to perform a given duty but exhibit a simple or extreme departure from the standard of care in performing that duty.

Lack of Knowledge (Incompetency)
An absence of qualification, ability or fitness to perform a prescribed duty or function.

If you conclude there is a lack of knowledge for a medical issue identified, you must explain in sufficient detail the basis for this conclusion.

In addition, if you determine the physician showed a lack of knowledge, you must also opine if there was a departure from the standard of care and to what degree (simple or extreme), and why.

If you determine the physician showed a lack of knowledge but do not find a departure from the standard of care, your report must explain why.

Terminology

Terms to Use	Terms NOT to Use
No departure	No Violation
Simple departure	Simple Negligence Ordinary Negligence Minor Violation Minor Departure Minor Deviation
Extreme departure	Gross Negligence Severe Departure Significant Departure Major Departure Major Deviation
Lack of knowledge	Incompetence Incompetent

References

Identify the medical literature and texts that are being relied upon to form the basis of the standard of care. List literature consulted at the end of the report or use footnotes supporting the concept expressed in the relevant standard of care findings. Apply the standards and literature in existence at the time of incident. Any reference material cited in the expert opinion must be provided with the report to the investigator/analyst as an attachment to the opinion. Voluminous literature or texts do not need to be provided but should be referenced in your report.

Multiple Patients

When reviewing a case involving more than one patient, individually summarize the care provided, state the standard of care that applies, analyze whether the care provided represents a departure from the standard of care, and set forth your conclusion(s) for each patient.

Format your report by patient (review your report format against the samples provided).

If you receive multiple cases on the same subject physician but they have different case numbers, prepare a separate report for each case number, **do not combine them in one report**.

Objectivity

It is critical to the integrity of due process that you conduct your review and prepare your report with objectivity. Remember that you are neither an advocate for the Board

nor for the physician. Do not make judgments or subjective comments, for example: "the patient twists Dr. Jones' conservative pattern of practice on obtaining EKGs on all new patients over the age of 20 as some kind of indication of sexual intent." A more objective phrasing would be "although some may find this conservative, it was not a departure from the standard of care to order an EKG on a new patient over the age of 20." View the assigned case without regard to any other legal activity that may surround it. Specifically, you should ignore the existence, nonexistence or magnitude of any civil judgments or settlements involving the case. Since you may not be reviewing the same documents which were used to support or refute a civil case, you should not consider any past adjudicatory history. As the expert reviewer, you should focus on the medical and other case records, not on the reports, depositions, or testimony of other expert witnesses.

Effect of Mitigation

In writing your opinion, you are asked to summarize the treatment rendered and the findings of the subject physician. There may have been factors in the case that prevented treatment consistent with the accepted standard of practice. If so, identify those factors. Please remember that it is your obligation to state the standard of practice and any departure from it.

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 (the ALJ). Therefore, you are asked to refrain from commenting whether the subject physician should or should not be punished because of certain mitigating or aggravating factors. Clearly state in your opinion what the mitigating or aggravating factors involved in the case are. Do not state an opinion as to the degree the circumstances should affect the discipline imposed. The actual discipline to be imposed on the physician is the province of the trier of fact, and you are not expected to prescribe or recommend any discipline in the case.

Injury Is Not Essential

The focus of an expert review is on whether there has been a departure from the accepted standard of practice, not whether the patient has been injured. Although the potential for injury exists due to the departure from the standard of practice, and the degree of that departure, actual injury is not required to establish a violation of the Medical Practice Act. Patient outcome is not to be considered when determining whether the departure is simple or extreme.

For the purposes of the Board fulfilling its public disclosure law in the Patient's Right to Know Act of 2018, you will be asked, in self-impairment cases, criminal conviction cases and inappropriate prescribing cases, whether or not the subject physician's behavior resulted in harm to a patient or patients.

Interim Suspension Orders:

Is the physician a danger to the public?

In some cases, your review may lead you to conclude that the physician's continued practice of medicine constitutes a threat to public safety. If this is the case, it is important for you to specifically note this, as then the Board can seek extraordinary (emergency) relief in the form of a suspension order to fulfill its mission of public protection.

Physician Supervisor Responsibility

During the course of a review, you may have to determine the level of responsibility of a supervising physician. The attending physician is ultimately responsible for the care provided to the patient. Therefore, if resident physicians are providing care to the attending physician's patient, part of the attending physician's responsibility is to provide appropriate supervision of the residents. Attending physicians are expected to use good judgment in determining the level of supervision appropriate for the situation.

Supervising or attending physicians must take into account the clinical problems being addressed and the resident's level of training, skill and knowledge. Reviewers, in assessing whether good judgment was used, should consider what a reasonable and prudent physician would do in the circumstances under review. Obviously, even a well-supervised resident can deliver substandard care. The attending physician, however, cannot be blamed for an adverse event if he or she took reasonable steps to provide appropriate supervision and oversight. Among the most useful evidence, indicating that appropriate actions were taken is documentation in the medical record.

Physicians may also supervise mid-level practitioners, such as Physician Assistants (PA) or nurse practitioners (NP). Physicians do not need approval from the Board to supervise physician assistants. However, pursuant to BPC 3502.3, a practice agreement with the following provisions must be obtained; the agreement must define exactly what tasks and procedures the PA is authorized to perform; policies and procedures to ensure adequate supervision of the PA; methods for continuing evaluation of the competency and qualifications of the PA; the furnishing or ordering of drugs or devices by a PA; and any additional provisions agreed to by the PA and physician. The agreement must be completed before the PA starts practicing. The agreement does not need to be submitted to the Board.

Physicians may supervise nurses so long as standardized procedures for nurses are in place to allow nurses to perform procedures while the physician is not on-site; however, they do not absolve physicians of their supervision responsibilities. "Supervision" is defined as the act of supervising, which is to oversee, to direct, to have charge, to

inspect, to provide guidance and evaluation. When functioning under "standardized procedures," physicians need not be present in the facility when the procedures are being performed. The facility, however, must be a medical setting. The standardized procedures must describe the circumstances under "which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition." Nurse practitioners are granted more autonomy than registered nurses. They are advanced practice nurses who are master's-level educated, and, for that reason, may perform certain functions with a different level of supervision than registered nurses. The major exception to the rules governing their supervision in cosmetic procedures is that they may be delegated the task of providing the appropriate prior examination and ordering the drug or prescriptive device for the patient, if acting under standardized procedures.

Assess the Standard of Practice at the Time of the Violation

The standard of practice 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 practice **AT THAT TIME**. For instance, the prescribing of a certain drug for a medical condition may be totally contraindicated now, but if the subject physician prescribed it in 2014, the state of knowledge about that drug and its contraindications may not have been as clear. Thus, any opinion should speak to the standard in 2014, not the standard at the present time.

Terms to Avoid

Exacerbation: Certain situations or conditions may exacerbate a physician's actions with respect to a case. For example, being inebriated while seeing a patient may exacerbate an underlying lack of knowledge or ability. While it is appropriate to describe exacerbating conditions, an expert reviewer should not assign value judgments to them. This will be done at hearing.

Guilt or Innocence: The expert reviewer's role is to determine whether, and in what manner, a physician's actions depart from the standard of medical practice, or demonstrate a lack of knowledge or ability. The trier of fact will determine guilt or innocence.

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

Malpractice: Malpractice is a term that applies to civil law (i.e., suits between individuals). The Board functions under administrative law and its cases are based on violations of that law involving unprofessional conduct. Expert reviewers should not let information regarding malpractice filings, settlements or judgments affect their review of a case. The standards of evidence and proof for civil cases differ from administrative cases.

Penalties: It is not the role of the expert reviewer to propose or recommend a penalty. This will be determined at hearing, based on detailed guidelines adopted by the Board and utilized by ALJs.

Personalized comments: Avoid characterizing the actions of the physician in personal terms: “she was rude and unprofessional to the patient.” Instead, describe what the expected standard was, and how the physician deviated from the standard: “The standard of practice is to explain the procedure, answer the patient’s questions, and obtain informed consent. There is no record showing that the procedure was explained to the patient and informed consent obtained.”

EXPERT REVIEWER LETTERHEAD

Phone (916) 263-2606
Fax (916) 263-2607
Email
Web site

Date: February 23, 2020

To: Insert Investigator/Analyst's Name and address
Health Quality Investigation Unit
Sacramento Field Office

Re: Insert Subject's Name
Insert Case No.: xxxx

Materials Reviewed:

1.
2.
3.
4.
5.

PATIENT A

Case Summary:

Medical Issues:

1. State the medical issue (e.g., choice of surgery)

Standard of care:

Analysis:

Conclusion:

2. State the medical issue (e.g., recordkeeping)

Standard of Care:

Analysis:

Conclusion:

PATIENT B

Case Summary:

Medical Issues:

1. **State the medical issue (e.g., choice of surgery)**

   Standard of care:

   Analysis:

   Conclusion:

2. **State the medical issue (e.g., failing to recognize complication)**

   Standard of Care:

   Analysis:

   Conclusion:

3. **State the medical issue (e.g., recordkeeping)**

   Standard of Care:

   Analysis:

   Conclusion:

Signature
Raymond Craig, M.D.
Department of Medicine

References:

MOST FREQUENTLY ASKED QUESTIONS

Will I have to testify?

If the case is submitted for disciplinary action, and no stipulated agreement is reached, you will be called upon to provide expert testimony. A stipulated agreement means that both parties have reached an agreement as to what discipline, if any, will be given in the matter. Currently, approximately 70% of cases are settled without a hearing.

Can I be sued for expressing my opinion?

Civil Code §43.8 provides immunity from civil liability for expert reviewers. While in theory one could be sued for expressing an opinion as an expert reviewer, such lawsuits are exceedingly rare. In addition, the AGs office would defend such suits and any specialty board action, at no cost to the expert reviewer.

Can I do some research?

Yes, you may consult peer-reviewed journal articles, medical texts and other authoritative reference materials that help define accepted standards. Apply the standards and literature in existence at the time of incident. Please cite or identify all references used in your written opinion and provide with the report to investigator (as an attachment to the opinion).

It is important that you do not attempt to conduct your own investigation. You cannot contact or discuss the case with the patients, the subject physician, other physicians, Board members, or anyone else. You must scrupulously protect the confidentiality of the subject of the case, and the patients involved.

What if I need additional information or clarification?

Contact the investigator/analyst assigned to the case as soon as possible and request whatever additional information you need to complete your review. Do not contact any outside witnesses or sources.

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

You are allowed 30 days. In a complicated case, involving multiple patients, your review could extend beyond our 30-day time frame, but no more than 60 days. Keep in mind that the physician under review will continue to see patients until a determination is made by the Board. If you feel this physician poses a danger to patients, it is vital that you inform investigator/analyst ***immediately***, and provide your opinion expeditiously, in order to protect the public.

If you find your background is not suited to review a particular case, or other commitments preclude you from meeting the deadline, or, for any reason, you need to be excused from a case (e.g., to avoid potential conflict of interest) immediately notify the investigator assigned to the case.

Who will see my report?

If an accusation (formal disciplinary charges) is filed, the subject physician will be provided a copy of your report as part of legal discovery. **Please be aware that once a case proceeds to an administrative hearing or to a criminal proceeding, through legal discovery, your report may become public record**. Public disclosure of medical expert reports, however, rarely occurs.

Your report, without personal identifiers, may be shared with the subject as an educational tool in cases that do not proceed to formal discipline.

Can you give me a copy of a sample report?

Yes, sample reports are posted online at: https://www.mbc.ca.gov/Enforcement/Expert-Reviewer-Program.aspx

What is the difference between a simple departure and an extreme departure from the standard of practice?

The "standard of care" (also referred to as the "standard of practice") for general practitioners is defined as that level of skill, knowledge and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question.

Physicians are held to the standard of skill, knowledge and care ordinarily possessed and exercised by other reasonably careful and prudent specialists in the same or similar circumstances at the time the care was provided. For example, although a physician may not be trained in plastic surgery, she or he is held to the standard of a board-certified, similarly situated plastic surgeon.

Negligence is the failure to use that level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. A negligent act is often referred to as a "**simple departure**" from the standard of care.

Gross negligence, on the other hand, is defined as "the want of even scant care" or "an **extreme departure** from the standard of care." Gross negligence can be established under either definition, both are not required. The difference between gross negligence and ordinary negligence is the degree of departure from the standard of care. Further information regarding simple vs. extreme departures is provided on page 31.

What is incompetency?

Incompetency is generally defined as "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837.) Do not use the term incompetence to describe a departure from the standard of practice, as the terms are not synonymous. Incompetence is synonymous with lack of knowledge. A physician may be competent to perform a duty but negligent in performing that duty.

How much will I be paid?

If you have attended the Board's expert reviewer training and have submitted a satisfactory sample expert opinion, you will be paid at the rate of $200.00 per hour for your evaluation and report. If you have not attended both the training and have not submitted a sample report, compensation is $150.00 per hour for your evaluation and report. It is important that you advise the assigned investigator/analyst when you are approaching 10 hours of review. Periodically, there are complex, voluminous cases that will require more than 10 hours for you to complete your review. In those situations, you **must obtain approval from the investigator, district office supervisor, or analyst before working more than 10 hours.**

For testimony, if you have attended the Board's expert reviewer training and have submitted a satisfactory sample expert opinion, you will be paid at the rate of $250.00 per hour or a maximum of $2000.00 per day. If you have not attended the training and have not submitted a satisfactory sample expert opinion, the rate of compensation is $200 per hour for a maximum of $1600 per day.

When a hearing is canceled, the time allotted for the hearing is not reimbursable, however time spent preparing for a canceled hearing is billable.

How soon will I be paid?

You should receive payment for your services within eight to ten weeks if your paperwork is accurately submitted.

COMPENSATION

The Board will provide you with the following forms to submit in order to receive compensation for your expert reviewer services:

- Expert Reviewer's Statement of Services.
- Task Order/Expert Reviewer Checklist Form. This form is necessary to comply with the State's contract requirements.
- You must complete a Statement of Services form and Task Order form for each case you review for the Board. Sometimes it is necessary to complete more than one Statement of Services form and Task Order form during the course of a case. Failure to fill out the forms completely will delay your compensation.
- Digital signatures are accepted, and forms may be forwarded electronically to the assigned investigator or the expert reviewer program. Hard copies are no longer required.

Initial Case Review for Experts

You will be compensated at the rate of $150.00 per hour for your evaluation and report if you have NOT attended expert reviewer training and have not submitted an adequate sample report. You will be compensated at the rate of $200.00 per hour for your evaluation and report if you HAVE attended the training and have submitted an adequate sample report. Please record the hours worked on each case. When billing fractional time for less than a full hour please calculate the time to the nearest quarter hour. For example, if you work 1 hour and 22 or fewer minutes, the time billed should be 1.25 hours (or 1¼ hours), if you work 1 hour and 23 or more minutes, the time billed should be 1.5 hours (or 1½ hours), and so on through the hour. You must specifically delineate how many hours are worked on particular date (see example). Otherwise, the bill will be returned to you for correction, and this will delay the amount of time it takes to reimburse you.

The Board keeps its accounts by fiscal year, which is July 1 through June 30. Please **do not** combine fiscal years on one form. Instead, use a separate form for each fiscal year.

Mental or Physical Examination

- The expert examiner will be paid his/her usual/customary examination fee for the face-to-face evaluation and any necessary diagnostic testing and the Board's expert rate of compensation for all other activities (i.e., report writing/record review) as described above under "Initial Case Review for Experts."
- Provide the investigator, medical consultant, or Board representative with an estimate of fees **prior** to conducting the mental or physical examination. You should not exceed the estimate unless pre-approved by the investigator or Board representative.

Consultation with the Deputy Attorney General

This includes any consultation, in person or by telephone, before the case is filed, while the action is pending, or in preparation for hearing. You will be compensated at the rate of $150.00 per hour if you have NOT attended the training and have not submitted an adequate sample report and at the rate of $200 per hour if you HAVE attended the training and have submitted an adequate sample report.

Testimony at Hearing

You will be compensated at the rate of $200.00 per hour for testimony, with the maximum fee allowable for a full day of testimony being $1600.00 if you have NOT attended the training and have submitted an adequate sample report. You will be compensated at the rate of $250.00 per hour of testimony, with the maximum fee allowable for a full day of testimony being $2000 if you HAVE attended the training and submitted an adequate sample report.

When a hearing is canceled, the time allotted for the hearing is not reimbursable, however time spent *preparing* for a canceled hearing is billable.

Miscellaneous Expenses

It is imperative that you contact the Expert Reviewer Program to arrange for any travel.

Please arrange all travel through the Expert Reviewer Program. The Medical Board expert reviewer program will arrange the necessary flights, ground transportation and lodging.

You will be authorized $75.00 per hour for actual drive time to attend a hearing or drive to a location (other than your regular business location) to administer a mental or physical examination.

Sample Expert Billing
Case Review
(Submitted by an expert who has not completed training and has not submitted a sample report that was reviewed and approved.)

MEDICAL BOARD OF CALIFORNIA
EXPERT REVIEWER PROGRAM
STATEMENT OF SERVICES

CONTRACT NUMBER: 00000 00000 00000 00000 00 | INVOICE NUMBER: MBC-

NAME: LAST: CRAIG | FIRST: RAYMOND | MI:

PAYMENT MAILING ADDRESS: 320 ARDEN AVENUE, SUITE 250 | CITY/STATE/ZIP CODE: GLENDALE CA 91203

DAY PHONE NUMBER: (818) 551-0000 | FAX NUMBER: (818) 551-0000 | LICENSE NUMBER: A012345

BUSINESS STATUS: (check one)
☐ Individual or Sole Proprietor (enter Social security Number or Individual Tax Identification Number)
Provide Last 4 digits of SSN or ITIN: _____

For the following business status, a Federal Employer Identification Number (FEIN) is required:
☐ Partnership ☑ Corporation ☐ Estate or Trust
Provide Last 4 digits of FEIN: 0000

IF A PARTNERSHIP, CORPORATION, OR ESTATE/TRUST, THE FOLLOWING INFORMATION IS ALSO REQUIRED:
Business Name: RAYMOND CRAIG, M.D., INC. (must match the name on contract)
Address: _____
City/State/Zip Code: _____
Phone Number: _____

Case Number: _____ Case Name: HAROLD WILSON, M.D.

☑ Field Office: _____ ☐ Probation Unit: _____ Index _____ PCA _____ Object Code: 5340540

EXPERT SERVICES

ACTIVITY CODES:
- R — Record Review/Report Preparation - $150.00 per hour.
- RPC — Case Review/Question Development for PC Exam - $150.00 per hour
- PC — Professional Competency Exam - $150.00 per hour, up to $600.00.
- AG — Conference/Consultation with Deputy Attorney General - $150.00 per hour.
- DA/CA — Conference/Consultation with Deputy District Attorney or City Attorney-$150.00 per hour.
- MC — Phone/Personal discussion with Medical Consultant or Investigator - $150.00 per hour.
- MP — Mental and/or Physical Evaluation - pre-approved examiner's usual and customary fees for the face-to-face evaluations and tests; Board's usual rates for the other activities (review/report, consultations with DAG/investigative team/probation @150/hour; testimony @$200/hour).
- T — Testimony at hearing - $200.00 per hour, up to $1600.00 per day.
- TV — Travel time - $75.00 per hour
- O — Other Expenses (describe in "Comments" section and attach receipts).

OTHER EXPENSES:
Mileage: _____ miles x $ _____ (current rate) = $ 0.00
Lodging *: Date(s) _____ $ _____
Meals *: Date(s) _____ $ _____
Other *: (Describe in "Comments" section) $ _____
SUBTOTAL $ 0.00
* *Receipts required*

Date (Month/Day/Year)	Activity Code	Rate per Hour	Hours	Amount
6/1/2020	MC	$ 150.00	0.5	$ 75.00
6/1-30/2020	R	$ 150.00	9	$ 1,350.00
		$		$ 0.00
FY 2019-2020		$		$ 0.00
GRAND TOTAL *(Include subtotal from "Other Expenses")*				$ 1,425.00

CERTIFICATION OF EXPERT REVIEWER: I certify under penalty of perjury that the above is a true statement of expenses.

_____ Signature _____ Date

FOR EXPERT REVIEWER PROGRAM USE

Original Contract Amount	50,000.00
Current Contract Balance	
Invoice Amount	
Remaining Contract Balance	

COMMENTS

TO BE COMPLETED BY INVESTIGATOR/INSPECTOR:
Date Expert Report was Received: _____
☑ Case Review: [Indicate status of expert performance evaluation(s)]
☐ Evaluation attached ☐ Evaluation to follow ☐ Evaluation on-line/intranet
☐ Professional Competency Exam
☐ Evaluation: ☐ Mental ☐ Physical

SUPERVISOR'S APPROVAL: The Expert Reviewer Statement of Services has been reviewed and the services are approved.
Printed Name _____
Original Signature _____ Date _____

Allow 8-10 weeks for payment

TASK ORDER and EXPERT REVIEWER CHECKLIST

Contract Number: 00000000000000000000 **Task Order Number/Case Number:** _____

Task Order is incorporated by reference into the aforementioned Contract.

TASK ORDER

I, _____, (hereinafter "Contractor") enter into this Task Order, according to the terms and conditions of the said contract.

1. **TASK(S):** Check each box that applies.
   - ☐ The preparation of expert opinions on enforcement related matters, including technical subject matters, professional standards and any deviations therefrom, the quality and completeness of evidentiary material, and assistance in all phases of the judicial and administrative process including hearings and appeals, if required.
   - ☐ The evaluation of the mental or physical health of a licensee or an applicant for licensure.

   Provide description of the task(s) to be performed:

   _____

   _____
2. **CASE(S) COMPLETION DATE:** _____
3. **TOTAL NUMBER OF ALLOCABLE HOURS SHALL NOT EXCEED:** _____
4. **AUTHORIZATION FOR PAYMENT:** My services will be billed

   - ☐ At a rate of $ 150 per hour for record review/report, consultations with DAG/Investigative team/Probation.
   - ☐ Other: Mental and/or physical examination rate is a pre-approved examiner's usual and customary fees for the face-to-face evaluation and diagnostic tests; and the Board's rate of compensation for all other activities (as detailed above).
     testimony at hearing is $200 per hour up to $1600 per day;
     travel time at a rate of $75 per hour plus applicable travel expenses

   I understand that the Agency will allocate an approximate number of hours for each task or service to be provided under this Contract. If I need to exceed those hours, I agree to contact _____ (Representative) of the Agency in advance for authorization. I further understand and acknowledge that I will not be compensated for work performed without specific prior written authorization from the Agency.

5. **AGENCY ☐ AUTHORIZES / ☐ DOES NOT AUTHORIZE TRAVEL AND/OR PER DIEM FOR THE TASK(S) SPECIFIED IN SECTION #1.**

EXPERT REVIEWER CHECKLIST

- ☐ I have reviewed all the materials provided to me, including the audio recording and transcript of the physician interview.
- ☐ I have followed the format for the expert report by identifying a list of medical issues, and for each issue, I have included a standard of care, analysis, and conclusion section.
- ☐ In my conclusion section, I have only used the correct terms of **no departure, simple departure, extreme departure, and/or lack of knowledge.**
- ☐ I identified the medical literature or texts relied upon to form basis for standard of care, as a footnote or listed at end of report under heading "Literature Consulted" or "References."
- ☐ Any reference material cited in my opinion is attached.
- ☐ I have submitted my expert report on my letterhead; it is dated, paginated, proof read, and includes my signature.
- ☐ I have included a current copy of my curriculum vitae.
- ☐ I have included my completed Expert Statement of Services Form and have attached the necessary receipts for items such as transcription costs.

Board/Bureau/Program: MEDICAL BOARD OF CALIFORNIA

Task Ordered By: _____ Signature _____ Date: _____
(PRINT) Investigator (HQIU or MBC)/Probation/Deputy Attorney General

Contractor: _____ Signature _____ Date _____
(PRINT) Expert

When you have completed your report and task order/expert reviewer checklist, please contact the assigned investigator to arrange for the return of your report and case materials. Make sure you have also completed an Expert Statement of Services Form (billing form) and submit it with your expert report, completed task order/ expert reviewer checklist, and your current curriculum vitae. Double check to make sure you have included receipts for any expenses, i.e. transcription costs, travel expenses, etc. Keep a copy of your statement of services and receipts for your records.

MBC Form, Task Order and Expert Reviewer Checklist (Rev 2021)

IF THIS IS AN INVESTIGATION, THE INFORMATION CONTAINED HEREIN IS CONFIDENTIAL.

Sample Expert Billing
Mental Examination

(Submitted by an expert who has attended training and submitted a sample report that has been reviewed and approved.)

MEDICAL BOARD OF CALIFORNIA
EXPERT REVIEWER PROGRAM
STATEMENT OF SERVICES

CONTRACT NUMBER: 00000 00000 00000 00000 00 | INVOICE NUMBER: MBC-

NAME: LAST: CRAIG | FIRST: RAYMOND | MI:

PAYMENT MAILING ADDRESS: 320 ARDEN AVENUE, SUITE 250 | CITY/STATE/ZIP CODE: GLENDALE CA 91203

DAY PHONE NUMBER: (818) 551-0000 | FAX NUMBER: (818) 551-0000 | LICENSE NUMBER: A012345

BUSINESS STATUS: (check one)
■ Individual or Sole Proprietor (enter Social security Number or Individual Tax Identification Number)
Provide Last 4 digits of SSN or ITIN: 6789

For the following business status, a Federal Employer Identification Number (FEIN) is required:
☐ Partnership ☐ Corporation ☐ Estate or Trust
Provide Last 4 digits of FEIN: _____

IF A PARTNERSHIP, CORPORATION, OR ESTATE/TRUST, THE FOLLOWING INFORMATION IS ALSO REQUIRED:
Business Name: _____
(must match the name on contract)
Address: _____
City/State/ZipCode: _____
Phone Number: _____

Case Number: _____ Case Name: HAROLD WILSON, M.D.

☐ Field Office: _____ ☐ Probation Unit: _____ Index _____ PCA _____ Object Code: 5340540

EXPERT SERVICES

ACTIVITY CODES:
R Record Review/Report Preparation - $200.00 /hr.
RPC Case Review/Question Development for PC Exam - $200.00 /hr
PC Professional Competency Exam - $200.00 per hour, up to$800.00.
AG Conference/Consultation with Deputy Attorney General - $200.00/hr.
DA/CA Conference/Consultation with Deputy District Attorney or City Attorney-$200.00 /hr.
MC Phone/Personal discussion with Medical Consultantor Investigator - $200.00 /hr.
MP Mental and/or Physical Evaluation - pre-approved examiner's usual and customary fees for the face-to-face evaluations and tests; Board's usual rates for the other activities (review/report, consultations with DAG/investigative team/probation @200/hour; testimony @$250/hour).
T Testimony at hearing - $250.00 /hr., up to $2000.00 per day.
TV Travel time - $75.00 per hour
O Other Expenses (describe in "Comments" section and attach receipts).
Neurological Surgery Experts @ 300/hr. for the following Activity Codes: R, RPC, PC, AG, DA/ CA, MC; and $400 /hr. up to $3200 per day for testimony (T). Travel (TV) $75 /hr.

OTHER EXPENSES:
Mileage: _____ miles x _____ (current rate) = $ 0.00
Lodging *: Date(s) _____ _____
Meals *: Date(s) _____ _____
Other *: (Describe in "Comments" section) _____
SUBTOTAL $ 0.00
** Receipts required*

Date (Month/Day/Year)	Activity Code	Rate per Hour	Hours	Amount
7/1/2020	MC	$ 200.00	0.5	$ 100.00
7/3/2020	R	$ 200.00	1.00	$ 200.00
7/4/2020	MP	$ 300.00	6	$ 1,800.00
7/5-25/2020	R	$ 200.00	5	$ 1,000.00
		GRAND TOTAL *(Include subtotal from "Other Expenses")*		$ 3,100.00

CERTIFICATION OF EXPERT REVIEWER: I certify under penalty of perjury that the above is a true statement of expenses.

Signature _____ Date _____

FOR EXPERT REVIEWER PROGRAM USE

Original Contract Amount	50,000.00
Current Contract Balance	
Invoice Amount	
Remaining Contract Balance	

COMMENTS

TO BE COMPLETED BY INVESTIGATOR/INSPECTOR:
Date Expert Report was Received: _____
☐ Case Review: [Indicate status of expert performance evaluation(s)]
☐ Evaluation attached ☐ Evaluation to follow ☐ Evaluation on-line/intranet
☐ Professional Competency Exam
■ Evaluation: ■ Mental ☐ Physical

SUPERVISOR'S APPROVAL: The Expert Reviewer Statement of Services has been reviewed and the services are approved.
Printed Name _____
Original Signature _____ Date _____

Allow 8-10 weeks for payment

TASK ORDER and EXPERT REVIEWER CHECKLIST

Contract Number: 00000000000000000000 **Task Order Number/Case Number:** _____

Task Order is incorporated by reference into the aforementioned Contract.

TASK ORDER

I, _____, (hereinafter "Contractor") enter into this Task Order, according to the terms and conditions of the said contract.

1. **TASK(S):** Check each box that applies.
   - ☐ The preparation of expert opinions on enforcement related matters, including technical subject matters, professional standards and any deviations therefrom, the quality and completeness of evidentiary material, and assistance in all phases of the judicial and administrative process including hearings and appeals, if required.
   - ☐ The evaluation of the mental or physical health of a licensee or an applicant for licensure.

   Provide description of the task(s) to be performed: _____
2. **CASE(S) COMPLETION DATE:** _____
3. **TOTAL NUMBER OF ALLOCABLE HOURS SHALL NOT EXCEED:** _____
4. **AUTHORIZATION FOR PAYMENT:** My services will be billed

   ☐ At a rate of $ 200__ per hour for record review/report, consultations with DAG/Investigative team/Probation.
   ☐ Other: Mental and/or physical examination rate is a pre-approved examiner's usual and customary fees for the face-to-face evaluation and diagnostic tests; and the Board's rate of compensation for all other activities (as detailed above).
   - Testimony at hearing is $250 per hour up to $2000 per day;
   - Travel time at a rate of $75 per hour plus applicable travel expenses

   ☐ Neurological Surgery Experts at a rate of $300 per hour for record review/report/consultations with DAG/Investigation.
   - Testimony at hearing is $400 per hour up to $3200 per day;
   - Travel time at a rate of $75 per hour plus applicable travel expenses

   I understand that the Agency will allocate an approximate number of hours for each task or service to be provided under this Contract. If I need to exceed those hours, I agree to contact _____ (Representative) of the Agency in advance for authorization. I further understand and acknowledge that I will not be compensated for work performed without specific prior written authorization from the Agency.
5. **AGENCY ☐ AUTHORIZES / ☐ DOES NOT AUTHORIZE TRAVEL AND/OR PER DIEM FOR THE TASK(S) SPECIFIED IN SECTION #1.**

EXPERT REVIEWER CHECKLIST

- ☐ I have reviewed all the materials provided to me, including the audio recording and transcript of the physician interview.
- ☐ I have followed the format for the expert report by identifying a list of medical issues, and for each issue, I have included a standard of care, analysis, and conclusion section.
- ☐ In my conclusion section, I have only used the correct terms of **no departure, simple departure, extreme departure, and/or lack of knowledge.**
- ☐ I identified the medical literature or texts relied upon to form basis for standard of care, as a footnote or listed at end of report under heading "Literature Consulted" or "References."
- ☐ Any reference material cited in my opinion is attached.
- ☐ I have submitted my expert report on my letterhead; it is dated, paginated, proof read, and includes my signature.
- ☐ I have included a current copy of my curriculum vitae.
- ☐ I have included my completed Expert Statement of Services Form and have attached the necessary receipts for items such as transcription costs.

Board/Bureau/Program: MEDICAL BOARD OF CALIFORNIA

Task Ordered By: _____ Signature _____ Date: _____
(PRINT) Investigator (HQIU or MBC)/Probation/Deputy Attorney General

Contractor: _____ Signature _____ Date _____
(PRINT) Expert

When you have completed your report and task order/expert reviewer checklist, please contact the assigned investigator to arrange for the return of your report and case materials. Make sure you have also completed an Expert Statement of Services Form (billing form) and submit it with your expert report, completed task order/ expert reviewer checklist, and your current curriculum vitae. Double check to make sure you have included receipts for any expenses, i.e. transcription costs, travel expenses, etc. Keep a copy of your statement of services and receipts for your records.

MBC Form, Task Order and Expert Reviewer Checklist (Rev 2021)

IF THIS IS AN INVESTIGATION, THE INFORMATION CONTAINED HEREIN IS CONFIDENTIAL.