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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
GAIL A. TASCH, Respondent.	:	LS0404301MED

Division of Enforcement Case No. 03 MED 305

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 20th day of JULY, 2005.

Member of the Board
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	PROPOSED FINAL DECISION AND ORDER
GAIL A. TASCH, M.D., RESPONDENT	:	
	:	Case No. LS 0404301 MED

Division of Enforcement Case File No. 03 MED 305

The parties to this action for purposes of Wis. Stats. § 227.53 are:

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Agency

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Procedural History

A hearing in the above captioned matter was held on November 9, 2004, before Administrative Law Judge William A. Black. The Division of Enforcement appeared by attorney James E. Polewski. Attorney Amy F. Scholl appeared on behalf of Gail A. Tasch, M.D. The record was completed on December 23, 2004, with the filing of written closing arguments.

Based on the entire record in this case, the undersigned administrative law judge recommends that the Medical Examining Board adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law and Order.

Findings of Fact

1. Gail A. Tasch, M.D., was born on March 22, 1957, and is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license number 27096, first granted on July 2, 1985. The respondent's specialty is psychiatry.

2. Twenty-nine times during the period June 1, 2001, through August 5, 2003, the respondent obtained cosmetology services at Designer Edition, a barbering and cosmetology establishment in Eau Claire, Wisconsin.

3. At Designer Edition the respondent dictated a portion of a chapter on medical necessity, (Exh. 6) which used the words, phrases and a sentence as follows:

- "suicidality, homicidality, psychosis, or inability to care for self."
- "mental illness"
- "self harm"
- "patient"
- "imminent risk"
- "I wish I were dead"
- "partial hospitalization"
- "contemplated suicides"
- "chronic illness"
- "substance abuse"
- "I review many records where I see the patient saying they are suicidal, but the nurse chart that the patient is 'bright, cheerful, social with peers."

4. At Designer Edition the respondent dictated a portion of a Physician Training Manual, (Exh. 10). The respondent wrote a sample review report for a fictitious patient, "Suzy Miller". The sample report includes the words, phrases and sentences:

- "The patient was a 13 year old female who was admitted to inpatient care due to having an argument with her mother."
- "She stated she would be better off dead."
- "The patient has a history of depression and has been seeing a psychiatrist for medication management."
- "The patient has a history of cutting and has numerous superficial cuts on both wrists."
- "She does not have psychosis."

5. At Designer Edition the respondent dictated a portion of a Physician Training Manual, (Exh. 10). The respondent wrote a sample review report for a fictitious patient, "John Conner". The sample report includes the words, phrases and sentences:

· "...admitted to inpatient care for treatment of depression and psychosis for depression and psychosis."
· "He has threatened to kill himself."
· "He has been depressed since he lost his job last month."
· "He denies any substance abuse."
· "He has had one previous hospitalization for depression last year."
· "Currently he feels like he can not go on and wants to die."
· "He is suicidal and medical necessity is met for inpatient care."

6. Exhibit 8 contains examples of insurance utilization reviews prepared by the respondent. The insurance utilization reviews are patient health care records as defined by Wis. Stat. § 146.81 (4).

7. None of the insurance utilization reviews prepared by the respondent contained in Exhibit 8 were dictated by the respondent at Designer Edition.

8. The complainant failed to prove by a preponderance of the evidence that any patient health care records or confidential patient information was disclosed by the respondent at Designer Edition.

Conclusions of Law

1. The Medical Examining Board has jurisdiction in this matter pursuant to Wis. Stat. § 448.02(3).

2. Respondent's conduct as set forth in the Findings of Fact does not violate Wis. Stat. § 146.82 (1) and does not constitute unprofessional conduct contrary to Wis. Stat. § 448.02(3), and Wis. Admin. Code § MED 10.02(2)(z).

Order

IT IS HEREBY ORDERED, that the disciplinary action against the respondent be and hereby is DISMISSED.

IT IS FURTHER ORDERED that the respondent's request for an award of costs incurred in connection with this case is DENIED.

Opinion

Applicable law

Wis. Stat. § 146.82 Confidentiality of patient health care records.

(1) Confidentiality. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient. This subsection does not prohibit reports made in compliance with s. 146.995, 253.12 (2) or 979.01; testimony authorized under s. 905.04 (4) (h); or releases made for purposes of health care operations, as defined in 45 CFR 164.501, and as authorized under 45 CFR 164, subpart E.

(2) Access without informed consent.

(a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

20. If the patient health care records do not contain information and the circumstances of the release do not provide information that would permit the identification of the patient.

Wis. Stat. § 146.82 (2)(b)

(b) Except as provided in s. 610.70 (3) and (5), unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.

Wis. Admin. Code § MED 10.02 (2) (z)

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

ANALYSIS

There are two aspects to the handling of confidential patient information contained in patient health care records that are at issue in this case. The records themselves are subject to the limitations on disclosure set forth in Wis. Stat. § 146.82. Similarly, information contained in the records is also subject to the requirement of confidentiality. Therefore, the analysis to determine the improper release of patient health care records also includes the related concept of the disclosure of confidential information contained in those records. Crawford v. Care Concepts, Inc., 2001 WI 45, 243 Wis. 2d 119.

Wis. Stat. Chapter 146, allows an exception for the release of patient health care records without patient consent where the patient health care records do not contain information and the circumstances of the release do not provide information that would permit the identification of the patient. The complainant in the present case has in fact released into the public record patient

health care records from Prest & Associates, details of which are redacted to prevent identification of the patient. (Exhibit 8)

To establish a violation of Wis. Stat. § 146.82, the complainant must demonstrate that patient health care records were released or confidential information was improperly divulged. Contained in this requirement is the additional concept that the record or information disclosed was such that a patient was or could have been identified. The complainant need not prove that a specific patient actually was identified; rather, the complainant need prove only that such identification was possible under the circumstances of release. The standard does not require the witnesses to recall specific patient names. The focus of inquiry centers on whether the context of disclosure created circumstances where a patient could have been identified. Conversely, if a patient could not have been identified, the respondent could have dictated in a public setting with impunity.[i]

Although not articulated by the prosecutor, there are two steps in the analysis for a violation here.

1) Threshold issue: Are patient records or confidential patient health care information being dictated at all?

2) If Issue 1 is found in the affirmative, is the information being disclosed such that the circumstances of the release provide information that would permit the identification of the patient.

As to issue 1, I find that the case has not been proven by a preponderance of the evidence.

As to issue 2, I find that it is not possible from the context of the testimony to determine whether sufficient information was dictated such that a patient was or could have been identified.

Summary of evidence

Gail Tasch, the respondent, is a psychiatrist. Twenty-nine times during the period June 1, 2001, through August 5, 2003, she obtained cosmetology services at Designer Edition, a barbering and cosmetology establishment in Eau Claire, Wisconsin. While at Designer Edition, she often dictated certain documents. These documents included a chapter for a book on medical necessity, a portion of a physician's manual, and a policy and procedure manual for a medical review business she was establishing. These documents contain medical terms and jargon. These documents contain many names, two of them fictitious patient names.

During the majority this time during 2001, 2002 and until May of 2003, the respondent was not seeing patients. She was, however, working for Prest & Associates performing independent utilization reviews for insurance, regarding the care and treatment of patients. She performed this work from 1997 to 2004. Samples of this work are included in Exhibit 8. None of the reviews comprising Exhibit 8 were claimed by the complainant to have been dictated at Designer Edition. None of the reviews contain social security numbers. The reviews do contain case numbers that end in four digit number groups; however, many of the remaining Exhibits also contain number groups.

[i] This is similar to the prosecution's use of Exhibit 8, where identifying information has been redacted.

Three witnesses who work at the salon claim that the respondent was dictating personal health care information while receiving services. They say they heard what sounded like patient names, social security numbers, medical condition information and names of medications.

The witnesses also say that they were trying not to listen to the respondent and trying not to see the documents that she was using. The witness testimony is generalized rather than specific. It appears to me that the witnesses, without malice, talked about this issue amongst themselves, and a general story began to evolve as to what they thought the respondent was dictating. There are indications in the record that this occurred.

The evidence adduced at hearing created no context to test how and why the witnesses thought a patient name was involved, or that a specific patient's medical condition was being discussed. The testimony of the salon workers related general characterizations rather than specific facts. Taken together, the three witnesses' testimony appears to be an amalgam of anecdotes, including to a very large degree hearsay evidence regarding what a witness may have been told was heard by the other witnesses. In my opinion the evidence is more fairly viewed in line with the respondent's argument, namely that the witnesses were merely mistaken as to what they thought they heard. The respondent states she never dictated confidential information at the salon.

Exhibit 8 consists of examples of the respondent's work for Prest & Associates during the time that the respondent was receiving services at the salon. The complainant argues that the materials contained in Exhibit 8 demonstrate the type of work the respondent was performing. However, none of the documents contained in Exhibit 8 were dictated at the salon.

The complainant argues that because Exhibit 8 is an example of the respondent's work during the time in question, and because the reviews contained in Exhibit 8 are patient health care records that contain personal confidential health care information, then the respondent's dictation at the salon during that period of time must have included patient health care records containing personal confidential health care information. The complainant asserts its witnesses' generalized testimony bolsters this position.

The prosecutor stated the complainant's theory of the case in his closing argument:

> "Respondent's defense is that the Division has not proven that she dictated specific patient reports on specific visits to the salon. Her argument misses the point entirely: the allegation of the complaint is that she routinely dictated confidential patient information in a beauty salon, and that is unprofessional conduct. Respondent is not charged with violating a specific patient's confidentiality on a specific date. Instead, she is charged with routinely dictating confidential patient information in a very public place; the overwhelming weight of the evidence is that Respondent's habit, custom and practice was to dictate confidential patient information at the salon while she was there receiving services." (DOE closing argument, p. 3)

The prosecution's argument amounts to no more than invited speculation. The evidence, however, does not support the desired conclusion. The complainant's line of argument would require the Board to jump from an example of work product admittedly not developed at the salon (Exhibit 8) to the conclusion that the respondent's work at the salon had to include personal health care information. The Board would need to in addition find that, based upon the generalized testimony

of the salon workers, that the respondent divulged sufficient information to identify the recipients of the health care involved.

The standard of proof that the complainant bears is that it is more probable than not that a violation occurred. I find that based on the complainant's evidence presented the burden of proof was not met.

Witness testimony

Celeste Weinzirl.

Direct examination

Ms Weinzirl worked as a hairstylist at Designer Edition in Eau Claire for three years. Ms. Weinzirl did Gail Tasch's hair for approximately one year to one year and a half, approximately once per month.

> A. During the time that you were working at Designer Edition, did you have occasion to become acquainted with Gail Tasch?
> A. I did her hair there for probably -- maybe a year, year and a half. I'm not exactly sure how long.
> Q. During that year or year and a half, approximately how often did you do Ms. -- Dr. Tasch's hair?
> A. Probably close to once a month. (RT p. 37)

What is not elicited is any narrowing of the timeframe of when this one and one half year period occurred. In fact, the witness is incorrect about the timeframe in any event. She indicated that she was "not sure" how long she did the respondent's hair. Exhibit 11 indicates that she did the respondent's hair six times in the year 2001, nine times in the year 2002, and eight times in the year 2003. This is a substantive discrepancy at the outset, indicative of the over generalized nature of the witness's testimony regarding the substantive issues.

The witness testified regarding the disclosure of confidential patient health care information as follows:

> Q. Was there anything that struck you as unusual about Gail Tasch while you were doing her hair?
> A. She would do her work while she was sitting, and -- and it happened to be talking about people's medical stuff while she was sitting there.
> Q. Sitting where?
> A. Sitting in my chair. I had put the color on her head and then she had her cell phone attached, and she would talk about people's medical history. Whether there was alcoholism, sexual dysfunction I heard her say one time, and their name, maybe a case number, whatever.
> Q. Do you remember any of the names?
> A. No.
> Q. Why not?

A. Because it was kind of uncomfortable, and I think I was trying not to listen. (RT pp. 37-38) (emphasis added)

Concerning the phrase, "people's medical stuff", it simply isn't known what this means or what was heard. It is in no context. Other Exhibit evidence demonstrates that the respondent dictated large amounts of "medical stuff" that did not consist of patient health care records. (Exhibit 6 and 10)

This testimony, standing alone, is not specific enough to establish a violation. There is no context to determine why the witness thought a patient name was involved, or why a case number was dictated. Such a generalized phrase "medical stuff", is a fact characterization that is simply too general to determine whether protected health care information was being disclosed.

Ms. Weinzirl's further indicated:

"she would talk about people's medical history. Whether there was alcoholism, sexual dysfunction I heard her say one time, and their name, maybe a case number" (RT p. 38)

There simply is no factual context for these generalizations to determine whether these instances involved actual patients and actual confidential information linked in a manner to contextually permit identification of a patient. It is unknown whether the words and phrases emphasized above occur in one instance, or bits and pieces of instances strung out over months or years, blending into a Meta statement.

No questioning occurred as to why the witness thought a "case number" was involved, or regarding how the "case number" was used in context with what she overheard, or even what "case number" means to her. It is unknown whether she heard 2, 3, 4, 5, 6, or more numbers, in a string, or alone or grouped in some manner. No foundational questioning occurred to judge the basis for the testimony.

This testimony is nothing more than fact characterizations, meaning that the witness determines what was heard in the witness' mind, and puts a label on it. But there is no way for a fact finder to test what the underlying words and phrases were and the context in which they allegedly were heard.

It is the fact finder who determines if a "case number" was used. But the witness has given the fact finder no factual tools to make that determination. This flaw in the witness questioning applies to all of the remaining conclusory testimony of the witness.

The problem with such lack of follow up questioning is that what she generally recounted could in fact be an amalgam of one and one half years of overhearing the respondent. It is not fair to the respondent to allow a witness to testify in such a generalized manner and characterize what she heard then accept that testimony as credible. The fact finder simply doesn't know any background establishing a foundation for the witness's characterization.

Finally, the witness admits that she was "trying not to listen". (RT p. 38) This is the context that I am most concerned with because it provides the best guide to frame her testimony. Simply put, taking the witness at her word, a fact finder must speculate as to what was actually heard, and when, and which aspects of her testimony were heard in a context that I can judge confidential patient health care information was involved. The witness admitted that when the respondent was on the phone the witness would often walk away, up to 75% of the time. (RT pp. 45-46) It cannot be known or tested to divine

what the witness thinks she heard in what context. The witness may simply be mistaken as to what she thinks she heard and the context in which she heard it.

The witness in fact admits that, impliedly, she did not read off the "reports" that the respondent was working on. So there is no way to verify if actual patient medical records were involved.

> Q. Were you able to see anything that Dr. Tasch was working with while you were doing her hair?
> A. If I wanted to read some reports that she was reading off of, I could. (RT p. 38)

The witness was then asked if she knew to whom Ms. Tasch was speaking on her cell phone:

> Q. Do you know to whom she was speaking on her cell phone?
> A. I assume that from what I heard she would be either speaking to a physician's office or an insurance company, because I -- I -- from what I gather, she must be -- go-between the insurance the physician's office. I'm not really sure.
> MS. SCHOLL: I'm just going to object and move to strike because that calls -- calls for speculation, but she already answered so -- (RT p. 38)

I sustained the objection for purposes of this record. The response is speculation because she said she wasn't really sure. However, I draw the board's attention to an aspect of the answer that affects credibility. She mentions that *her assumption* was that Ms. Tasch was either talking to a physician's office or an insurance company. I consider this response, specifically regarding the insurance company, to be a very astute assumption. So astute in fact that I question whether this witness had discussions with others after the fact regarding to whom Ms. Tasch would most likely be making a cell phone call. The prosecutor never questioned the witness for a factual background upon which she based her assumption. This causes concern that this witness and the remaining two witnesses, perhaps unwittingly received this information from some source, and built a common story by discussing their impressions of the respondent during her receiving services at the salon for one and one half years.

Cross examination of Celeste Weinzirl.

The witness further explained that she did the respondent's hair between the end of 2002 and into 2004, but couldn't recall how many times:

> Q. As you sit here today, do you know if you did Dr.'s -- Dr. Tasch's hair in 2001?
> A. Probably not.
> Q. Do you know if you did it in 2002?
> A. Probably. The end of the year at least.
> Q. And then 2003?
> A. Yes.
> Q. So what you're certain of today as you're testifying is that you did Dr. Tasch's hair at the end of 2002 and in 2003?
> A. And some of 2004. (RT p. 40)

Exhibit 11, however, shows that the witnesses' memory is wrong, she actually did work on the respondent's hair, six times in 2001, and not at all in 2004. If general recollection of the past can be

wrong in this instance, this weakens the credibility of other general statements of details concerning the respondent's dictation during that time frame. This is because if general witness statements are not fully accurate, other general general testimony should be closely scrutinized for an adequate factual foundation or possible corroboration. A fact finder shouldn't automatically read into her remaining testimony the necessary credibility invited by the complainant, without some means of bolstering her mere word.

Ms. Weinzirl claimed that Dr. Tasch worked on "work" related items every time she worked on the respondent's hair, and also dictated on her cell phone. (RT p. 40) The witness did not know any specific patient names, social security numbers, or specific medicines that were dictated. (RT pp. 40-41) Therefore, it is simply unknown if the work related items concerned patient health care records or in some manner otherwise dealt with confidential patient information.

The witness does claim to recall Dr. Tasch talking about "outpatient" treatment and "inpatient" treatment:

> Q. You don't know any types of treatment perhaps that Dr. Tasch may have dictated about, do you?
> A. I know that she would say that they probably would do an outpatient thing for so long and they would do inpatient for so many days. That's about all I --
> Q. And as you sit here today, do you have a specific recollection of that?
> A. Mm-hmm.
> Q. Yes?
> A. Yes. (RT p. 41)

However, it isn't clear whether such dictation was from or to a medical record. Nor is it clear whether a patient was identified in the course of this dictation. Additionally, other Exhibits in the record *that do not contain confidential patient information* contain references to "outpatient" and "inpatient".

The witness admitted to "toning out" the respondent:

> Q. Okay. And so you actually kind of toned Dr. Tasch out, is -- is that what I -- I'm hearing? And so, in fact, in some of the visits you weren't even listening to what she was saying, true?
> A. True.
> Q. So what she was exactly dictating about during some of those visits you can't say, because you weren't listening, true?
> A. Some of those visits, true. (RT pp. 41-42)

As to documents that she claims to have seen she can't recall specifics:

> Q. Can you identify by hospital what kind of document you saw?
> A. It had patient names on there, and she made notes as she talked.
> Q. As you sit here today, do you know any specific name on --
> A. No.
> Q. -- on any of those records?
> A. No.
> Q. Can you identify any health care provider where those doc -- documents originated from?
> A. No.
> Q. Did you actually read any of those documents?
> A. No.

Q. So exactly what was contained in those documents, you don't know because you did not read them, true?
A. Not as far as -- I know there was names on there. I read names, and like I said, she just took notes, so I -- you know, I couldn't give you verbatim. It's been a long time ago.
Q. And what particular name you saw you don't know?
A. No. (RT pp. 42-43)

Without more particularity, it isn't possible to know if the witness actually saw a patient health care record or not, or whether patient names or confidential information was actually revealed. The witness is simply making assumptions. Indeed, she concedes other workers are as well:

Q. And so you're making a lot of assumptions today about what Dr. Tatch was actually dictating about, aren't you?
A. I'm make -- I'm making assumption, sure. But what's everybody else around me doing? (RT p. 46)

I reject the testimony of this witness. Her testimony has no reasonable probative value for the issues in this case. It is my opinion that the witness's testimony is insufficient to support a finding of the assumptions that she is making,

DeAnn Fern

Direct Examination

Ms. Fern has been the owner of Designer Edition for 14 years. She claims the respondent came to the salon 26 times during the years 2001, 2002 and 2003. (Exhibit 11 lists 29).

The witness recalls two specific types of instances about the respondent. The first was the respondent's habit of coming into the salon in her riding clothes:

Q. Well, what was the incident that doesn't pertain?
A. She would come into our salon after her riding her horses having horse manure on her boots and an odor, which we are an Aveda concept salon and we pride ourselves on having a really fresh smelling area. And she'd bring this, and the girls would try to say, well, don't you think you could say something to her? Do you think we could have this not happen? And I'm just like, well, maybe it's just an isolated incident, let's just let it -- let it slide for now.
Q. Did you eventually have to speak to Dr. Tatch about this?
A. I believe that Celeste did. She even tried to come in and change her clothing in the bathroom and let the clothes hang in our restroom, and changed so that she wouldn't have those particular items on, but you know – and eventually it did stop. (RT p. 57)

The second incident involved the respondent purportedly dictating about patients:

Q. What was the incident that did pertain to this matter?
A. Dictation of personal matters about clients of hers, names, Social Security numbers, graphic information about what had happened. (RT p. 57)

Note however, that the above testimony is a fact conclusion and this statement can't be tested for the underlying facts to determine whether she was assuming this was done or whether it was actually done.

> Q. Like what?
> A. Conversations between the -- the one that I remember most vividly was the conversation between the desk person -- my heart is beating -- the desk person that was admitting a patient and how he -- he jumped over the counter and grabbed her by the throat and used some expletives words that I don't care to use to get out of there, and if something wasn't done. And I tried to tune out to the rest of it, because it was just -- I have a son who has a lot of mental problems. And I certainly wouldn't want anyone describing -- and I live it on a daily basis as well, so I don't like to relive it for someone else either.
> Q. You said one incident. Was this --
> A. Oh.
> Q. -- one time or was this many times?
> A. Every time she came in.
> Q. How do you know? (RT 57-58)

Nothing can be gleaned from the above description about whether confidential health information was improperly divulged. In fact, this interchange indicates the opposite. No follow up questioning occurred as to whether this was dictation or conversation by the respondent. In any event, this information regarding a patient assault is not confidential patient information as a matter of law. *See,* Crawford v. Care Concepts, Inc., *Id.*

The witness indicated a generalized description of other incidents as follows:

> Q. How do you know?
> A. My staff would come and complain to me. Can't you do something about this? You know, and I -- you know, I didn't know where my -- my rights and wrongs were there. I didn't know if I could step out of turn to say, have you no shame, can't you -- I didn't want to offend the client. I mean she was a paying customer. But once other customers began to complain to the staff, you know, then I felt like maybe a letter should have been sent. And then another incident happened with how Celeste had done her hair to provoke her so she didn't come back anymore. And we certainly didn't try to seek her out to come again. (RT p. 58-59)

This testimony consists of a general paraphrase of hearsay; it contains no specific details for a fact finder to evaluate. Testimony such as this, standing alone, carries little if any weight. The respondent characterizes all three witnesses' testimony as comprised of wrong assumptions combined with gossip. Without additional means to verify these witnesses credibility, I find this contention must prevail. The complainant has the burden of proof.

Ms. Fern testified regarding the disclosure of social security numbers as follows:

> Q. When you heard Dr. Tatch, other than the one incident where the patient jumped over the desk, were there any others that stuck in your mind?
> A. I remember that the staff would come to me and ask me to come and listen to what she was doing. She is dictating. She is talking about staff. She's talking about her clients. She's talking -- she's talking -- she's giving out Social Security numbers. Is that not what she's doing? And I'm like, yeah, it sounds like that to me. (RT pp. 59-60)

The state admitted into evidence certain reviews created by the Respondent for Prest & Associates. (Exhibit. 8) The reviews were not admitted to prove that they were dictated at the salon. Rather, the prosecutor used these reviews to establish that they 1) discussed medications, and 2) demonstrate the work product she was producing for Prest & Associates. However, the reviews do *not* contain social security numbers. It is agreed that they were not dictated at the salon.

When pressed further on the social security numbers issue, the witness simply disregards that question, instead, jumping to "people's names" and "symptoms":

Q. You went and listened?
A. Yes. They -- they summoned me to come.
Q. And you -- you listened to Dr. Tatch when your staff summoned you over?
A. Yes.
Q. And you heard what sounded like Social Security numbers?
A. People names, the spelling of their names. You know, it was dictation, and -- and descriptions of illnesses, or -- what's the best word to use -- symptoms. Definitely -- it was definitely to do with -- cause I asked, what does she do, and they --
(RT p. 60)

I decline to afford much weight to the "social security numbers" allegation. No documents were introduced reflecting work product that was dictated at the salon that contained social security numbers. There is, however, documentary evidence in the record that contains number strings other than social security numbers. All the witnesses claimed not to be listening closely, and Ms. Fern in particular never answers the follow up question regarding what she claims to have heard to be a social security number.

As to this witness' testimony regarding names, saying or spelling a person's name does not indicate it was a patient, or that the respondent was even working with a health care record. Without such a foundation, the witness presents only her assumptions of what she overheard.

Cross Examination

The witness could not answer whether she ever heard the respondent spell physicians' names. She didn't identify any individual based on information that was dictated. As to specifically seeing medical records, she admitted they weren't necessarily medical records:

Q. You didn't personally see any medical records?
A. I saw an awful lot of papers.
Q. But --
A. I wouldn't identify them as necessarily being medical records.
Q. You saw Dr. Tatch carrying a bunch of papers, but exactly what those papers were, you don't know?
A. No, she could have been making this up for attention as far as I knew. (RT p. 65)

The witness was unaware of any types of policy or procedures or manuals which are required in order to become accredited as an independent medical reviewing company. (RT p. 66) She was unaware of procedural manuals or what's contained in a procedural manual for an independent

review company. She has never seen a physician's training manual nor knows what is contained in one. She didn't know what type of documentation is necessary to apply to the State of Wisconsin to become certified as an independent review organization. She never saw the respondent use any type of website documents or documents from a website. She didn't know what is contained in a book regarding medical necessity or whether there's information in a book on medical necessity regarding inpatient or outpatient treatments. (RT pp. 66-67)

She also stated that she wouldn't know if the respondent was "dictating about medical necessity books", letters to physicians, procedural manuals or physician training manuals. She also did not know that the respondent never treated patients with sexual problems between 2001 and 2003. (RT pp. 68-69)

She also didn't think it was professional for the respondent to track manure into the salon but did not tell her to not do it. (RT p. 71)

Re-direct

The attorney for the state once again questioned on the witness's perception:

> Q. It's accurate to say that you do know that Dr. Tatch was dictating what sounded like patient names, Social Security numbers, and mental health conditions?
> A. Correct.
> Q. And as far as you know, that's what she as doing?
> A. Correct. (RT p. 73) [emphasis added]

Asking if a name "sounded like" a patient name, or social security numbers or mental health conditions is insufficient to rehabilitate this testimony.

Laura Peterson

Direct Examination

Ms. Peterson has worked at Designer Edition for fifteen years. She is a hairstylist and manages the hair section. Her work station is approximately four feet directly across from Celeste Weinzirl. Ms. Peterson testified that while working in the salon she heard the respondent dictating people's names and Social Security numbers and medications. Additionally she testified she heard why people were being held in a mental health facility, for actions such as suicide attempts, violent acts and overdosing. (RT pp. 76-77)

Like the other witnesses, however, Ms. Peterson doesn't recall any specific names, wasn't trying to, "pay attention that close. I just did not -- that type of thing -- when I'm working on a client and -- it was very uncomfortable." (RT p. 77)

At this point the three witnesses all seem to have commonality to their testimony. It is reiterated in almost the same order with the same generalized elements, concluded with the disclaimer that, they weren't really listening closely, because they were uncomfortable. The testimony of all three

witnesses appears to me to be rehearsed, if unconsciously, between these witnesses. There is a hint of this that the perceptions of the witnesses melded together, and continued develop over time:

> A. As in a date? Or -- this went on for such a long period of time that it -- it was every six weeks. You know, every month to six weeks when she'd get her hair colored, and so during those times I guess we talked about how disturbing it was to the clients. I -- I work with the public. You -- you live with a lot of things. I can live with it. But I felt bad for my clients to have to hear this. So yes, we did talk about it. (RT p. 79) [emphasis added]

During all of this time none of the witnesses actually talked to the respondent about what the respondent was working on while she was receiving salon services.

Cross Examination

At one point when the respondent didn't like the way her hair was done, the witness called her to discuss it. At that same time the witness also claims she asked the respondent to stop dictating but the respondent ignored her:

> A. And so I did. I called her, and she was very apologetic for -- she had a little bit of an outburst I guess at the salon -- very apologetic for that. And I just said, Dr. Tatch, what you're dictating or talking about at the salon is very disturbing for people. And she just said, I didn't realize, I'm sorry. I didn't realize it was disturbing. And I asked her to please not do that anymore in the salon. And she continued.
> Q. She did continue?
> A. Yes.

According to the witness, the respondent ignored the request to stop dictating, and continued to dictate. In actuality, the incident was the last time the respondent went to that salon:

> Q. It's your testimony that you didn't have this conversation with Dr. Tatch until after Celeste -- there was an issue with the -- the -- the hair job that she received from Celeste?
> A. Right. That is -- I -- I basically used that for a reason to call.
> Q. And you're aware that that was actually the last time Dr. Tatch was in the salon, aren't you?
> A. I -- I was under the understanding -- I remember her being back after that.
> Q. If -- strike that. Assume for me that the ALJ will hear testimony from Celeste that the last time she did Dr. Tasch's hair was when there was an issue regarding -- regarding the style. Would you have any reason then to dispute that that was the last time Dr. Tatch --
> A. Oh --
> Q. -- was --
> A. No.
> Q. -- at the salon?
> A. Absolutely not. I -- I just thought in my mind that she had been back after that.
> Q. Okay. And so you could be incorrect?
> A. Yes.
> Q. All right. You would defer to Celeste on that?
> A. Certainly. (RT pp. 84-85)

This interchange exposes once again the over-generalized perception of this witness regarding the events concerning the respondent at the salon. This witness states that when she asked the respondent to stop dictating, the respondent ignored her - essentially that the respondent brushed off the request to stop dictating what appeared to be confidential patient information. However, this event as recounted by the witness could not have occurred. The respondent in fact never came back to the salon and never "continued to dictate". (RT p.48) Yet, this witness places her back at the salon and continuing in arguably improper conduct.

Similar to Celeste Weinzirl, Ms. Peterson also saw the respondent leaving the salon with hair dye in her hair, and thought it unusual:

> Q. Did you see Dr. Tatch coming and going from the salon with the hair dye in her hair?
> A. Yes.
> Q. That was kind of unusual?
> A. Very.
> Q. She'd go out to her car with the actual hair dye in her hair?
> A. She left once, yeah.
> Q. And do you know what she was doing or why she did that?
> A. No, I just mentioned to Celeste, did you realize that your client just left? And she said, yes, I advised her not to, but, you know, she drove away. (RT p. 89)

Ironically, as the respondent later testified, the respondent went out to her car when she was working on material that she considered confidential. (RT pp. 219-220)

Gail Tasch

Cross Examination by the Complainant

A portion of the respondent's deposition was read into the record. In the deposition she denied dictating patient information, and denied the same at the hearing:

> Q. -- you were asked the question, ma'am, you had an interview with an investigator from the Department of Regulation and Licensing. The investigator reports that she asked you about dictating patient notes in public places like the beauty salon, and you said, I did do that, but I never used any patient names. Answer, I did dictate, but I did not dictate patient information. I was dictating. I was not dictating confidential information. Correct?
> A. That's correct. (RT p. 92)

The Respondent testified that she worked on the documents contained in Exhibits 1 through 7 while she was at the salon. (RT pp. 97-98) The Respondent worked for Prest & Associates performing independent utilization reviews for insurance regarding the care and treatment of patients. She performed this work from 1997 to 2004. She did approximately 5 reviews per day for Prest & Associates during the later part of 2002. (RT pp. 183-184) A portion from the respondent's deposition was first read to the respondent whereby she testified that she reviewed records for Prest at the salon:

Answer, I have stayed in the salon, and I have -- I recall reviewing for Prest, reading the record, insuring that nobody was around, not anybody seeing a record, not when somebody was cutting my hair. Correct?
A. Correct. I insured the privacy of the record. There were times where I would look at a record. I didn't dictate any confidential information. I was doing work, but not confidential dictation in the salon. But there might have been a time where I had a file that contained confidential information. I -- I can't recall a specific instance, but that's a possibility. (RT p. 99)

Next was an attempt to impeach the respondent because she stated she didn't "deal" with medications. Yet, it is clear that the Prest records (Exh. 8) indicate medications on them:

Q. Deposition Page 25, Lines 13 continuing. Okay. I don't -- this is in answer to question. I don't practice, and in the reviews I don't deal with -- at the time in question, I wasn't dealing with any medications at all. Where -- why the cosmetologists thought I was talking about the medications, I don't know where that came from. At the time 2001, 2002, 2003, I wasn't dealing with medications at all. I didn't know of the new psychiatric drugs. In my -- even when my reports for Prest & Associates I do not include medications in those reports. Is that still your testimony?
A. Yes. (RT pp.98-99)

The respondent also indicated that she usually didn't deal with medications. (RT p. 105)

The prosecuting attorney stated that Exhibit 8 was to challenge the credibility of the witness:

MR. POLEWSKI: To challenge the credibility of the witness, move Exhibits 8, which are reports to Prest & Associates, by this witness, admissions of party opponent. As we go through Exhibit 8 you will see that there are indeed are numerous comments on diagnoses, medications and like. (RT p. 99)

I don't see the fact that the reviews comprising Exhibit 8 contain medications to affect the credibility of the respondent to any great degree. The respondent indicated that she usually didn't deal with medications. In Exhibit 8, I found six reviews that did mention medications. Given that she prepared five reviews per day during this period, a larger sample of her work should be reviewed to determine whether the degree of mentioning specific medications was such that it affects her credibility.

The issue of whether the respondent dictated confidential patient information for Prest & Associates is the critical lynchpin for the Complainant's case. The respondent testified that the dates on the reports themselves indicate the day it was done or possibly the day before it was done:

Q. Page 5 again is a report that you did for Prest &Associates?
A. Correct.
Q. And you did that report on or about September 4th,2002?
A. I'm not sure when I did it.
Q. Under your name, ma'am, as physician reviewer there's a line that says date of report?
A. Yeah, it probably was that day. I mean, sometimes I do it the next day and the day the case took place on the day before, so I can't say for sure I did this on the 4th.

Q. On or about September 4th --
A. Right. (RT pp. 101-102)

Therefore, it should be expected that there would be Prest & Associates work product dated on or perhaps a day after the salon visits of the respondent. If such were the case, then it could be cross checked with the time indicated on the report that the case was reviewed. This could perhaps place dictation at the salon. During the later part of 2002 at least, the respondent was performing approximately five reviews per day for Prest & Associates. The frequency of reviews for other time periods is unknown. The complainant elicited no testimony regarding how many reviews the respondent was performing for Prest & Associates in 2001 and 2003. There could have been fewer, or more reviews.

The complainant alleged that the respondent dictated social security numbers while at the salon. Attorney argument by the prosecutor contended that the patient numbers were derived from social security numbers. However, the Respondent testified that the prosecutor's assumption was incorrect. No official from Prest & Associates was called to settle this issue.

Q. Ma'am, Page 1 of Exhibit 8 for identification was a dictation that you did?
A. Yes.
Q. And you did it for a patient whose initials were EM?
A. Correct.
Q. And you included a case number ending in 8175?
A. Correct.
Q. Many of those case numbers were devolved from Social Security numbers, correct?
A. I don't believe they were Social Security numbers.
Q. In the course of your practice as a physician reviewer, you are familiar that oftentimes physician -- medical insurance is done on the basis of Social Security numbers, correct?
MS. SCHOLL: Objection, relevance.
A. Usually the number isn't the same number of characters as a Social Security number, so -- (RT pp. 99-100)

The reviews prepared for Prest & Associates generally contained patient histories, diagnoses, findings and opinions and for some of the reviews, mention specific medications. (Exhibit 8) Following a page by page review of the documents in Exhibit 8 the prosecutor moved to enter it into evidence for the limited purpose of impeachment:

MR. POLEWSKI: Credibility of the witness, veracity of the witness, relevance of the witness, habit, custom and practice in her business. I think that'll probably cover it.
MS. SCHOLL: Your Honor, I don't object to its admission for impeachment purposes, but there has been no foundation as to when this document or these reports were dictated, and whether or not the dictation occurred at the salon, and so for purpose -- for that purposes I would request that the -- the document Exhibit 8 be admitted for limited purposes.
LAW JUDGE: I'm going to admit it for a limited purpose of impeachment, and specifically note that there's been no foundation laid that any of these reports contained in Exhibit 8 were dictated at the salon. (RT pp. 116-117)

The respondent asserts that she never did dictate this information in the salon. The burden falls to the complainant to produce work product that could colorably be argued to have been dictated at the salon.

The respondent's work product- Exhibits

The respondent reviewed Exhibits introduced by the complainant that the respondent states were dictated in the salon:

Exhibit 1- Policy and procedure manual for Medwork, the respondent's independent review business. The manual was either dictated or written by hand when the respondent was at the salon. Mixed in with extensive medical jargon, the exhibit contains the words and phrases: "medical or clinical services", "medical necessity", "medical appropriateness", "experimental or investigational therapies", "personal health information", "personally-identifiable information" (page 4), "case number", "medical evidence", "medical necessity" (page 5), "attending provider", "health care practitioner", "patient", "injured worker" (page 12), "patient", "injured worker" (page 14) "medical or clinical services" "patient" (page 15), "personal health information" (page 26) "patient" (page 31), "patient's medical records" (page 36), "confidentiality of personal medical information" (page 41)

I agree with the respondent that the material contained in Exhibit 1 is replete with medical terms:

> Q. Which specific line on Page 5 tells you that you were talking about a particular patient when you dictated Page 5?
> A. I didn't say that, and I don't think there's a particular line that talks about a specific patient. But I think these pages talk about medical necessity for hospitalization and treatment, and, you know, medical reviews, information considered during the review, name credential, specialty of reviewer, and date of first review, board certification, and licensure. I mean there's a lot of information here about medical issues, hospitalizations, patients, so not -- not about a specific patient, but about patient information certainly. (RT pp. 121-122)

Given the extremely general nature of the testimony of the complainant's witnesses, I find it highly plausible that at times listening to such information as contained on Exhibit 1 could give the impression to someone that they are hearing dictation related to potentially confidential information.

Exhibit 2- The respondent's application to the State of Wisconsin to become a certified independent review agency. The application does not contain specific patient's diagnosis, name, condition, treatment recommendations, or medications. The application consists of the state form to which is appended the Exhibit 1 document. Page 6 also contains the phrases, "psychiatrist" and "inpatient psychiatric hospital". Page 9 contains the respondent's social security number.
The respondent explained her drafting process:

> Q. When you were working with this, it was sitting on -- on your lap, I presume, at the salon?
> A. Well, I probably --
> Q. Was it in outline form then?

A. I probably had handwritten stuff. Handwritten. And then I talk into the phone or a tape recorder, and then it just gets recorded, because I -- I don't type very well, so I have a secretary transcribe it.
Q. Okay. So you would have had some sort of rough form of this manual?
A. Right. I -- it --
Q. With notes on it?
A. It would have handwritten notes.
Q. I see.
A. And I'd probably do like a chapter a week or -- you know, I actually had another policy and procedure manual that I copied a lot from. But I was using the definitions from another manual that I had that was actually from aprevious business. And I was -- I actually used the outline from a previous manual and then kind of filled in the blanks so --
Q. Okay. (RT p. 176)

This explanation by the respondent of her drafting process illustrates the context of drafting which had not been explored prior to this point, namely, the respondent was not sitting in a chair in the salon reading from the exhibit as occurred at the hearing. Rather, when she was drafting it, it was in note form, in handwriting. From that, she was dictating. Therefore, it is all the more likely that certain materials dictated may or may not have survived to final form, but most importantly, a causal observer viewing a collection of handwritten notes could reasonably misconstrue what was being observed, in combination with overhearing random disconnected portions of the dictation.

Exhibit 3- The respondent's website pages.

Exhibit 4- A response letter to the Office of Commissioner of Insurance. The letter does contain a name and medical terms.

Exhibit 5- The respondent's notes used to fill out her accreditation paperwork. The majority of that exhibit she did not write. (RT p. 185) It is unlikely that a witness at the salon would have either heard the contents of Exhibit 5 being dictated, nor concluded it contained confidential health care information.

Exhibit 6- A portion of a chapter on medical necessity This document contains a fairly detailed outline of factors determining the need for inpatient care. It uses the words and phrases, "suicidality, homicidality, psychosis, or inability to care for self.", "mental illness", "self harm", "patient", "imminent risk", "I wish I were dead", "partial hospitalization", "completed suicides", "chronic illness", "substance abuse". It contains the sentence: "I review many records where I see the patient saying they are suicidal, but the nurse chart that the patient is 'bright, cheerful, social with peers."

Exhibit 7- Newsletter for the respondent's review company Medwork.

Exhibit 8- Prest & Associates insurance utilization reviews

Exhibit 9- Respondent CV

Exhibit 10- Medwork Physician Training Manual

The respondent wrote two sample review reports. The first was for a patient, "Suzy Miller", the Patient ID# is a three digit code, not a social security number.

> Summary of Case: The patient is a 13 year old female who was admitted to inpatient care due to having an argument with her mother. She stated she would be better off dead. The patient was angry after her mother told her she could not go to a friend's house. The patient has a history of depression and has been seeing a psychiatrist for medication management. She has also been involved in outpatient counseling for the past year. The patient has a history of cutting and has numerous superficial cuts on both wrists.
>
> Case hour setting. No medical necessity is present for inpatient care. Findings: The patient denies thoughts of self harm. She has no acute suicidal thoughts. She does not have psychosis. She does not require a 24 hour setting. No medical necessity is present for inpatient care. Recommend a lower level of care.

The next patient review report was for "John Conner".

> Summary of Case: The patient is a 36 year old male who was admitted to inpatient care for treatment of depression and psychosis. He has threatened to kill himself. He has been depressed since he lost his job last month. He denies any substance abuse. He has had one previous hospitalization for depression last year. Currently he feels like he can not go on and wants to die. His family has been concerned about him and feel they cannot leave him alone.
>
> Case hour setting. The patient is at risk for self harm. He requires clinical supervision. He is suicidal and medical necessity is met for inpatient care. The patient requires treatment for depression. The patient can not be safely treated at a lower level of care. Inpatient care is recommended.

The two patients, "Suzy Miller" and "John Conner" are fictitious. (RT p. 217) The witness's testimony is sufficiently similar to these fictitious reports to support the respondent's defense that the witnesses misunderstood what they were hearing.

Direct Examination

In reviewing Exhibit 8, one of the reviews is dated August 5, 2003. The respondent testified that she did go to the salon on August 5, 2003, but did not dictate the report in the presence of the witnesses:

> Q. The next is August 5 of 2003.
> A. Did not visit the salon that date.
> Q. August 5 of 2003?
> A. Oh, yeah I did actually. Yes, sorry.
> Q. Okay. So we have one that you were actually at the salon that day?
> A. That's correct.

Q. Did you dictate this report while you were at the salon?
A. No.
Q. Did you dictate this report in the presence of Celeste, DeAnn or Laura Peterson who testified earlier today?
A. No. (RT p. 208)

The report does include the phrase, "sexual desire". She claims she never talked about "sexual disfunction" at the salon. (RT p. 210)

The respondent testified that she didn't dictate much at the salon, but talked to family:

> A. Well, I would sit in Celeste's chair, and she would put color on my hair for -- a hair rinse, and then I'd have to sit for 45 minutes. And she was never around, and it was during the 45 minutes that I would be working on files, or talking on my cell phone. And I really didn't do very much dictation. It sounds like that's all I did. I mean they said, oh, she's dictating every day, and every time she comes in. But actually I was just -- I'd be talking on the phone to my mom or my brothers, and there really wasn't a lot of dictation. I mean I would be on the phone and nobody would be really close enough to me to even really hear. Celeste was never around and – (RT pp. 218-219)

When the respondent did deal with confidential information she would go out to her car which Celeste Weinzirl thought was weird. (RT pp. 219-220) The respondent was not seeing any patients in 2001, 2002 and until May of 2003.

Regarding the witness's ability to perceive, (or misperceive) what she was doing, the respondent indicated that she didn't even recognize Laura Peterson, and never said more than "hello" to DeAnn:

> Q. I'd like to talk to you about Laura Peterson's testimony. You did you discuss any patient with Ms. Peterson?
> A. No.
> Q. Or in her presence?
> A. No.
> Q. Did you ever show her any medical records?
> A. No.
> Q. Was she ever in a position to see any medical record?
> A. Oh, no. She was -- Laura Peterson, I didn't even recognize her. When she came into the deposition, I never even -- I never saw her before. She worked in the salon, but I -- I had never seen her. She's never talked to me. And the -- the second woman, DeAnn, I don't think we've done anything more than just say hello.
> Q. Well, let's --
> A. So these people were never near me. You know, they might have been -- maybe they walked by, but they didn't sit next to me or talk with me. They were never around. (RT pp. 232-233)

This testimony that DeAnn Fern and Laura Peterson were "never around", conceptually is consistent when the testimony of the two witnesses and Celeste Weinzirl are compared. As

previously noted, Ms. Fern's and Ms. Peterson's testimony appear in part to be derived from after the fact discussions with Ms. Weinzirl.

The respondent considers that Ms. Fern's testimony regarding her dictating about a patient jumping over a counter and grabbing someone by the throat is "bizarre":

> Q. She testified that there was -- she overheard something to the extent of a desk person that was being admitted, a patient, and how the patient jumped over the -- the counter and grabbed someone by the throat.
> A. You know, I don't know what that is. That is so bizarre. I don't know what she heard. Remember, she was never within a few feet of me except for walking by me. I have -- she said she introduced herself to me. I don't think she did. I don't recall her introducing herself. But you know what, I wonder, gee, I would like to talk to that lady. I'd be curious to have a conversation. She's a business owner. I -- I've been curious about the woman, but she's never had any conversation with me, and has never been within a couple feet of me unless she happened to walk by. (RT p. 233)

Beth Dennis

Ms. Dennis works as a nurse at Sacred Heart Hospital, working with the respondent from April, 2003. Ms. Dennis testified that in the workplace environment the respondent has a reputation for truthfulness.

Deanna Hanson

Ms. Hanson also works at Sacred Heart Hospital as an employee working with Chapter 51 patients. She has known the respondent since 1985. Ms. Hanson stated that the respondent has a reputation in the community for being honest and truthful.

Conclusion

For the reasons stated above, I conclude that the Division of Enforcement failed to meet its burden of proof and recommend that the proceedings against the respondent should be dismissed.

COSTS

In addition to asking for dismissal, the respondent has requested an award of costs in her answer to the complaint. Under the statutory scheme in the State of Wisconsin, costs may be awarded under either of two provisions.

The statutory provisions of Wis. Stat. §227.485, allow for an award of costs to the prevailing party in certain circumstances. In the circumstances where the decision is contrary to the state agency,

the agency shall pay costs unless there is a finding that the losing party was substantially justified in taking its position. Substantially justified is defined to mean having a reasonable basis in law or fact. In the event costs are awarded the respondent would not be eligible to receive them if his reported federal gross income was $150,000.00 or more in each of the three (3) calendar years immediately prior to commencement of the case.

Costs may also be awarded under the provisions of Wis. Stat. §227.483. The award of costs under this section may be made if the hearing examiner finds that an administrative hearing was commenced, or continued under one of the following circumstances;

- That the claim was commenced, used or continued in bad faith, solely for purposes of harassing or maliciously injuring another. *or*
- That the party's attorney knew or should have known, that the claim was without any reasonable basis in law or equity and could not be supported by a good faith argument for an extension, modification, or reversal of existing law.

The respondent has not presented a factual basis or legal argument to support the awarding of costs under the provisions of Wis. Stat. §227.483 or §227.485.

Dated: May 18, 2005

William Anderson Black
Administrative Law Judge
Department of Regulation and Licensing

tasch5-18-05

NOTICE OF RIGHTS OF APPEAL

TO: Gail A. Tasch

You have been issued a Final Decision and Order. For purposes of service the date of mailing of this Final Decision and Order is July 22, 2005. Your rights to request a rehearing and/or judicial review are summarized below and set forth fully in the statutes reprinted on the reverse side.

A. REHEARING.

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in section 227.49 of the Wisconsin Statutes. The 20 day period commences on the day of personal service or the date of mailing of this decision. The date of mailing of this Final Decision is shown above.

A petition for rehearing should name as respondent and be filed with the party identified below.

A petition for rehearing shall specify in detail the grounds for relief sought and supporting authorities. Rehearing will be granted only on the basis of some material error of law, material error of fact, or new evidence sufficiently strong to reverse or modify the Order which could not have been previously discovered by due diligence. The agency may order a rehearing or enter an order disposing of the petition without a hearing. If the agency does not enter an order disposing of the petition within 30 days of the filing of the petition, the petition shall be deemed to have been denied at the end of the 30 day period.

A petition for rehearing is not a prerequisite for judicial review.

B. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in section 227.53, Wisconsin Statutes (copy on reverse side). The petition for judicial review must be filed in circuit court where the petitioner resides, except if the petitioner is a non-resident, the proceedings shall be in the county where the dispute arose. The petition should name as the respondent the Department, Board, Examining Board, or Affiliated Credentialing Board which issued the Final Decision and Order. A copy of the petition for judicial review must also be served upon the respondent at the address listed below.

A petition for judicial review must be served personally or by certified mail on the respondent and filed with the court within 30 days after service of the Final Decision and Order if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing. Courts have held that the right to judicial review of administrative agency decisions is dependent upon strict compliance with the requirements of sec. 227.53 (1) (a), Stats. This statute requires, among other things, that a petition for review be served upon the agency and be filed with the clerk of the circuit court within the applicable thirty day period.

The 30 day period for serving and filing a petition for judicial review commences on the day after personal service or mailing of the Final Decision and Order by the agency, or, if a petition for rehearing has been timely filed, the day after personal service or mailing of a final decision or disposition by the agency of the petition for rehearing, or the day after the final disposition by operation of the law of a petition for rehearing. The date of mailing of this Final Decision and Order is shown above.

The petition shall state the nature of the petitioner's interest, the facts showing that the petitioner is a person aggrieved by the decision, and the grounds specified in section 227.57, Wisconsin Statutes, upon which the petitioner contends that the decision should be reversed or modified. The petition shall be entitled in the name of the person serving it as Petitioner and the Respondent as described below.

SERVE PETITION FOR REHEARING OR JUDICIAL REVIEW ON:

Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison WI 53708-8935