

**STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE BOARD OF PSYCHOLOGY**

In the Matter of the  
Psychology License of  
Michael A. Appleman, M.A., L.P.  
License No. LP 2613

**FINDINGS OF FACT, CONCLUSIONS  
AND RECOMMENDATION**

Administrative Law Judge Bruce H. Johnson (the ALJ) conducted a hearing in this contested case proceeding beginning on Monday, October 23, 2000, at the Office of Administrative Hearings in Minneapolis, Minnesota. The hearing continued for twelve additional hearing days and ended on Wednesday, November 8, 2000. The record closed on Monday, April 23, 2001, when the ALJ received all of the parties' post-hearing submissions.

Peter J. Krieser, Assistant Attorney General, Suite 1400 NCL Tower, 445 Minnesota Street, St. Paul, Minnesota 55101-2131, appeared as counsel for the Petitioner, the Complaint Resolution Committee (the Committee) of the Minnesota Board of Psychology (the Board). Leo Dorfman, Attorney at Law, of the firm of Dorfman & Dorfman, Ltd., 336 Parkdale Plaza Building, 1660 South Highway 100, Minneapolis, Minnesota 55416-1532, appeared as counsel for the Respondent, Michael A. Appleman.

**NOTICE**

This Report is a recommendation, not a final decision. The Minnesota Board of Psychology will make the final decision after reviewing this Report and the hearing record. The Board may adopt, reject or modify these Findings of Fact, Conclusions of Law, and Recommendation. Under Minnesota Law,<sup>[1]</sup> the Board may not make its final decision until after the parties have had access to this Report for at least ten days. During that time, the Board must give each party adversely affected by this Report an opportunity to file objections to the report and to present argument to it. Parties should contact Pauline Walker-Singleton, Executive Director, Minnesota Board of Psychology, 2829 University Avenue, S.E., Suite 320, Minneapolis, Minnesota 55414, to find out how to file objections or present argument.

## STATEMENT OF THE ISSUES

The following issues are raised concerning those charges described in Appendix I to this Report,<sup>[2]</sup> which the Board did not previously adjudicate on motion for summary disposition or which the Committee has not subsequently withdrawn:

- (1) Whether the Notice of Hearing, as amended, gives Mr. Appleman fair notice about the nature of the remaining charges;
- (2) Whether the doctrine of *res judicata* precludes the Board from considering many of the Committee's charges of inadequate documentation;
- (3) Whether the doctrine of collateral estoppel conclusively establishes the merits of Claims Nos. 20-1, 20-2, 20-8, and 20-13;
- (4) Whether the same legal standards for assessing Mr. Appleman's professional and ethical practices apply to acts committed before and after May 15, 1993;
- (5) Whether Mr. Appleman's documentation practices violate licensing laws by failing to conform to the usual, customary, and prevailing practice standards recognized by Minnesota psychologists; and
- (6) Whether the Committee has established by a preponderance of the evidence each of the charges described in Appendix I which the Board concludes should not be dismissed.

## FINDINGS OF FACT

### Procedural Background

1. Minnesota law<sup>[3]</sup> authorizes the Board to regulate and discipline persons licensed to practice psychology in the State of Minnesota. It also authorizes the Board to review complaints against psychologists, to refer those complaints to the Office of the Attorney General for investigation, and to bring disciplinary proceedings against licensed psychologists when the Board considers it appropriate. The Board, in turn, has empowered the Committee to review complaints made against licensed psychologists and to initiate disciplinary proceedings.

2. The Committee began this contested case proceeding on June 29, 1998, when it issued a Notice of and Order for Prehearing Conference and Hearing.<sup>[4]</sup> The Committee alleged Mr. Appleman had engaged in 201 instances of professional misconduct while evaluating and treating twenty-three different clients.<sup>[5]</sup> The Committee further claimed that those alleged instances of professional misconduct violated twenty-six different licensing statutes and rules. About a year later on May 17, 1999, the Committee moved to Amend its Notice of Hearing by adding one further allegation of professional misconduct.<sup>[6]</sup> By Order entered on June 2, 1999, the ALJ allowed that amendment.<sup>[7]</sup>

3. On June 11, 1999, Mr. Appleman moved for summary disposition.<sup>[8]</sup> He argued that this proceeding should be dismissed in its entirety because the Committee had committed fatal procedural errors in initiating these disciplinary proceedings and also that the Committee had deprived him of his constitutional right to due process of law.

4. Also, on June 11, 1999, the Committee made a motion for partial summary disposition.<sup>[9]</sup> Relying largely on admissions made by Mr. Appleman during discovery and a body of opinion evidence in an affidavit submitted by its expert, Dr. Norman J. Cohen, the Committee argued that Mr. Appleman had committed approximately ninety-one separate violations of applicable licensing statutes and rules.<sup>[10]</sup>

5. On October 14, 1999, the ALJ recommended that the Board deny Mr. Appleman's motion for summary disposition.<sup>[11]</sup> On the same day, the ALJ also made a recommendation about the Committee's motion for partial summary disposition.<sup>[12]</sup> Concluding that nineteen of the claims that the Committee was asserting raised no genuine issues of material fact, the ALJ recommended that the Board grant summary disposition of those nineteen claims. But the ALJ also concluded that seventy-two other claims did raise genuine issues of material fact, thereby requiring an evidentiary hearing for their adjudication.<sup>[13]</sup>

6. After proceeding on the ALJ's recommendations, the Board on March 30, 2000, denied Mr. Appleman's motion for summary disposition, granted summary disposition of thirteen of the Committee's claims, and denied summary disposition of the Committee's remaining seventy-eight claims.<sup>[14]</sup> Based on the thirteen claims that it had adjudicated, the Board ordered that certain disciplinary measures be imposed on Mr. Appleman.<sup>[15]</sup> But the Board stayed its order pending a contested case hearing on the remaining claims and remanded the administrative record to the ALJ for an evidentiary hearing and recommendations on the remaining issues.<sup>[16]</sup>

7. The hearing on the merits of the Committee's unadjudicated claims began on Monday, October 23, 2000, and ended on Wednesday, November 8, 2000. During that hearing, the Committee indicated it was withdrawing several of its claims. The ALJ requested that the Committee subsequently provide Mr. Appleman and the ALJ with an updated listing of which claims it was asserting and which it was withdrawing.<sup>[17]</sup> In so doing, the ALJ specifically stated that the listing that he had previously compiled<sup>[18]</sup> had been received in evidence "for illustrative and reference purposes only" and that it would "not be taken as any legally binding conclusion on [his] or the Committee's part or a substitute for what the Notice of Hearing contain[ed]."<sup>[19]</sup>

8. On December 7, 2000, the Committee filed a revised claims list, which the ALJ received in evidence as Exhibit 86. That exhibit indicated that during the hearing the Committee had withdrawn twenty-seven of the claims that it had been asserting at the summary disposition stage of this proceeding. The Committee also indicated that two claims had been "withdrawn and replaced" and characterized sixteen of its earlier

claims as having been “amended.” Finally, Exhibit 86 referred to forty-one claims that had not previously been identified as being “new.”<sup>[20]</sup>

## Mr. Appleman

9. Since 1983 Mr. Michael A. Appleman, M.A., L.P., has been licensed to practice psychology in the State of Minnesota and has been subject to the Board’s jurisdiction.<sup>[21]</sup>

10. Mr. Appleman resides at 2530 West Lake the of Isles, Minneapolis, Minnesota 55405. He maintains an office at 600 University Avenue, S.E., Minneapolis, Minnesota 55414. He is currently fifty-four years old, is married and has three children.

11. In 1968 Mr. Appleman graduated from the University of Minnesota with a bachelor of arts degree in psychology.<sup>[22]</sup> After graduating, he worked for two years as an elementary school teacher at St. Austin School in Minneapolis.<sup>[23]</sup> From 1971 to 1974 he attended graduate school at the University of Minnesota on a fellowship in educational administration. In the course of that post-graduate training, he received both a master of arts degree and a Ph.D. in educational administration, with collateral studies in psychology.<sup>[24]</sup> While in graduate school, he published a psychological test called “Piaget and Readiness for Math” in the *Journal of Educational Research and Development*. His doctoral dissertation was entitled, “The Educational, Psychological, and Legal Aspects of Using Stimulants on Hyperactive School Children.”<sup>[25]</sup>

12. Subsequently, in 1978 Mr. Appleman attended a one-week seminar on neuropsychological evaluation, taught by Dr. Ralph Reitan, a neuropsychologist at the University of Arizona.<sup>[26]</sup> In the following year he took post-doctoral course work at the University of Minnesota in childhood psychopathology and vocational assessment, and in 1982 he took additional post-doctoral course work in school psychology and in psychological testing of exceptional children.<sup>[27]</sup> Mr. Appleman has also received training in psychometric testing at the University of Wisconsin at River Falls and participated in test norming when he was employed by Measurement Learning Consultants while in graduate school.<sup>[28]</sup>

13. From September 1973 to July 1977, Mr. Appleman was employed as an administrative assistant to the Deputy Commissioner, Minnesota Department of Education. His duties primarily involved providing consultative services on hyperactive school children and included providing in-service training for school districts on ADHD children and performing educational and legal research in that field. He published articles on “Legal Aspects of Student Rights,” “Age of Majority,” and “Legal Aspects of Student Records,” and he was named “Educator of the Year” by the Minnesota Association of Children with Learning Disabilities. He also published a booklet on the treatment of attention deficit disorder children.<sup>[29]</sup>

14. From July 1977 through August 1978, Mr. Appleman was employed as Chief Ward Clinical Psychologist at the Hawaii State Mental Hospital in Honolulu. His

duties included psycho-diagnostic testing and developing behavior modification programs for persons with mental retardation.<sup>[30]</sup>

15. From September 1978 through September 1980, Mr. Appleman worked as a child and adult psychotherapist at the Corman Psychiatric Clinic in Golden Valley, Minnesota. His duties there consisted of providing patients with individual, group, and family therapy services and conducting psycho-educational evaluations.<sup>[31]</sup>

16. After leaving the Corman Psychiatric Clinic, Mr. Appleman took a position as an adult program coordinator and psychotherapist at Nexus, Inc., a treatment center for convicted felons. He held that position from September 1980 through May 1983 and provided clients with individual, group, and family therapy services. He also administered personality, intelligence, and vocational assessment tests.<sup>[32]</sup>

17. In June 1983, Mr. Appleman left Nexus, Inc., and established his own private practice in clinical psychology, known as University Avenue Psychology Center.<sup>[33]</sup> That practice has involved affiliations with other groups. From June 1983 to 1987, he served as a psychologist with Minneapolis Clinical Associates of Psychiatry at St. Mary's Hospital in Minneapolis, where his duties consisted of administering inpatient psychological evaluations of adolescents and adults.<sup>[34]</sup>

18. While he was engaged in the private practice of psychology, Mr. Appleman also served as a child and adult psychologist with Group Health, Inc., from May 1984 to November 14, 1990.<sup>[35]</sup> There, he conducted inpatient psychological assessments of significantly disturbed children and adolescents, as well as providing individual, group, and family therapy, coordinating inpatient treatment, and participating in discharge planning.<sup>[36]</sup> He was dismissed from his employment with Group Health as of November 15, 1990, after that organization conducted an internal investigation and had concluded that Mr. Appleman had acted unprofessionally while in its employ.<sup>[37]</sup>

19. Mr. Appleman describes the nature of his private practice as evaluating and treating trauma victims; providing child, adolescent, and family therapy; assessing intelligence and personality functioning; screening for neuro-psychological problems; and triaging patients for neuropsychologists or social workers.<sup>[38]</sup> On average, he provides between 1,500 and 2,000 hours of direct client per year.<sup>[39]</sup>

20. During the last seven years, Mr. Appleman has made several presentations at professional development seminars sponsored by various professional organizations.<sup>[40]</sup>

21. As required by the Board's rules,<sup>[41]</sup> Mr. Appleman has filed four statements of competency with the Board.<sup>[42]</sup> On December 12, 1997, he filed a statement of competency in the area of evaluation and treatment of trauma patients (car accidents, workers' compensation, assault, and other victims). On September 30, 1997, he filed a statement of competency in the area of child custody evaluations.<sup>[43]</sup> On May 10, 1998, he filed a statement of competency in the area of neuropsychological screening and seminar presentation of neuropsychological screening, and on July 21,

1998, he filed a statement of competency in the area of evaluation, treatment, and providing of expert testimony regarding sex offenders.<sup>[44]</sup>

22. Mr. Appleman has completed all continuing education requirements prescribed by the Board's rules.<sup>[45]</sup>

23. Based on his continuing experience as a psychologist in private practice and his other involvement in the field, Mr. Appleman is familiar with the usual and customary standards of practice that were commonly accepted by practicing psychologists in the State of Minnesota in the mid-1990s.<sup>[46]</sup>

#### **Expert Witnesses:**<sup>[47]</sup>

24. Norman J. Cohen, Ph.D., L.P., is a clinical neuropsychologist. He is licensed by the Board to practice psychology in the State of Minnesota, and he has been specifically approved to provide neuropsychology services.<sup>[48]</sup> Dr. Cohen graduated *magna cum laude* from Brown University in 1980 with a double major in psychology and English. Thereafter, he completed an internship in clinical psychology and adult and pediatric neuropsychology at the University of Minnesota Hospital in 1984. Dr. Cohen then held a fellowship in psychology in the Division of Pediatric Neurology at the University of Minnesota Hospital from September 1985 to August 1986, and a fellowship in psychology at the Uptown Mental Health Center in Minneapolis from January to July 1987. He received a Ph.D. in clinical psychology from the University of Minnesota in 1987.<sup>[49]</sup> Dr. Cohen served as a staff psychologist in the Department of Rehabilitation Services at the University of Minnesota Hospital from August 1986 to April 1993; his practice there included adult and child personality and neuropsychological assessment, behavioral medicine, pain management, and cognitive rehabilitation. Dr. Cohen maintained a private practice in psychology in Minneapolis from January 1987 to April 1993. His private practice included child and adult psychotherapy, forensic evaluations, family therapy, personality and neuropsychological assessment of adults, and children's behavioral medicine consultations. From April 1993 to the present, Dr. Cohen has been employed by Courage Center where he performs child and adult neuropsychological assessments, designs cognitive rehabilitation programs, and conducts individual psychotherapy and forensic evaluations. He also supervises doctoral and master's level psychology students.<sup>[50]</sup> Since being employed by Courage Center, he has also maintained a private consulting practice on his own time.<sup>[51]</sup> Dr. Cohen has filed five statements of competency with the Board in the areas of individual and group psychotherapy, neuropsychology, biofeedback, pain management, and supervision.<sup>[52]</sup> Based on his clinical experience and other involvement in the field, Dr. Cohen is familiar with the usual and customary prevailing standards of practice that were commonly accepted by practicing psychologists in the State of Minnesota in the mid-1990s.<sup>[53]</sup>

25. Jack S. Rusinoff, M.A., L.P., is a general psychologist in private practice, as well as a sex offender treatment professional, currently employed by the Metropolitan Community Mental Health Center in St. Paul.<sup>[54]</sup> He has been licensed by the Board to practice psychology in the State of Minnesota since 1992.<sup>[55]</sup> Mr. Rusinoff graduated

*magna cum laude* from the State University of New York at Potsdam in 1982 with a double major in psychology and sociology. Thereafter, he attended graduate school at the University of Minnesota. While in graduate school, Mr. Rusinoff worked as a mental health practitioner in the Twin Cities area. That work experience included part-time positions at the Midway Hospital Center for Domestic Abuse in St. Paul and the Rape and Sexual Assault Center and the Domestic Abuse Project in Minneapolis. While in graduate school, Mr. Rusinoff also authored treatment manuals for practitioners in sexual assault and domestic abuse treatment centers.<sup>[56]</sup> In 1989 he received a master of arts degree in counseling and student personnel psychology from the University of Minnesota.<sup>[57]</sup> After receiving his master's degree, Mr. Rusinoff continued to work at the Domestic Abuse Project in Minneapolis until February 1991 when he accepted a position as a therapist at the Program for Healthy Adolescent Sexual Expression in St. Paul. He held that position until January 1993, and his duties consisted of providing psychotherapy to adolescent sex offenders, male victims, and their families.<sup>[58]</sup> In January 1993 Mr. Rusinoff became the clinical director at Alpha Human Services, a community-based residential adult sex offender treatment program in Minneapolis. Besides providing psychotherapy for program residents, his duties included supervision of the program's other mental health practitioners.<sup>[59]</sup> Then, in April 1998 he accepted a position as a division director at the Metropolitan Community Mental Health Center in St. Paul, a position that he currently holds. In that capacity, he is responsible for administering the Center's sex offender programs, for supervising two other licensed psychologists, and for providing outpatient group therapy for approximately sixty clients.<sup>[60]</sup> Since 1992, Mr. Rusinoff has also maintained a private consulting practice in psychology on his own time.<sup>[61]</sup> Among other affiliations, Mr. Rusinoff is a member of the Association for Treatment of Sex Abusers and its Minnesota chapter.<sup>[62]</sup> He was also a member of the Minnesota Department of Corrections' Adult Residential Sex Offender Advisory Committee in 1996-97 and a member of the Minnesota Department of Health's Sexual Assault Prevention Committee in 1998. Mr. Rusinoff has filed seven statements of competency with the Board in the areas of supervising other psychologists, treatment of domestic assault offenders, treatment of sexual assault and abuse victims and offenders, cognitive behavioral therapy, clinical hypnosis, diagnostic assessments, and individual, couple, and family counseling.<sup>[63]</sup> Based on his clinical experience and other involvement in the field, Mr. Rusinoff is familiar with the usual and customary prevailing standards of practice for treating sex offenders that were commonly accepted by practicing psychologists in the State of Minnesota in the mid-1990s.

26. Theodore H. Wohl, Ph.D., L.P., currently serves as dean and director of special clinical programs at Union Institute of Cincinnati in Ohio. In that capacity, he administers a graduate program in psychology that serves 150 graduate students. He also is currently an emeritus professor of psychology and fellow of the graduate school of the University of Cincinnati. He has held progressively higher faculty positions at that institution since 1955 and also served as a consultant and an adjunct professor of psychology at Wright State University in Dayton, Ohio, from 1988-1990.<sup>[64]</sup> Dr. Wohl received a bachelor of arts degree in psychology from the University of Cincinnati in 1950 and a Ph.D. in psychology from Western Reserve University in 1956.<sup>[65]</sup> Beginning in 1956 he served for nine years first as a staff clinical psychologist and later

as Chief of Inpatient Psychology at the Veterans Administration Hospital in Cincinnati.<sup>[66]</sup> In addition to serving on the faculty of the University of Cincinnati and his service with the Veterans Administration, Dr. Wohl has maintained an active consulting practice in psychology in the State of Ohio over the last forty-five years and has been affiliated with a number of hospitals and other institutions.<sup>[67]</sup> He has served twice as president of the Cincinnati Psychological Association and once as president of the Ohio Psychological Association. Dr. Wohl also served for five years as a member of the Ohio Board of Psychology, the licensing authority for psychologists in that state.<sup>[68]</sup> Over the last forty-five years, he has participated in numerous professional organizations and been the author of numerous professional publications, including a 1994 article in the *Ohio Psychologist*, entitled, "The Maintenance of Office Psychological Clinical Records."<sup>[69]</sup> Among the honors that he has received, are distinguished service awards from several organizations.<sup>[70]</sup> Throughout his career, Dr. Wohl has kept abreast of developments in the ethical standards that are generally accepted to apply to practicing psychologists throughout the country, including Minnesota and including the standards that prevailed in the mid 1990s.<sup>[71]</sup> Based on his teaching activities, his clinical practice, and his other involvement in the field, Dr. Wohl is familiar with the usual and customary prevailing standards of practice that were commonly accepted by practicing psychologists in the State of Minnesota in the mid-1990s.<sup>[72]</sup>

27. Murray R. Klane, is an attorney licensed to practice law in the State of Minnesota; he has also received a certificate from the Minnesota Board of Accountancy as a certified public accountant. Mr. Klane graduated *summa cum laude* from the University of Minnesota in 1977 with a bachelor of arts degree in child psychology. He subsequently received a J.D. degree from the University of Oregon Law School in 1981 and a master of law degree in taxation from Washington University School of Law in 1982.<sup>[73]</sup> Over the last nineteen years, he has been employed in a variety of settings as a tax accountant, a legal associate, and a law partner. From January 1995 to April 1998, Mr. Klane served as chief executive officer for a legal and accounting practice that served over 200 clients, including Mr. Appleman.<sup>[74]</sup> From April 1998 to the present, he has been serving as chief executive officer of Millenium Properties, L.L.C., which is in the business of providing affordable housing for senior citizens; he also has been serving as a principal in Prairie Senior Cottages, L.L.C., which is in the business of providing assisted living facilities for people with Alzheimer's disease.<sup>[75]</sup> Mr. Klane has also served as an adjunct professor at the University of Minnesota.<sup>[76]</sup> Based on his experience in handling accounting and tax matters for psychologists, Mr. Klane is familiar with the customary practices of psychologists for maintenance of records in Minnesota in the mid-1990s.<sup>[77]</sup>

### **Charges of Altering Client Records (Claims 1-13 and 1-13.1)**

28. On or about November 23 and 24, 1993, Mr. Appleman billed Client #1's insurer for services he provided to Client #1 on those two dates.<sup>[78]</sup> On December 9, 1993, the insurer acknowledged receipt of the billings and asked Mr. Appleman for treatment notes or other written verification of the services provided on those two dates.<sup>[79]</sup> On or about December 16, 1993, Mr. Appleman sent the insurer a copy of

progress notes for Client #1 that contained notes for therapy provided on November 23, 1993, followed immediately by a note for therapy provided on December 11, 1993, but no note for therapy provided on November 24, 1993 (Progress Note A).<sup>[80]</sup> On or about May 2, 1994, the insurer again asked Mr. Appleman for written documentation of services provided to Client #1, including the period November 23 and 24, 1993.<sup>[81]</sup> In response, Mr. Appleman sent the insurer a second copy of Progress Note A.<sup>[82]</sup> But the second copy differed from the first copy in that it contained additional information in Mr. Appleman's handwriting purporting to be a progress note "addendum" for November 24, 1993.<sup>[83]</sup> Mr. Appleman offered no explanation about why he had altered Progress Note A sometime after December 16, 1993, to record what appeared to be a progress note for November 24, 1993.<sup>[84]</sup>

29. On or about December 16, 1993, Mr. Appleman billed Client #1's insurer for services provided to Client #1 on that date.<sup>[85]</sup> On May 2, 1994, the insurer acknowledged receipt of that and other billings and asked Mr. Appleman for treatment notes or other written verification of the services he provided on December 16, 1993, among others.<sup>[86]</sup> On or about May 6, 1994, Mr. Appleman sent the insurer a copy of progress notes for Client #1 that contained notes for therapy provided on December 11, 1993, followed immediately by a note for therapy provided on December 17, 1993, but no note for therapy provided on December 16, 1993 (Progress Notes A and B).<sup>[87]</sup> On or about September 13, 1994, the insurer again asked Mr. Appleman for written documentation of certain of the services that he had provided to Client #1.<sup>[88]</sup> In response, Mr. Appleman sent the insurer a second copy of Progress Notes A and B.<sup>[89]</sup> But the copies he sent differed from the first copies in that Progress Note B contained the date "12/16/93" in Mr. Appleman's handwriting suggesting that what previously had appeared to be part of a progress note for December 11, 1993, was now a progress note for December 16, 1993.<sup>[90]</sup> Mr. Appleman offered no explanation about why he had altered Progress Note B sometime after May 6, 1994, to record what appeared to be a progress note for December 16, 1993.<sup>[91]</sup>

30. On or about March 25, 1994, Mr. Appleman billed Client #1's insurer for services provided to Client #1 on that date.<sup>[92]</sup> On May 2, 1994, the insurer acknowledged receipt of that and other billings and asked Mr. Appleman for treatment notes or other written verification of the services provided on March 25, 1994, among others.<sup>[93]</sup> On or about May 6, 1994, Mr. Appleman sent the insurer a copy of progress notes for Client #1 that contained notes for therapy provided on March 11, 1994, followed immediately by a note for therapy provided on April 8, 1994, but no note for therapy provided on March 25, 1994 (Progress Notes C and D).<sup>[94]</sup> On or about September 13, 1994, the insurer again asked Mr. Appleman for written documentation of certain of the services that he had provided to Client #1.<sup>[95]</sup> In response, Mr. Appleman sent the insurer a second copy of Progress Notes C and D.<sup>[96]</sup> But the copies he sent differed from the first copies in that Progress Note D contained the date "3/25/94" in Mr. Appleman's handwriting suggesting that what previously had appeared to be part of a progress note for March 11, 1994, was now a progress note for March 25, 1994.<sup>[97]</sup> Mr. Appleman offered no explanation about why he had altered Progress Note D sometime after May 6, 1994, to record what appeared to be a progress note for March 25, 1994.<sup>[98]</sup>

31. On or about April 27, 1994, Mr. Appleman billed Client #1's insurer for services provided to Client #1 on that date.<sup>[99]</sup> On May 2, 1994, the insurer acknowledged receipt of that and other billings and asked Mr. Appleman for treatment notes or other written verification of services that Mr. Appleman had provided to Client #1.<sup>[100]</sup> On or about May 6, 1994, Mr. Appleman sent the insurer a copy of progress notes for Client #1 that contained a note for therapy provided on April 22, 1994, but no note for therapy provided on April 27, 1994 (Progress Note E).<sup>[101]</sup> On June 13, 1994, the insurer received a second copy of Progress Notes E from Mr. Appleman.<sup>[102]</sup> But the second copy of Progress Note E differed from the first copy in that it contained the date "4/27/94" in Mr. Appleman's handwriting suggesting that what previously had appeared to be part of a progress note for April 22, 1994, was now a progress note for April 27, 1994.<sup>[103]</sup> Mr. Appleman offered no explanation about why he had altered Progress Note D sometime after May 6, 1994, to record what appeared to be a progress note for March 25, 1994.<sup>[104]</sup>

32. Between November 23, 1993, and October 3, 1994, the usual and customary prevailing standards of professional practice and behavior accepted by psychologists practicing in Minnesota was to specifically note any subsequent amendments or alterations of progress notes and to provide explanations for any such amendments or alterations.<sup>[105]</sup>

### **Charges of unprofessional conduct in interactions with Client #15 (Claims OF-17 and OF-20)**

33. On January 8, 1993, Client #15 pleaded guilty to a charge of Criminal Sexual Conduct in the Second Degree for fondling Client #17, his seven-year-old daughter, in the spring of 1992. Client #15's attorney referred him to Mr. Appleman for sex offender treatment, and the Court thereafter ordered Client #15 to complete that sex offender treatment program.<sup>[106]</sup> Client #15 remained in Mr. Appleman's program from late May 1992 through the end of 1994.<sup>[107]</sup>

34. In a psychological evaluation on January 4, 1993, it was Mr. Appleman's opinion that Client #15 was unequivocally amenable to treatment, had reflected openness and honesty in terms of his sexual assault, had reflected dramatic remorse, had not missed any sessions, had for the most part been a model client in terms of treatment, and had an excellent prognosis.<sup>[108]</sup>

35. On or about May 10, 1993, Client #15 made a request to his probation officer for transfer to a different sex offender treatment program.<sup>[109]</sup> When Client #15 told Mr. Appleman about the transfer, Mr. Appleman contacted the attorneys involved in the matter and the probation officer and told them that Client #15 was attempting to manipulate his way out of treatment. Contrary to Mr. Appleman's prior statements that Client #15's prognosis was favorable, Mr. Appleman now called Client #15 one of the most manipulative sex offenders he had ever treated.<sup>[110]</sup> Based on Mr. Appleman's statements, Client #15's probation officer rescinded an agreement to allow Client #15 to transfer to another program, and Client #15 remained in Mr. Appleman's program for another nine months.<sup>[111]</sup>

36. On May 14, 1993, two therapists who had evaluated Client #15 at another treatment program wrote a letter to Mr. Appleman expressing the following opinions about Client #15:

We are writing in response to the copy of your letter to [probation officer] which was forwarded to [our clinic] and to let you know that our experience with this client seems to be markedly different from yours.

Specifically, we do not agree that he has been particularly manipulative in his negotiations to transfer . . .

In addition, we are somewhat confused by the abrupt turnabout in your assessment of this client. On 5 February 1993 you met with . . . the therapists working with [Client #15's] victim and partner, to discuss preparations for an apology session. At that time you described [Client #15] as a "model" client who had worked a consistently honest program and was ready to participate in an apology session followed by family work and movement toward reunification . . . . Thus, your more recent communication by letter appeared both inconsistent and somewhat contradictory . . . . [W]e were unable to make sense of your recent shift in position regarding [Client #15's] progress in therapy. Further concerns include your extreme tardiness to scheduled appointments including the apology session itself during which the victim, perpetrator and partner waited for forty minutes out of an hour of scheduled time for your arrival . . .  
[112]

37. In a January 31, 1994, letter, Mr. Appleman responded to Client #15's probation officer that "[p]atient is one of the two most highly manipulative individuals that has moved through my treatment program in over ten years. He has sexually molested daughters in all three of his marriages. He lied, during his presentence investigation about his deviant history as a pedophile. His sentence would have likely been harsher, if the Court had an accurate victim history."<sup>[113]</sup> Mr. Appleman sent copies of this letter to Client #15's new therapist, to a psychologist working with Client #16's ex-husband, and to a *guardian ad litem* involved with the family.<sup>[114]</sup>

38. On December 29, 1992, Client #11 was convicted of Criminal Sexual Conduct in the Second Degree. Prior to sentencing, his attorney referred him to Mr. Appleman for sexual offender treatment, which Mr. Appleman began on October 30, 1992.<sup>[115]</sup> On December 7, 1992, Mr. Appleman sent a treatment update report containing the following statements, to Anoka County Community Corrections, which was conducting Client #11's pre-sentence investigation: "Concomitant with the confrontational sex offender treatment, [client #11] has attended Alcoholics Anonymous on a weekly basis. . . . Patient and his wife . . . have participated in Alcoholics Anonymous on a weekly basis. Both recognize that they have problems with alcohol dependence. Patient is motivated to change the behavior the [sic] led to his sexual acting out. He is, unequivocally, amenable to treatment. Prognosis is excellent, if he continues in the Sex Offender Program at University Avenue Psychology Center, and

Alcoholics Anonymous.” Under “Recommendations” Mr. Appleman stated that Client #11 “is clearly amenable to motivational therapy. The court should take this into account in his sentencing.”<sup>[116]</sup>

39. On or about January 30, 1993, Client #11’s probation officer transferred him to a different sex offender treatment program.<sup>[117]</sup> Between December 7, 1992, and the time when Client #11 left Mr. Appleman’s program, Mr. Appleman’s assessment of Client #11 amenability to sex offender and chemical dependency treatment did not change.

40. In contrast to the statements that Mr. Appleman had made during Client #11’s pre-sentence investigation, in January 1995 Mr. Appleman submitted a case analysis on Client #11 to the Board in which he characterized Client #11 as very resistive toward treatment, manipulative and deceitful, and stated that “[h]e clearly did not want to continue in my program because of suggestions of chemical dependency treatment.”<sup>[118]</sup>

### **Charge of billing for services not provided (Claim 20-8)**

41. Client #20 was referred to Mr. Appleman by a Qualified Rehabilitation Counselor (QRC) who was coordinating Client #20’s care for a work-related injury. Client #20 had injured his knees while working as a valet parking attendant and appeared depressed while attempting to make a transition back to work. These medical and psychological problems were the subject of a workers’ compensation claim. Mr. Appleman was asked to assess and treat Client #20 for his adjustment reaction to the work-related injuries and his subsequent stress and depression.<sup>[119]</sup>

42. Respondent billed the workers’ compensation insurer a total of \$200 for testing on July 25, 1994, including a charge of \$100 for administration of Strong-Campbell’s Interest Test and a charge of \$100 for a Career Assessment Test.<sup>[120]</sup> Account summaries that Mr. Appleman’s office prepared to summarize the charges for the services that he been providing to Client #20 contain conflicting information about what testing was performed on July 25, 1994. Mr. Appleman had an account summary printed on January 3, 1995, listing that testing as having been administered, and those charges having been incurred, on July 25, 1994.<sup>[121]</sup> He submitted that account summary in a workers’ compensation claim petition proceeding in which he was seeking reimbursement for those services.<sup>[122]</sup> But an account summary prepared on or after June 1, 1995, indicates that no such testing or assessment services were performed on July 25, 1994.<sup>[123]</sup>

43. On or about July 25, 1994, Mr. Appleman gave Client #20 copies of the Strong-Campbell’s Interest Test and the Career Assessment Test. Client #20 then took those tests home but never returned them to Mr. Appleman for scoring. No test results or interpretations for these tests are in Mr. Appleman’s file for Client #20, and Mr. Appleman admitted that in this case he billed the workers’ compensation insurer for testing that was never completed or interpreted.<sup>[124]</sup>

### Charge of failure to give required warnings (Claim 3-4)

44. Client #3 was injured in a motor vehicle accident on October 8, 1993, and Mr. Appleman assessed and treated him during the period from January 25, 1994, to March 7, 1994.<sup>[125]</sup>

45. On January 25, 1994, Mr. Appleman administered a number of psychological tests to Client #3,<sup>[126]</sup> including a Sentence Completion Test, which contained the following responses:

I am afraid of nothing.  
My worst fault is my temper.  
The other people around me I would like to kill.  
I regret not kickin D.B.'s ass.<sup>[127]</sup>  
Power is my destiny.  
One must never cross me.  
Most of all I want to kill B.  
I am different because I'll do what it takes.  
I hate D.B.<sup>[128]</sup>

Mr. Appleman's report of the testing that he conducted on January 25, 1994, did not specifically discuss Client #3's responses in the Sentence Completion Test.<sup>[129]</sup>

46. The progress notes that Mr. Appleman prepared following his January 25, 1994, session with Client #3 attributed the following statements to him: "I get angry. I want to beat the hell out of the guy that hit me."<sup>[130]</sup> And Mr. Appleman's notes for a therapy session on January 27, 1994, include the following observations about Client #3: "Pt. is more 'short-fused' since the accident" and "Pt. has difficulty talking about anger."<sup>[131]</sup>

47. On the other hand, Client #3 expressly denied to Mr. Appleman that "he had any intentions of ever assaulting the person that (sic) hit him nor having any intention of any homicidal thoughts."<sup>[132]</sup>

48. Mr. Appleman made no written assessment of apparent homicidal ideation by Client #3, nor did he include any written appraisal indicating an opinion that Client #3 was not homicidal.<sup>[133]</sup>

49. It was Dr. Cohen's opinion that in the mid-1990s the usual and customary prevailing standards of professional practice and behavior for psychologists practicing in Minnesota were:

that you would inquire quite formally of the client as to the nature of his feelings about, in this case DB, the potential victim, whether the client had any plans or intentions about this, and in other words, try to evaluate how close the client was to perhaps taking some act that had the potential of harming DB. If as a clinician you found that you thought there was some legitimate threats to DB or any one else, of course, it then would be under the Tarasoff standards, where you would be required to notify the intended

victim or police or both. If you felt that it was not a true threat to, in this case, DB or whomever, then you would put in your report a note explaining that you had realized the potential implications of the statements made by Client 3, that you ha[d] assessed this formally, and you did not feel it was a significant threat and explain your reasons why. This kind of information clearly requires further exploration and further explication.<sup>[134]</sup>

It was further Dr. Cohen's opinion that Mr. Appleman's documentation of the thoughts that Client #3 had verbalized failed to meet usual and customary prevailing standards of professional practice because "[t]here is simply nothing in the record that indicates that he understood the potential implications of these statements, assessed them in any kind of formal way, and then recorded that record, what had happened in his report."<sup>[135]</sup>

50. It was Mr. Appleman's opinion that when a client verbalized thoughts such as those articulated by Client #3, prevailing practice standards required a clinician to inquire further with the client about those thoughts, and that the clinician then had to exercise clinical judgment about whether or not those thoughts were serious, significant, or dangerous.<sup>[136]</sup> If the clinician concluded the statements were not, there was neither a duty to warn nor to document the thoughts that had been verbalized.<sup>[137]</sup>

51. It was Mr. Appleman's clinical judgment that the thoughts that Client #3 had verbalized in the Sentence Completion Test and during therapy sessions were expressions of anger that did not represent homicidal ideation. For that reason, Mr. Appleman neither warned the subject of those thoughts nor specifically discussed those thoughts in the records that he maintained on Client #3.<sup>[138]</sup>

### **Charge of administering and billing for a non-standard test (General Claim-3)**

52. Mr. Appleman administered the Goldberg's Stress Test to Clients #1, 2, 3, 6, and 20<sup>[139]</sup> and billed them or their third-party payors for administering the test.<sup>[140]</sup> Nowhere in Mr. Appleman's records for those clients does he indicate that the Goldberg's Stress Test is not a standardized test, that it lacks underlying normative data, and that he had no test manual for the test.

53. The Goldberg's Stress Test is not a standardized test,<sup>[141]</sup> and it lacks "a manual or other published information which fully describes the development of the test, the rationale for the test, the validity and reliability of the test, and normative data".<sup>[142]</sup>

54. It was Dr. Cohen's opinion that Mr. Appleman's use of the Goldberg's Stress Test failed to meet the usual and customary prevailing standards of professional practice by psychologists in Minnesota in the mid-1990s.<sup>[143]</sup> Dr. Wohl had no personal knowledge of the Goldberg's Stress Test and therefore offered no opinion about it.<sup>[144]</sup> Mr. Appleman's opinion was that the Goldberg's stress test "may be used in standard clinical practice,"<sup>[145]</sup> and that it is a projective and clinical instrument accepted by community psychological practitioners."<sup>[146]</sup>

## Charge of failure to coordinate services (Claim OF-11)

55. On August 18, 1992, Client #10 pleaded guilty to a charge of trespassing after being arrested for indecent exposure. He reported to the court that he was being treated by Mr. Appleman. As part of his plea agreement, he agreed to complete that treatment, including chemical dependency treatment.<sup>[147]</sup> On August 11, 1992, Client #10 began receiving sex offender treatment from Mr. Appleman. Client #10 attended eleven individual therapy sessions and three group therapy sessions between August 11, 1992, and March 23, 1993, with a gap in therapy between August 19, 1992, and January 6, 1993.<sup>[148]</sup>

56. On or about August 11, 1992, Mr. Appleman administered the following tests to Client #10: WAIS-R, WRAT (Reading Recognition Portion), Bender-Gestalt, "Sentence Completion," and House-Tree-Person. Mr. Appleman's file for Client #10 contained testing data on those tests,<sup>[149]</sup> as well as two chemical dependency evaluations. One of the chemical dependency evaluations was performed on February 26, 1993 by a practitioner at another clinic,<sup>[150]</sup> and the other was performed on March 20, 1993, by an independent contractor at Mr. Appleman's clinic.<sup>[151]</sup>

57. In September 1992, Client #10 asked his probation officer to transfer him to another sex offender treatment program.<sup>[152]</sup> In a February 19, 1993, letter to Client #10's probation officer and to the judge assigned to the case, Mr. Appleman stated:

It is our understanding that [Client #10] will have an intake session at the sex-offender program at Pathfinders. It is further understood that there will be close communication between Pathfinders and Dakota County Community Corrections, relating to his treatment experience. That means that all reports and records from University Avenue Psychology Center will be submitted to Pathfinders.<sup>[153]</sup>

58. On or about March 15, 1993, Client #10 participated in an admission interview at Pathfinders, another sex offender treatment program.<sup>[154]</sup> On March 23, 1993, Mr. Appleman met with Scott Johnson, a psychologist employed by Pathfinders, to discuss Client #10's transfer from Mr. Appleman's program to Pathfinders' program. Mr. Appleman indicated that he had testing results and other records for Client #10 and would make sure that Client #10's records were sent expeditiously.<sup>[155]</sup>

59. Following the March 23, 1993, meeting, Mr. Appleman discharged Client #10 from his program.<sup>[156]</sup> Client #10 signed a release authorizing Pathfinders to exchange information with Mr. Appleman.<sup>[157]</sup>

60. On April 5, 1993, Mr. Johnson faxed a letter to Mr. Appleman requesting that he "[p]lease send copies of all testing on [Client #10], including raw scores, CD assessment, and recommendations. This will help to avoid unnecessary test duplication."<sup>[158]</sup>

61. On April 6, 1993, responding to Mr. Johnson's records request, Mr. Appleman's office manager faxed a copy of the February 26, 1993, chemical

dependency evaluation of Client #10, indicating that it was “the only available assessment right now.”<sup>[159]</sup> On the same day, Mr. Appleman called Mr. Johnson and indicated that no other testing of Client #10 had been done while he was in Mr. Appleman’s care.<sup>[160]</sup> Mr. Appleman transmitted neither the remaining chemical dependency assessment nor the results of his testing of Client #10 to Mr. Johnson.<sup>[161]</sup>

### **Charge of improperly releasing confidential information (Claim OF-10)**

62. Mr. Appleman’s records for Client #15 contain two Consents for Release and Exchange of Information signed by that client. The first, which expired on December 31, 1993, permitted an exchange of information with Client #15’s probation officer.<sup>[162]</sup> The second, which expired on January 14, 1994 permitted Mr. Appleman to exchange information with another named therapist.<sup>[163]</sup> Mr. Appleman’s client records contain no signed release permitting him to exchange information with Client #15’s attorney.<sup>[164]</sup>

63. On May 11, 1993, Mr. Appleman released private information about Client #15 to that client’s attorney without having a written release to do so.<sup>[165]</sup> On January 31, 1994, Mr. Appleman released private information about Client #15 to his probation officer and the therapist named in the other consent after his written releases to do so had expired.<sup>[166]</sup> At the same time Mr. Appleman also released that information to therapists who had not been named in any previous written release.<sup>[167]</sup>

64. It was Mr. Rusinoff’s opinion that at the time those releases of information occurred, it was not the usual and customary standard of practice for psychologists to release private client information without a current release of information.<sup>[168]</sup> It was Mr. Appleman’s opinion that “[r]eleasing information to client’s attorney, probation officer, and other[s] involved directly in their treatment is not a violation of confidentiality.”<sup>[169]</sup> It was also his opinion that he had obtained current releases to release information to the Court in Client #15’s case (which included his attorney and probation officer) but that the releases had been misfiled.<sup>[170]</sup>

### **Charge of misdiagnosing Client #1 as having PTSD (Claim 1-1)**

65. On November 1, 1993, Client #1 was involved in minor automobile accident in which he injured his ankle, and his attorney referred him to Mr. Appleman for assessment and treatment.<sup>[171]</sup> Mr. Appleman first saw Client #1 two weeks later on November 15, 1993.<sup>[172]</sup> At that time Mr. Appleman conducted an assessment of Client #1, administered a number of psychological tests, and made the following findings: “Patient has severe Post-Traumatic Stress Disorder, secondary to and precipitated by the motor vehicle accident,”<sup>[173]</sup> and his diagnosis was “Axis I. 1. Post-Traumatic Stress Disorder DSM III-R 309.89.”<sup>[174]</sup>

66. On November 17, 1993, Mr. Appleman first billed Client #1’s insurer for the services that he had provided to Client #1. The billing form lists “309.89” as the diagnosis.<sup>[175]</sup>

67. On or about December 9, 1993, Mr. Appleman sent a letter to Client #1's insurer requesting reimbursement. The letter also forwarded an itemized billing, progress notes, and information on psychological testing, and copy of a psychological evaluation report. The letter stated: "[Client #1] entered treatment on November 17, 1993. . . because of severe Post-Traumatic Stress Disorder secondary to and precipitated by the motor vehicle accident of November 1, 1993."<sup>[176]</sup>

68. In the *Diagnostic and Statistical Manual of Mental Disorders* (3rd Edition – Revised)<sup>[177]</sup> the diagnosis assigned to code 309.89 is "Post-Traumatic Stress Disorder."<sup>[178]</sup> DSM-III-R goes on to establish five diagnostic criteria for PTSD, the last of which is

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.<sup>[179]</sup>

69. Nowhere in Mr. Appleman's records for Client #1 is there an explanation of why he diagnosed PTSD where symptoms had only been present for two weeks.

70. It was Dr. Cohen's opinion that diagnosing PTSD where the duration of symptoms is only two weeks does not conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota, unless the clinician clearly delineates the reasons why.<sup>[180]</sup>

71. It was Dr. Wohl's opinion that DSM-III-R was just a guideline with which psychologists may take liberties.<sup>[181]</sup> But it was also his opinion that a third party payor would be justified in withholding reimbursement from a psychologist who departed from DSM-III-R criteria in making a diagnosis.<sup>[182]</sup>

### **Charge of misdiagnosing Client #1 as having somatoform pain disorder (Claims 1-2 and 1-4)**

72. On November 24, 1993, twenty-three days after Client #1's automobile accident, Mr. Appleman also diagnosed Client #1 as having somatoform pain disorder.<sup>[183]</sup>

73. Mr. Appleman's December 9, 1993, letter to Client #1's insurer also made the following statement: "We see an individual that has Post-Traumatic Stress Disorder, Somatoform Pain Disorder, and Depression secondary to and precipitated by the motor vehicle accident."<sup>[184]</sup>

74. In DSM-III-R the diagnosis assigned to code 307.80 is "Post-Traumatic Stress Disorder." It goes on to establish two diagnostic criteria for PTSD, the first of which is

A. Preoccupation of pain for at least six months.<sup>[185]</sup>

75. Nowhere in Mr. Appleman's records for Client #1 is there an explanation of why he diagnosed somatoform pain disorder where symptoms had only been present for twenty-three days.

76. It was Dr. Cohen's opinion that diagnosing somatoform pain disorder where the duration of symptoms is only twenty-three days did not conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota.<sup>[186]</sup>

77. Dr. Wohl indicated that Dr. Cohen had correctly stated "that there is an average of six months and it is down there as a cut off."<sup>[187]</sup> Nevertheless, it was his opinion that: the six months duration criterion was just "an average" or "mean" and that there is "nothing magic about six months."<sup>[188]</sup>

### **Charge of inappropriately attributing Client #9's PTSD to a recent automobile accident (Claim 8/9-1)**

78. On December 31, 1990, Client #9 was involved in an automobile accident. Mr. Appleman first evaluated her on April 23, 1991, and in the report of that evaluation made the following diagnosis: "Post-Traumatic Stress Disorder due to a car accident".<sup>[189]</sup>

79. Mr. Appleman received reports from other medical providers indicating that Client #9 had a history of a previous automobile accident,<sup>[190]</sup> but he did not note such a history in his own psychological evaluation report.<sup>[191]</sup>

80. Mr. Appleman also received a report from another medical provider indicating that Client #9 had a history of a "nervous breakdown" before her second automobile accident,<sup>[192]</sup> but he did not note such a history in his own psychological evaluation report.<sup>[193]</sup>

81. The history that Mr. Appleman took from Client #9 indicated that she was experiencing stresses relating to her relationship with her daughter.<sup>[194]</sup>

82. It was Dr. Cohen's opinion that concluding the second automobile accident was the cause of Client #9's PTSD, without first ruling out other stressors in her life as causes, did not conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota.<sup>[195]</sup>

83. It was Mr. Appleman's opinion that concluding the second automobile accident was the cause of Client #9's PTSD did conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota.<sup>[196]</sup>

**Charge of substandard interpretation of the MMPI administered to Client #1 (Claim 1-7)**

84. On October 13, 1994, Mr. Appleman administered a Minnesota Multiphasic Personality Inventory<sup>[197]</sup> test (MMPI) to Client #1. The test was subsequently scored by Professional Assessment Services of Minneapolis and a score sheet for Client #1 returned to Mr. Appleman for interpretation.<sup>[198]</sup>

85. In a progress note dated October 24, 1994, Mr. Appleman reported the following: "Went over MMPI. Pt. is highly depressed w/ significant physical complaints. Social relationships are impaired. Pt. should be on antidepressant medication." Mr. Appleman went on to record the following diagnoses: "PTSD in Remission. Adj. Rxn. To Physical Complaints. Depression: Major."<sup>[199]</sup>

86. It was Dr. Cohen's opinion that Mr. Appleman's interpretation of Client #1's MMPI did not conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota<sup>[200]</sup> for several reasons, namely:

Mr. Appleman interprets the profiles suggesting the client as highly depressed and has physical complaints, but the scales that primarily reflect physical complaint, which were hypochondriasis and hysteria, scales one and three as we discussed before. Both have T-scores within what is regarded as the normal range, and in the case of the MMPI, the T-score, the score you give them, was below 70. They're both in normal limits, and they are, of those ten clinical scales we discussed, the second and the fourth are the lowest. Other scales which have much higher scores and indeed are in a range which may be considered deviant are not interpreted.

\* \* \*

I feel that Mr. Appleman interpreted only specific scales that were not the highest scales on the MMPI. In fact, they were among the lowest, and he chose, for whatever reason, not to interpret other scales which were of much greater clinical significance.<sup>[201]</sup>

87. At the hearing, neither Mr. Appleman nor Dr. Wohl offered any specific opinions about Mr. Appleman's interpretation of Client #1's MMPI. In an earlier affidavit, Mr. Appleman stated that Dr. Cohen's opinion that the interpretation of Client #1's MMPI was "totally erroneous."<sup>[202]</sup> He also indicated that he had never made a written interpretation of Client #1's MMPI but had only used the test results as one of several sources of information in formulating his clinical hypothesis of depression.<sup>[203]</sup>

**Charge of substandard interpretations of the WAIS-R and Trails A and B tests administered to Client #2 (Claim 2-7)**

88. In the course of assessing Client #2, Mr. Appleman administered the Wechsler Adult Intelligence Scale – Revised (WAIS-R) test and the Trail Making Test, Parts A and B (Trails A and B) to her.<sup>[204]</sup> In the psychological evaluation report that he prepared for Client #2, Mr. Appleman made the following test interpretations, among others:

Subtest patterns suggest that she has problems with long term memory, short term memory, and vocabulary and language problems. She has difficulties solving arithmetic problems that are presented to her auditorily.

\* \* \*

Problem solving and perceptual organization are dramatically low.

\* \* \*

Trails A & B (neuropsychological screening tests) suggests that she has difficulty tracking.<sup>[205]</sup>

89. It was Dr. Cohen's opinion that Mr. Appleman's interpretation of Client #2's WAIS-R and Trails A and B tests did not conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota<sup>[206]</sup> for the following reasons:

Moreover, in an analysis of the WAIS, the client again - - I'm sorry, Mr. Appleman again says that the client has long- and short-term memory deficits, which I do not believe are discernible using the WAIS. He says the client has vocabulary and language problems, when in fact the client's scores on verbally based subtests are consistently average or in the average range. As you read from Dr. Lezak's book, the average range is the 25<sup>th</sup> to 75<sup>th</sup> percentile, which covers half the population, and all those scores are contained – all the verbal scores are contained in that range.

Mr. Appleman says problem solving and perceptual organization are dramatically low. While those scores may be slightly below average, for example, the client's full-scale IQ. That is, with that standard error of measurement idea, there is no statistical difference between the patient's overall IQ and her scores on the tests that have to do with perceptual organization and problem solving.

Finally, on the Trailmaking Test, Mr. Appleman reported that the scores show difficulty tracking. While scores are just slightly below average, in the low-average range, consistent with the client's score on the other visual tests that I just mentioned from WAIS and not statistically below what we would expect given the client's overall IQ score. So I don't think there is any evidence that the client has difficulty tracking as shown by the Trailmaking test.<sup>[207]</sup>

90. At the hearing, neither Mr. Appleman nor Dr. Wohl offered any specific opinions about Mr. Appleman's interpretation of Client #2's WAIS-R test. In an earlier affidavit, Mr. Appleman expressed his opinion that the "subtests of Information, Digit Span, Arithmetic and Coding are all memory tests. Dr. Cohen is mistaken in stating that the WAIS-R does not measure memory. The WAIS-R Subtests measure auditory and written short and long term memory."<sup>[208]</sup> Mr. Appleman also indicated that his conclusion that Client #2 had difficulty tracking was based primarily on direct observations of that client during the diagnostic interview rather than on the results of the Trails A and B tests.<sup>[209]</sup>

**Charge of substandard interpretation of the WAIS-R test administered to Client #4 (Claim 4-3)**

91. In the course of assessing Client #4, Mr. Appleman administered the WAIS-R test to her.<sup>[210]</sup> In the psychological evaluation report that he prepared for Client #2, Mr. Appleman made the following test interpretations, among others:

Subtest pattern analysis suggests that she has problems with long term memory. Vocabulary and language development are at a lower than average level. Patient has difficulty with concentration, as reflected in the lower score on the arithmetic subtest.

In the nonverbal area patient has difficulty picking the essential details out in her visual environment. Sequencing, perceptual organization, and problem solving are also impaired due to depression and the severity of her anxiety.<sup>[211]</sup>

92. Dr. Cohen expressed the following opinions about some of the principles for interpreting the WAIS-R that usual and customary standards of prevailing psychological practice incorporate:

Q In terms of usual and customary standards of acceptable and prevailing practice, is there any clinical significance to a score which falls within the statistical error of measurement?

A No. It's just simply all the same, so similar, you can't make interpretations.

Q. Why, can you explain to us why there isn't?

A. It's a very practical matter. Sometimes the difference of one or two points is an answer to one or two test items. On a more statistical level, the differences are, as I have explained, insignificant. On a purely clinical level, you should just know that there is so little difference between scores of one or two points that to emphasize differences based on those is inappropriate. It's just clinically nonsignificant.<sup>[212]</sup>

93. Mr. Appleman expressed the following opinions about some of the principles for interpreting the WAIS-R that usual and customary standards of prevailing psychological practice incorporate:

[T]here is a standard error of measurement of approximately two in the subtests. And I'm not sure of the standard error of measurement in overall IQ. But, nevertheless, this is not a statistical analysis. This is a clinical interpretation. In clinical interpretation one does not adhere to strict — a neuropsychologist does more so because they are trying to determine the precise level of cognitive functioning of individuals. I am looking for clinical clues as to whether or not the person's emotional condition is interfering with their functioning.<sup>[213]</sup>

My interpretation is not a statistical interpretation. It is a clinical interpretation. And one has to differentiate the two.

Q. That's what I would like to know. What is the difference between the two?

A. The statistical interpretation is primarily used for research purposes and it is a helpful guide, but it's not an absolute. For example, the information subtest score of 7 I indicate is below average. The average is 10. But if you do a statistical conversion as Mr. Krieser did where you take her IQ and then you move the -- then as you see in Exhibit KK, he did a statistical analysis of her IQ and moved it over. That's very interesting from an academic perspective, but it's not meaningful in terms of a clinical perspective.<sup>[214]</sup>

94. It was Dr. Cohen's specific opinion that Mr. Appleman's interpretation of Client #4's WAIS-R test did not conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota<sup>[215]</sup> for the following reasons:

In terms of interpretation, the client (sic) says there were problems with long-term memory as based on WAIS-R, again to avoid being repetitive, is not a function that can be said from WAIS-R. He said vocabulary is below average, and it simply isn't. It's within the average range.

He says the client has attentional problems based on a low score in the arithmetic subtest, but in fact, the client's two highest scores out of the 11 subtests given on the WAIS-R were in Digit Span and Digit Symbol, two subtests highly dependent on attention.

He said non-verbal skills were, I quote, "impaired," but actually all of his scores on the nonverbal subtests from the WAIS-R are in the low-average range or better, and the impaired range is considerably below that. He reports or opines that this impairment is due to depression and anxiety, but the pattern of impairment in scores on the WAIS-R for those people who are depressed or anxious actually is typically reflected in those scores on those tests most sensitive (sic) to attention. Digit Symbol, a subtest of the WAIS-R, is one of the subtests most sensitive to both brain injury and mood disturbance, and it was one of his two highest scores on the test. So there is no actual evidence from the WAIS-R that the client is depressed or anxious. Again, this may stem from Mr. Appleman's interpretation of the arithmetic subtest score which as reflection of a problem with attention, which it clearly does not. In addition, I don't see anything that says the client was evaluated for a learning disability. Mr. Appleman might, for example, have considered giving the WRAT arithmetic subtest in order to determine whether the client had a specific deficit in that.<sup>[216]</sup>

95. It was Mr. Appleman's opinion that his interpretation of Client #4's WAIS-R test did conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota<sup>[217]</sup> for the following reasons:

Now, my question to you is, having heard all that, what is your response to what the witness Cohen says about your interpretation of your battery of tests [for Client #4] including the WAIS-R?

A. That his interpretation is not based on fact. It's a very narrow neuropsychological statistical criticism, as Dr. Wohl indicated,<sup>[218]</sup> because these issues of standard error of measurement as portrayed in Exhibit LL are from a neuropsychological examination interpretation. That is where this is from. This is not a standard textbook that is used in the interpretation of the WAIS-R. Nor does it supplant the clinical interpretation that one gets from observing the client.

Let me comment, if I may, as to the use of the testing. First of all, in the WAIS-R, the actual raw data converted to to the scale score and then converted to the IQ scores is accurate. That is not substandard. He states that information —

Q. When you say that's accurate, you mean that in your opinion if Dr. Cohen had referred to the same scales that you referred to he should get the same result?

A. If he referred to the same scale and did an arithmetic computation and found out that there were gross errors, that would be substandard.<sup>[219]</sup>

### **Charge of substandard interpretations of the tests administered to Client #5 (Claims 5-5 and 5-8)**

96. Client #5 was involved in an automobile accident on January 12, 1996.<sup>[220]</sup> He first saw Mr. Appleman about six months later on June 13, 1996, when Mr. Appleman evaluated him and administered a number of psychological tests, including the WAIS-R, the Bender-Gestalt test, the Wide Range Achievement Test (WRAT), the Trails A and B test, the Sentence Completion test, the Beck's Depression Inventory, and the Goldberg's Stress Test.<sup>[221]</sup> At the time of that testing, Client #5 was fifty-eight years old. He spoke minimal English even though he had moved to the United States from Jerusalem in 1966, and his native language had remained Arabic. Client #5's son translated for him during Mr. Appleman's interview and during administration of the psychological tests.<sup>[222]</sup>

97. In referring to the WAIS-R, Mr. Appleman noted in his psychological evaluation report that "[b]ecause patient does not speak English well, only the Performance Subtests were administered from the WAIS-R."<sup>[223]</sup>

98. Mr. Appleman also reported that Client #5 "has hearing and vision problems, where he 'sees streaks'"<sup>[224]</sup> and other physical problems, including "blurred vision" and "problems with speech, hearing, and reading."<sup>[225]</sup>

99. In his psychological evaluation report of Client #5, Mr. Appleman made the following test interpretations:

Patient's rate of intellectual functioning falls within the Retarded range, with a prorated Full Scale IQ of 63, placing him below the first percentile of cognitive functioning. . . .

\* \* \*

Subtest pattern analysis [of the WAIS-R] suggests that patient has dramatic difficulty picking out the essential details in his visual environment. Sequencing, perceptual organization, problem solving and speed of mental operation are all at the Retarded Range.

Trails A & B (Neuropsychological Screening Test) strongly suggest organic brain damage. Patient could not follow the direction to complete Trails A nor (sic) B. Patient has dramatic distortions in the Bender-Gestalt, with rotation and configuration errors.

\* \* \*

Patient's personality reflects that of Depression and Closed Head Injury secondary to and precipitated by the motor-vehicle accident. In terms of depression, the Beck's Depression Inventory gives us insight into the profundity of his hopelessness by the response to the following items: [A large number of specific responses are then listed.]<sup>[226]</sup>

100. On or about July 2, 1996, Mr. Appleman referred Client #5 to David C. Fisher, Ph.D, L.P., for a complete neuropsychology evaluation.<sup>[227]</sup> After obtaining a medical history, Dr. Fisher reported that Client #5 had diabetes and typically saw physicians every two months for treatment of that condition.<sup>[228]</sup>

101. Dr. Fisher decided not to administer any neuropsychological tests to Client # 5, for a number of reasons, including:<sup>[229]</sup>

a. "[L]anguage and culture differences would likely invalidate much of the testing."

b. "He seemed in very significant pain and those too would limit useful data that could be obtained."

c. "Finally, measures of perceptual motor speed were not given because he reported significant problems with extremity range of motion."

d. "The writer also checked with several sources, without success, for resources to assist in neuropsychological testing with a native Arabic speaker."<sup>[230]</sup>

102. Dr. Cohen expressed several opinions about why Mr. Appleman's choice of psychometric tests and interpretation of those tests failed to meet usual and customary prevailing standards of professional practice:

a. It was Dr. Cohen's opinion that:

"[T]ests such as picture completion and picture arrangement, which are on the performance section of the WAIS, are indeed very culturally dependent.

\* \* \*

There is a subtest which is called Object Assembly, but which is essentially a puzzle, which is part of the administration of the WAIS and was a subtest that Mr. Appleman gave to the client. I don't know in this client's specific instance how much exposure he has had to puzzles, but that is a specific example of how cultural factors must be taken into account very, very considerably, and Mr. Appleman doesn't do that.<sup>[231]</sup>

b. Dr. Cohen also expressed the opinion that:

"[T]he sentence completion test, as we have also heard, partially has incomplete sentences, and, you know, some of those are rather sensitive, potentially sensitive things, my mother, my father and opinions like that. I can only imagine that having those administered through one's child would change one's responses as compared to being able to read the question and writing on the paper oneself.<sup>[232]</sup>

c. Dr. Cohen also noted that:

Mr. Appleman also gives tests such as the Sentence Completion and the Beck Depression Inventory, which I believe are culturally dependent, and I am not sure how they were administered. My assumption is that because the client's son was present at the testing, and there is some notation in Mr. Appleman's report that the son helped with administration of the test, my guess is the son read the material to the client. But as we discussed yesterday, that really changes the standardizations of the administration, and I can imagine two things. First, the Beck is a test with normative data, and we heard at some length yesterday about the importance of normative data and how changing administration procedure changes interpretation.

d. Dr. Cohen also expressed the following opinion about Mr. Appleman's testing of Client #5:

. . . Mr. Appleman does note in his report that the client has visual streaks and blurring, and, you know, many of the tests that Mr. Appleman gave such as the Trailmaking Test or attempted to give such as the Trailmaking Test and the performance subtests of the

WAIS are extremely visual in nature, require careful visual attention.

I guess there are two things I would say about that. The first is clearly if you have verbal (sic) streaks and blurring, if you note that earlier in your report, perhaps you would want to comment on or I think you really must comment on whether that affected your testing — you must know that their vision is adequate for that test.<sup>[233]</sup>

e. Finally, Dr. Cohen expressed the opinion that Mr. Appleman's administration of the WRAT failed to conform to usual and customary prevailing standards of professional practice because:

The WRAT, as Mr. Appleman's testimony had earlier this week, the portion of the WRAT that he gave involved reading words written in English, and this client is not well familiar with the English language.<sup>[234]</sup>

103. It was Mr. Appleman's opinion that he provided Client #5 with "excellent standards of care for many reasons" and that his care was "above the standards."<sup>[235]</sup> Dr. Wohl offered no specific opinion on whether the testing of Client #5 met prevailing practice standards.

#### **Charge of substandard interpretations of the tests administered to Client #6 (Claim 6-8)**

104. Client #6 was involved in an automobile accident on December 11, 1995.<sup>[236]</sup> She first saw Mr. Appleman about two months later on February 21, 1996, when Mr. Appleman evaluated her and administered a number of psychological tests, including the WAIS-R, the Bender-Gestalt test, the House-Tree-Person test, the Wide Range Achievement Test (WRAT), the Trails A and B test, the Sentence Completion test, the Beck's Depression Inventory, and the Goldberg's Stress Test.<sup>[237]</sup>

105. In his psychological evaluation report of Client #6, Mr. Appleman made the following test interpretations:

Subtest pattern analysis suggests that patient has average long term memory, slightly above average short term memory and above average vocabulary and language development. Patient has dramatically lower ability to solve arithmetic problems that are presented to her auditorily, suggesting impaired concentration secondary to MVA. Patient has average social and practical judgement. Abstract reasoning is below average.

In the nonverbal area, patient has slightly below average ability to picking (sic) out the essential details in her visual environment. Sequencing is at average level. Perceptual organization and problem solving are slightly above average.

\* \* \*

Bender-Gestalt reflects mild perceptual distortions.<sup>[238]</sup>

106. It was Dr. Cohen's opinion that Mr. Appleman's interpretation of Client #6's WAIS-R and Bender-Gestalt tests did not conform to the usual and customary prevailing standards of professional practice for psychologists practicing in Minnesota<sup>[239]</sup> for the following reasons:

He also notes that the client's attention is dramatically lower than other scores. While it appears that this was based solely on his interpretation of the client's arithmetic subtests, I believe that we went a little into this yesterday, arithmetic sub — a lower arithmetic subtest score may be associated with decreased attention. It may also be associated with a variety of other things, for example, a learning disability.

The client on two other subtests that reflect attention, one verbal subtest called Digit Span and one nonverbal subtest called Digit Symbol, scored in the average to high average range

So, it would be quite clear even from just a quick perusal of these data, you know, by a standard psychologist, that attention was not the issue here. That this is actually more suggestive of a learning disability in mathematics. I wonder why that wasn't elucidated if Mr. Appleman, for example, had the WRAT at his disposal, he could have given the arithmetic portion of that to provide a more clear assessment of whether this was a learning disability, a specific deficit in mathematics, or perhaps related to attention, although I consider it extremely unlikely considering the patient's scores.

Also, the client (sic) says the Bender Gestalt reflects mild perceptual distortions, and, as I mentioned, there are standard scorings for the Bender which I don't see here, and it's difficult to -- there is not really any interpretation of it beyond that.

Certainly the client scored in the average to high average range on all of the nonverbal subtests of the WAIS, and there is no attempt to reconcile why those two findings, even if it's true that the Bender Gestalt reflects mild perceptual distortion, why is that so different from this client who did so well on the nonverbal section of another test.

107. Neither Mr. Appleman nor Dr. Wohl offered any opinions at the hearing about whether or not Mr. Appleman's interpretations of the tests that he administered to Client #6 met usual and customary prevailing practice standard. In an earlier affidavit, Mr. Appleman merely stated that "[t]echnical differences of opinion on certain tests do not override the well-founded clinical judgement of Respondent."<sup>[240]</sup>

**Charge of inappropriately administering tests to Client #20<sup>[241]</sup> (Claim 20-12)**

108. It was Dr. Cohen's opinion that:

Any deviation from the prescribed standardized administration decreases the validity of the test, and any such — and it's certainly the standard that any such deviation from the procedures would be something to be noted in a report and discussed in terms of the way one looks at the normative scores on that test.

My opinion is that any time you deviate, you are not giving the same test. The more you deviate, the less it's the same procedure the less it's the same test.<sup>[242]</sup>

109. It was Mr. Appleman's opinion the testing procedures for the Strong-Campbell's Interest Test and the Career Assessment Test did not require that those tests be taken at the psychologist's office.<sup>[243]</sup>

### **Charge of failure to reconcile Client #21's test results with the diagnosis (Claim 21-3)**

110. In April of 1994, Client #21 immigrated to the United States from China. In April of 1995, she learned that her mother had been hospitalized in China for depression. Client #21 was concerned about the quality of care her mother was receiving there and was looking for a way to obtain antidepressant medications for her.<sup>[244]</sup> On August 26, 1995, Client #21 saw Mr. Appleman for the first time.<sup>[245]</sup> She saw Mr. Appleman again on August 30 and September 6, 1995.<sup>[246]</sup> On her third visit, Mr. Appleman administered the Beck's Depression Inventory and Sentence Completion Tests to her.<sup>[247]</sup>

111. Mr. Appleman did not prepare any written report containing his interpretations of those two tests. His scoring of the Beck's Depression Inventory resulted in a score of 20, which indicates "Borderline Depression."<sup>[248]</sup> Client #21's Sentence Completion Test contains only one reference to depression. In Item #24, she completed the sentence beginning "Things look hopeless when" with the phrase "I am depressed."<sup>[249]</sup>

112. When submitting his charges to Client #21's insurer for payment, Mr. Appleman assigned diagnosis codes 296.20 and 309.81 to Client #21.<sup>[250]</sup> In the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition<sup>[251]</sup> the diagnosis assigned to code 296.20 is "Major Depressive Disorder, Single Episode."<sup>[252]</sup> The diagnosis assigned to code 309.81 is "Posttraumatic Stress Disorder."<sup>[253]</sup>

113. In response to a question at the hearing of whether the interpretations that Mr. Appleman made of the tests he administered to Client #21 met prevailing practice standards, Dr. Cohen expressed the following opinions:

I also think it's true that this client was given a diagnosis of depression in some interpretation of this testing, and on the Beck Depression — was given a diagnosis of depression. On some of the

testing, for example, on the Beck Depression Inventory she scored in the borderline range, which would not be consistent with a diagnosis of major depression.

That on the Sentence Completion test the only reference to depression is the client's finishing the supplied start of the sentence on this was "Things look hopeless when," and the client responded, "When I am depressed." Which I don't think indicates even current depression. It's just probably simply a factual statement for the client, if she is sad or blue, that things look more hopeless at those times.<sup>[254]</sup>

114. Mr. Appleman testified that he made the diagnosis of depression based on his initial interview with Client #21 on August 26, 1995, about a week and a half before he administered the tests during his third session on September 6, 1995. He indicated that there was nothing in the testing that suggested that he change his diagnosis.<sup>[255]</sup>

### **Charge of using substandard treatment techniques with sex offender clients (Claims OF-9 and OF-18)**

115. Nexus, Inc., a treatment center for convicted felons, employed Mr. Appleman as a therapist from September 1980 to May 1983,<sup>[256]</sup> and Alpha House, an inpatient treatment center for sex offenders, also employed him as a therapist for seven weeks in the early 1980s.<sup>[257]</sup> Mr. Appleman and the other therapists commonly used profanity and very strong confrontational treatment approaches while treating sex offender clients in those programs.<sup>[258]</sup>

116. Mr. Appleman also used profanity "many times"<sup>[259]</sup> and "in a confrontational way"<sup>[260]</sup> during the therapy sessions that he conducted on his own with sex offenders in the mid-1990s.<sup>[261]</sup> He used profanity and a confrontational approach to therapy to maintain what he believed was an appropriate therapeutic process in his sex offender group whenever a group member's behavior began to escalate and became disruptive to the group process.<sup>[262]</sup> He also used profanity whenever a group member was "resisting therapy, trying to get out, was lying or directly offensive to [Mr. Appleman]."<sup>[263]</sup>

117. It was Mr. Rusinoff's opinion that the confrontational approach in sex offender treatment:

Is an older approach that developed in the prisons and it involved putting someone in the hot seat and sham[ing] them, degrading them, laying into them, tearing apart their defenses and hopefully bringing the reality of their — what they've done to the forefront of their consciousness in the effort and hope that they won't do it again.<sup>[264]</sup>

Moreover, it was Mr. Rusinoff's opinion that the confrontational approach to sex offender treatment involved the use of profanity by the therapist.<sup>[265]</sup>

118. But it was also Mr. Rusinoff's opinion that the confrontational approach to sex offender treatment "pretty much died out in the middle 1980s" and by the mid-1990s was no longer considered to be consistent with the usual and customary prevailing practice standards of psychologist who treat sex offenders because:

First of all, it was not a professional approach based in any kind of academic research. It was something that happened in prisons originally. And I believe it was originally related to chemical dependency treatment and treatment of other kinds of felony behaviors, people who had anti-personality (sic) disorders went through that kind of therapy. But it was judged or deemed to be abusive and shaming and inappropriate. And I believe it didn't provide appropriate or proper role modeling to clients. And I also think that sex offenders could adapt to it and not really make changes from it because it didn't really treat them how to do things differently that they needed to learn.<sup>[266]</sup>

119. Finally, it was Mr. Rusinoff's opinion that in the mid-1990s the usual and customary prevailing practice standards of psychologists who treat sex offenders was to employ the modeling behavior approach to treatment, which involved:

. . . demonstrat[ing] appropriate behaviors in all aspects of their treatment. And if they want — for example, if a psychologist wants a client to become empathetic, they need to demonstrate it because the client may not know how to. If the therapist or psychologist wants clients to be respectful, then the therapist and psychologist needs to demonstrate that. Otherwise it's hypocritical.<sup>[267]</sup>

120. It was Mr. Appleman's opinion that the practice of using profanity conformed to the usual and customary prevailing practice standards of psychologists who treat sex offenders in the mid-1990s and today. The reasons for that opinion were:

The use of swearing and profanity is generally considered unprofessional conduct in treating most patients. However, as one who treats sex offenders whose vocabulary often, is limited to profanity, it is an appropriate method of communication, as long as it is not emotionally abusive. The use of profanity was used extensively at Nexus, which is a treatment center for convicted felons. Respondent also worked for Alpha Human Services, where profanity was used. Profanity was used as a method of emphasis. It was never used to demean pedophiles or other sex offenders. . . . [U]se of profanity is often confrontational, appropriate and effective methodology in treating pedophiles.<sup>[268]</sup>

**Charge of threatening sex offender clients with revocation of probation (Claim OF-19)**

121. Mr. Appleman occasionally tells his sex offender clients that they will go to prison or jail if they do not complete treatment when they appear resistant to treatment

or when Mr. Appleman wants to motivate them to participate more intensely in treatment.<sup>[269]</sup>

122. In Mr. Rusinoff's opinion, unless a therapist has developed a strong therapeutic relationship with a sex offender client, making progress in persuading the client to give up deviant behavior is difficult.<sup>[270]</sup> It was also his opinion that therapists inherently have a large power differential over their sex offender clients because of the regular communications the latter have with the courts that sentence the offenders. And therapists are able to exploit sex offender clients relatively easily if they wish to do so.<sup>[271]</sup>

**Charge of providing services to Client #20 that were neither reasonable nor necessary.<sup>[272]</sup> (Claim 20-13)**

123. In deciding Mr. Appleman's claim for reimbursement from a workers' compensation insurer for services provided to Client #20, a workers' compensation judge found on April 23, 1995, that "the psychological services provided by Mr. Michael Appleman, M.A., were . . . not reasonable nor necessary to cure and/or relieve the employee's work-related conditions."<sup>[273]</sup>

**Charge of Taking Inadequate History from Client #3<sup>[274]</sup> (Claim 3-10)**

124. On January 24, 1994, Mr. Appleman's assessed Client #3's symptoms as reflecting "Depression, Post-Traumatic Stress Disorder, Somatoform Pain Disorder, and possibly a Closed Head Injury secondary to and precipitated by the motor vehicle accident."<sup>[275]</sup> In the raw notes of Client #3's first session, Mr. Appleman notes : "Prior Tx – none."<sup>[276]</sup> In reviewing a Closed Head Injury Symptom Checklist with Mr. Appleman, Client #3 indicated that increased use of alcohol had been more severe since the accident.<sup>[277]</sup> And in completing Item 31 on the Sentence Completion that Mr. Appleman administered to Client #3 on the same date, Client #3 responded, " I feel happiest when drinking."<sup>[278]</sup>

125. In response to a question of whether Dr. Cohen had an "opinion whether the documentation concerning the history of Client Number 3 meets or met the minimum community standards of acceptable and prevailing practice in the early to mid-1990s," Dr. Cohen gave the following opinions, among others:

While he notes that on a closed-head injury checklist that the client's alcohol use has increased apparently since the time of the accident, there is no record into further inquiry into what that means, and so there is contained in the written report something which says essentially the client has increased alcohol use, but no attempted explanation as to whether that use is now abuse or detrimental to the client or whether it reflects a truly significant deviation from an already elucidated behavior or problem behavior.

\* \* \*

Once again, Mr. Appleman records that the client did not receive prior psychotherapy without trying to explicate whether that indicates any of kind of previous mental illness.<sup>[279]</sup>

### **Charge of Taking Inadequate History from Client #6 (Claims 6-3 and 6-10)**

126. On December 11, 1995, Client #6 was in a motor-vehicle accident. Mr. Appleman first saw her on February 21, 1996. At that time he found that she was reporting symptoms of depression, panic attacks, memory impairment, a suicide attempt, and nightmares. He concluded that all that all those symptoms were occurring as the result of her car accident,<sup>[280]</sup> and he made the following diagnosis, "Secondary to and precipitated by the motor-vehicle accident, [Client #6] is experiencing Depression, Post-Traumatic Stress Disorder, with Panic Attacks as well as the possibility of a Closed Head Injury."<sup>[281]</sup> His progress note for that first session noted that the client had received four sessions of psychotherapy two years ago "from which she completely recovered."<sup>[282]</sup> There was also a note to himself to rule out chemical dependency.<sup>[283]</sup>

127. In a session with Client #6 on February 22, 1996, Mr. Appleman documented that Client #6 had reported nightmares that "involved aliens, blood, ghosts." He then quoted Client #6 as saying "I have dreams of my friend that kill [myself]. I looked at him at the funeral. . . . I try to stop him from killing himself. I feel that I should have stopped [him]. . . . He shot himself in the mouth."<sup>[284]</sup>

128. On May 11, 1996, Mr. Appleman referred Client #6 to an emergency room and recommended admission to the psychiatric unit because Client #6 was "experiencing racing thoughts, including dramatic feelings of fear, and panic attacks."<sup>[285]</sup> Mr. Appleman's records for client #6 contain the hospital History and Physical Exam report dated May 12, 1996, which documents history provided by client #6, including the following:

[Client #6] presents her current symptoms as being related to a number of prominent psychological stressors that have occurred over the past year. She was married one year ago and one month after the marriage, the couple's best friend suicided. At about the same time, her husband appeared to have changed completely and then he started using drugs and becoming abusive towards her. The abuse consisted of physical abuse, sexual abuse and emotional abuse. He called her employers and said things that led [sic] the employers to fire her. . . . Every time she became tearful thinking about the best man's suicide, he attributed this to the fact that they had a sexual relationship. . . . [Her husband] has threatened to kill her on several occasions and she has a restraining order against him. . . . She has insomnia and unusual dreams . . . She describes a number of obsessional thoughts that have been present for at least the past 8-9 years. As an example, she said that she has become obsessed with John F. Kennedy's assassination. She has collected pictures of Lee Harvey Oswald and has pictures all over the walls of her room. . . . She has a compulsive behavior that consists of placing her

hands over the nape of her neck in order to prevent someone from coming up behind her and 'cutting my throat.'<sup>[286]</sup>

129. In response to the question of whether Dr. Cohen had an "opinion whether the documentation concerning the history of Client Number 6 meets or met the minimum community standards of acceptable and prevailing practice in the early to mid-1990s," Dr. Cohen gave the following opinions, among others:

\* \* \* I think in this case the history is quite significantly deficient. There is in Mr. Appleman's report a brief history of education, vocational, and I believe the mention that the client was married, and that she had been married for a year and now separated, that is in his report.

However, in reports -- in other reports generated relatively shortly thereafter there is other significant history which has been missed, including significant previous depression, significant abuse in her marriage by her husband from whom she was then separated, and the suicide of a very close friend of this client's within the year prior to Mr. Appleman's seeing her.

These are all extremely important things that would certainly affect one's diagnosis and treatment plan for the client and which are unaccounted for. In examining Mr. Appleman's raw data, he only notes on previous psychological or psychiatric history two years ago -- that two years ago the patient had four sessions for which -- or I think it's from which she completely recovered.

There is no medical history, no other history of the friend's suicide or things like that, and I think this reads -- it leads rather graphically to misinterpretation of the client's symptoms. \* \* \*

[Mr. Appleman's report notes] "Flashbacks and nightmares consistent with PTSD may be inferred. Nightmares about aliens, blood and ghosts. Patient had dreams -- has dreams of killing herself. Patient has had one suicide attempt since the MVA." Now, those are good observations, and I think the problem is the making of the inference that these nightmares or flashbacks are related solely to the motor vehicle accident. Indeed when you consider this women as having been abused and when you consider the death of a very close friend, in one report it's named as a best friend, that you would certainly expect that those two things together would have contributed to this, and the fact that there is no history of that is certainly an extreme limitation of those.<sup>[287]</sup>

### **Charge of Taking Inadequate History from Client #8<sup>[288]</sup> (Claim 8/9-1.1)**

130. On December 31, 1990, fourteen-year-old Client #8 was a passenger in a car driven by her mother, Client #9, when they were both involved in an automobile

accident. Mr. Appleman first evaluated Client #8 on July 24, 1991, when he diagnosed her as having:

1. Post-Traumatic Stress Disorder.
2. Adjustment reaction with depressed mood.
3. Rule out depression.
4. Rule out Organic Brain Syndrome (Mild Closed-Head Injury).<sup>[289]</sup>

131. On February 10, 1992, Mr. Appleman filed a complaint against Client #8's insurer with the Minnesota Department of Commerce. In making that complaint, he stated that the services that he had provided to Client #8 were:

. . . necessary as a result of a car accident that occurred on December 31, 1999. [Client #8] has suffered extensive extensive (sic) physical as well as psychological injuries, precipitated by and secondary to the accident. [Client #8] has only been treated for Post-Traumatic Stress Disorder from the accident.<sup>[290]</sup>

132. The information that Mr. Appleman received from others concerning Client #8 included the following:

- a. Client #8 was in foster care when Mr. Appleman first saw her.<sup>[291]</sup>
- b. Client #8 was the alleged victim in a Sexual Abuse Report filed on January 3, 1990, by the Renville County Human Service and Welfare Department.<sup>[292]</sup>
- c. On April 20, 1990, a psychologist evaluated Client #8 after she had run away from a temporary foster home. The examining psychologist's Axis diagnosis was Adjustment Disorder with disturbance of conduct.<sup>[293]</sup>
- d. On August 30, 1990, a statutorily mandated reporter filed three Suspected Child Abuse reports identifying Client #8 as the victim of physical abuse by her mother and of sexual abuse by a certain males.<sup>[294]</sup>

133. In response to a question of whether Dr. Cohen had an "opinion whether the documentation concerning the history of Client Number 8 meets or met the minimum community standards of acceptable and prevailing practice in the early to mid-1990s," Dr. Cohen answered that, "It does not meet those standards."<sup>[295]</sup> Thereafter, he was asked the following question and gave the following opinion in response:

Q. Where does the history recorded in Mr. Appleman's records deviate from minimum community standards of acceptable and prevailing practice in the early to mid 1990s with regard to Client Number 8?

A. Sadly, Client 8 has a long and extremely difficult history of physical, sexual and emotional abuse. She had a history of running away

from her mother's home and from a group home in which she was placed and had been placed in a foster home.

In Mr. Appleman's section entitled findings, there is no such history of the client's extremely important and significant meaningful past. There is — I think this is particularly important because in this case Mr. Appleman by the time he saw Client 8 had been seeing the mother of this client for approximately three months, and so he had I would imagine ample opportunity to gain some information on the mother — from the mother about Client #8.

\* \* \*

So he's clearly had an opportunity to talk to the mother about Client 8 and had not elicited any of this information and does not use it in any way later in the report in interpreting the results of his testing and his assessment.<sup>[296]</sup>

134. Mr. Appleman gave three reasons why additional history on Client #8 would have been unavailing. First, he indicated that Client #8 was referred to him because she was having "profound" difficulty riding in cars. A second reason was that he "was not competent in the area of assessment and treatment of sexual abuse," and the third was that other therapists were then treating Client #8 to help her deal with sexual abuse issues.<sup>[297]</sup>

135. It was Dr. Wohl's opinion that the fact that Mr. Appleman's records for Client #8 do not contain any follow-up history on Client #8's background does not necessarily mean that Mr. Appleman did not obtain any follow-up information.<sup>[298]</sup>

### **Charges of substandard documentation (general considerations)**

136. The American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct*<sup>[299]</sup> contain the following ethical standards relating to documentation of psychology services:

#### **1.23 Documentation of Professional and Scientific Work**

(a) Psychologists appropriately document their professional and scientific work in order to facilitate provision of services later by them or by other professionals, to ensure accountability, and to meet other requirements of institutions or the law.

(b) When psychologists have reason to believe that records of their professional services will be used in legal proceedings involving recipients of or participants in their work, they have a responsibility to create and maintain documentation in the kind of detail and quality that would be consistent with reasonable scrutiny in an adjudicative forum.

#### **1.24 Records and Data**

Psychologists create, maintain, disseminate, store, retain, and dispose of records and data relating to their research, practice, and other

work in accordance with law and in a manner that permits compliance with requirements of this Ethic Code.

### **1.25 Accuracy in Reports to Payors and Funding Sources**

In their reports to payors for services or sources of research funding, psychologists accurately state the nature of the research or service provided, the fees or charges, and where applicable, the identity of the provider, the findings, and the diagnosis.

137. Dr. Cohen stated that he was familiar with “the minimum standard of acceptable and prevailing practice in the State of Minnesota . . . in the early to mid 1990s” regarding the nature and extent of documentation necessary for each individual therapy session that a psychologist had with a client.<sup>[300]</sup>

138. It was Dr. Cohen’s opinion that:

a. There was and is no difference in the standards of documentation for a Ph.D. psychologist and a Master’s level psychologist.<sup>[301]</sup>

b. The purpose of documentation by psychologists is:

to provide a permanent and accurate record of all that's taken place, both in terms of whatever assessments you have done with a client, or in the case of therapy, the treatment you have done with the client, and so that you have a record available to yourself and so other practitioners who see the record are able to determine what has been going on, what you have done and what is to be done.<sup>[302]</sup>

c. The term “continuity of care” means “being able to, between various practitioners, to understand the plans of those practitioners and to be able to integrate that care in an appropriate fashion.”<sup>[303]</sup>

d. Usual and customary prevailing practice involved obtaining the following information during the initial interview: (1) accurate statistical information about the client; (2) early life history that included cultural background, educational history, and the occurrence of any traumatic events during early life; (3) further schooling and vocational history as an adult; (4) psychosocial history of adult years; (5) fully documented medical history; (6) accurate history of psychological evaluation and treatment; and (7) client’s view of the goals for seeking psychological assistance.<sup>[304]</sup> A psychological evaluation report that lacks that information fails to conform to usual and customary prevailing standards.<sup>[305]</sup>

e. Where a client has experienced trauma, it is critical for a psychologist to estimate premorbid condition as accurately as possible.<sup>[306]</sup>

f. Usual and customary prevailing practice required documentation for each individual therapy session of the date of service, the service provided, and some description of the content of the therapeutic session. [\[307\]](#)

g. Usual and customary prevailing practice required documentation for each group therapy session of each individual's presence in the group, the date the length of time of the session, and some description of the content of what went on during the session. Usual and customary prevailing practice also required that each client have a specific note in his or her chart, even if it is only a copy of a group note or a note which contains the names of several clients. [\[308\]](#)

h. Concerning psychometric testing, usual and customary prevailing practice required documenting

the name of the test, the score for the test, some interpretation as to the meaning of that score usually in conjunction with other tests administered at the same time, and then any reservations or limitations you may have about the conditions of testing or the meaning of the test score.

\* \* \*

There was a requirement that you had to state whether or not you thought the testing provided an accurate representation of the client's ability or mood or whatever was being tested at that time. There is also a community standard that says it is the assumption the tests were administered under standardized normal conditions unless specifically described otherwise, and that means if there was any variance or variance from that condition that that would be reported. [\[309\]](#)

\* \* \*

[T]here is the absolute community standard that if you administer a test to an individual that you name the test in your interpretation and discuss what the results and your interpretation of those results are. [\[310\]](#)

i. There is no difference in the information that usual and customary prevailing practice requires psychologists to report with reference to normal and abnormal test results. Rather, it is important for psychologists "to report full information for both kinds of tests." [\[311\]](#)

j. concerning treatment plans, usual and customary prevailing practice required:

. . . a type of treatment or treatments, there are often many different kinds of treatment, anticipated length of treatment, and treatment goals, specific often objectifiable treatment goals that you were working towards, and often, though not always, short-term

intermediate goals that were steps upon the path of longer-term treatment goals.<sup>[312]</sup>

Practice standards required that all of those general categories be addressed in a psychologist's records and reports.<sup>[313]</sup>

k. concerning billing for office visits, usual and customary prevailing practice standards required that a psychologist have some documentation for each visit billed, and that it did not conform to usual and customary prevailing practice standards to bill for office visits that did not occur.<sup>[314]</sup>

l. concerning billing for testing, usual and customary prevailing practice standards required that a test be complete and the psychologist score the test, where applicable, before the psychologist bills for administering the test.<sup>[315]</sup>

m. The standards about which Dr. Cohen gave opinions were not aspirational, but rather were commonly accepted by the community of psychologists in Minnesota during the early 1990s.<sup>[316]</sup>

139. In 1992 and 1993, Dr. Wohl was Secretary of the Ohio Board of Psychology, the licensing authority for psychologists in that state.<sup>[317]</sup> It was his opinion that in establishing practice standards, all psychology licensing authorities rely on such common sources like the APA's ethical standards,<sup>[318]</sup> so he considers himself familiar with what the standards of usual and customary prevailing practice in the State of Minnesota were in the early to mid 1990s.

140. It was Dr. Wohl's opinion that:

a. concerning usual and customary prevailing practice standards generally,

The state rules and regulations are intended "to provide an idealized setting in a sense because actual practice of psychology may be different and be under different constraints and different rules. \* \* \* [Y]ou do consider them. You have to meet their requirements, but at the same time your actual functioning is being governed by a whole set of other rules."<sup>[319]</sup>

b. With regard to general standards of documentation, there is no "type of protocol or national requirement that's been issued by any national group as a standard for psychologists in what their records should consist of."<sup>[320]</sup> There is no official document of any national organizations, no general guideline as such that specifies what should be in an evaluation or plan of treatment.<sup>[321]</sup>

c. There is no agreement within the field about what psychological documentation should contain. So,

psychologists have not gone into detail about the nature and length of documents. Although we agree they're valuable and needed. We also agree that flexibly they can be modified according to who was interested in them or wants them.<sup>[322]</sup>

However, a distinction can be made between documentation of research and documentation of clinical practice:

If a psychologist were doing research there would be a research protocol developed which he would have to follow or explain why he didn't follow it. In the case of clinical practice, there are so many variables involved that frequently the victory belongs to the more skillful, that is, how you can best approach and utilize your techniques to answer the problems at hand or else to work towards certain goals that you might set down for yourself. There are just so many things to consider so that any rigid set of rules and applications is counter-productive.<sup>[323]</sup>

d. There is no rigid formula for determining what to record as a client's history.<sup>[324]</sup>

e. Concerning documentation of test interpretations, Dr. Wohl finds "that very appropriate to flexibly pick and choose from among parts of tests and incorporate them into my clinical overview. So the presence or absence of something in the absence of any other information about the patient doesn't mean very much to me."<sup>[325]</sup>

f. With regard to treatment plans, "each case requires a different plan and treatment."<sup>[326]</sup>

141. Mr. Appleman expressed the following opinion about what the usual and customary prevailing practice is for documentation by psychologists:

The general standard of record keeping is that one should have all correspondence and all relevant material in one's file, in particular material that relates to the client's treatment, and that that is the basis for the ability from one therapist to communicate to another therapist or another therapist to communicate to the court. However, that does not replace in many instances the oral communication between therapists, the oral communication between counsel, the oral communication between the court. You cannot apply rigid standards. One has to be practical and take a look at the type of practice that one has and be realistic as to record keeping.

In my case, I have produced 10,000 documents for the Board of which maybe 50 to 100 items are either missing, inaccurate or in some way not in the file, and I recognize that could -- the record keeping could have been better, but my files are being torn apart by my office manager

on a regular basis. For one or two or three or four documents to be missing is not, I think, below the standards of practice. If you don't have anything in your records or notes when you do take of clinical instance, that would be below standards.<sup>[327]</sup>

### **Charge of substandard documentation of Client #1's history (Claim 1-5)**

142. Neither the raw progress notes of Mr. Appleman's first appointment with Client #1 on November 15, 1993, nor the psychological evaluation report of Client #1 that Mr. Appleman prepared on the same date contain a family history, a history of family dynamics, a medical history, a history of medication use, a chemical dependency assessment, an assessment of school background, a psychosocial history, or a systematic evaluation of psychological status.<sup>[328]</sup>

143. It was Dr. Cohen's opinion that the history that Mr. Appleman recorded for Client #1 did not meet minimum community standards of acceptable and prevailing practice in the early to mid-1990s because it lacked the information described in Finding of Fact No. 142, above.<sup>[329]</sup> Dr. Wohl gave no specific opinions about whether or not the history for Client #1 met any standards. And it was Mr. Appleman's opinion that he only had to note history about Client #1 that related to the referral question and what Mr. Appleman felt Client #1 needed for treatment.<sup>[330]</sup>

### **Charge of substandard documentation of Client #2's history (Claim 2-2)**

144. On November 1, 1993, Client #2 was involved in an automobile accident in which she sustained back and neck injuries. She was driving the automobile in which Client #1 was a passenger, and Client #1 referred Client #2 to Mr. Appleman for evaluation and treatment.<sup>[331]</sup> Mr. Appleman first saw Client #2 nearly ten months later on August 23, 1994. At that time he assessed her, administered a number of psychological tests and recorded the following diagnostic impression:

1. Post-Traumatic Stress Disorder Severe, DSM IV 309.87
2. Adjustment Reaction With Physical Complaints, DSM IV 309.892
3. Somatoform Pain Disorder, DSM IV 307.80
4. Rule Out Brain Damage (Organic Brain Syndrome), DSM IV 310.10<sup>[332]</sup>

145. Mr. Appleman's psychological evaluation report of Client #2 dated August 23, 1994, indicated: "Patient has no prior history of psychological treatment. No pre-existing conditions may be inferred."<sup>[333]</sup> In fact, Client #2 had a pre-existing anxiety condition that Mr. Appleman failed to document.<sup>[334]</sup>

146. Neither the raw progress notes of Mr. Appleman's first appointment with Client #2 on August 23, 1994, nor his psychological evaluation report of the same date contain any previous mental health history, medical history, social history, family history, or discussion of past or present psychosocial stressors in Client #2's life.<sup>[335]</sup>

147. It was Dr. Cohen's opinion that the history that Mr. Appleman recorded for Client #2 did not meet minimum community standards of acceptable and prevailing practice in the early to mid-1990s because it failed to document Client #2's pre-existing anxiety condition and because it lacked the other information described in Finding of Fact No. 146, above.<sup>[336]</sup> Neither Dr. Wohl nor Mr. Appleman gave specific opinions about whether or not the history for Client #2 met any standards.

#### **Charge of substandard documentation of Client #3's history<sup>[337]</sup> (Claim 3-5)**

148. Neither the raw progress notes of Mr. Appleman's first appointment with Client #3 on January 25, 1994, nor his psychological evaluation report of the same date contain any educational history, family history, prior medical history, prior mental health history of prior accidents or injuries, or psychosocial history.<sup>[338]</sup> Additionally, although Client #3 reported that his "increased use of alcohol had been more severe" since the accident,<sup>[339]</sup> Mr. Appleman failed to document Client #3's pre-existing use of alcohol or information about whether the increased alcohol was detrimental or rose to the level of abuse.

149. It was Dr. Cohen's opinion that the history that Mr. Appleman recorded for Client #3 did not meet minimum community standards of acceptable and prevailing practice in the early to mid-1990s because it lacked the other information described in Finding of Fact No. 148, above.<sup>[340]</sup> Dr. Wohl did not give any specific opinions about whether or not the history for Client #3 met any standards. Mr. Appleman stated that he dictated Client #3's history in his presence and relied on the client to correct any inaccurate history information.<sup>[341]</sup>

#### **Charge of substandard documentation of Client #4's history (Claim 4-6)**

150. On March 24, 1994, Client #4 was involved in an automobile accident. Mr. Appleman first saw and evaluated her on October 5, 1994. Mr. Appleman's report of that evaluation stated that "[Client #4] was referred by [a chiropractor] because of severe Post-Traumatic Stress Disorder and severe Panic Attacks, secondary to and precipitated by the motor-vehicle accident of March 24, 1994."<sup>[342]</sup>

151. Neither the raw progress notes of Mr. Appleman's first appointment with Client #4 on October 5, 1994, nor his psychological evaluation report of the same date contain any medical history and only a limited psychosocial history. Neither do they contain any reference to another automobile accident that occurred in December 1988.<sup>[343]</sup>

152. On November 9, 1994, another psychologist, Dr. Beth Harrington, performed a psychological evaluation of Client #4. On November 17, 1994, she sent a copy of her psychological evaluation report to Mr. Appleman. The report stated that before the March 24, 1994, accident: "[Client #4] had been seeing [a chiropractor] for a previous car accident suffered in December of 1988, once every five weeks."<sup>[344]</sup>

153. It was Dr. Cohen's opinion that the history that Mr. Appleman recorded for Client #4 did not meet minimum community standards of acceptable and prevailing

practice in the early to mid-1990s because it lacked the information described in Finding of Fact No. 151, above.<sup>[345]</sup> Dr. Wohl did not give any specific opinions about whether or not the history for Client #4 met any standards. Mr. Appleman stated that the reason he did not document Client #4's medical history was that he relied on her family practitioner, who had made the referral, for that.<sup>[346]</sup>

### **Charge of substandard documentation of Client #5's history<sup>[347]</sup> (Claim 5-3)**

154. Neither the raw progress notes of Mr. Appleman's first appointment with Client #5 on June 14, 1996, nor his psychological evaluation report of the same date contain any medical history, psychological history, or educational history and only a brief social and vocational history. Neither do they contain any reference to Client #5's diabetes.<sup>[348]</sup>

155. It was Dr. Cohen's opinion that the history that Mr. Appleman recorded for Client #5 did not meet minimum community standards of acceptable and prevailing practice in the early to mid-1990s because it lacked the information described in Finding of Fact No. 154, above.<sup>[349]</sup> Dr. Wohl did not give any specific opinions about whether or not the history for Client #5 met any standards. Mr. Appleman stated that he did not document Client #5's diabetes because Client #5 did not report that condition when asked about his medical history.<sup>[350]</sup>

### **Charges of substandard documentation of Client #8's history<sup>[351]</sup> (Claims 8/9-1 and 8/9-11)**

156. Mr. Appleman's psychological evaluation report of Client #8 on July 24, 1991, did not contain any discussion of Client #8's history of physical, sexual, and emotional abuse, including the information described in Finding of Fact No. 132, above.<sup>[352]</sup>

157. It was Dr. Cohen's opinion that the history that Mr. Appleman recorded for Client #8 did not meet minimum community standards of acceptable and prevailing practice in the early to mid-1990s because it lacked the information described in Finding of Fact No. 156, above.<sup>[353]</sup>

158. Dr. Wohl noted the absence of information relating to Client #8's history of physical, sexual, and emotional abuse in Mr. Appleman's report, but stated that did not necessarily mean Mr. Appleman had failed to elicit or consider that information. Mr. Appleman testified that there were two reasons why he did not attempt to obtain more information about abuse from Client #8 herself. First, he was not proficient in assessing and treating sexual abuse cases, and, second, he did not want to interfere with the treatment of other therapist who were treating Client #8 for sex abuse.<sup>[354]</sup>

### **Charge of substandard documentation of Client #20's history<sup>[355]</sup> (Claim 20-9)**

159. On or about July 22, 1994, Mr. Appleman prepared a psychological evaluation of Client #20.<sup>[356]</sup> Mr. Appleman noted that Client #20 had sustained three work-related injuries, and that his "[e]valuation and treatment was indicated as an adjunct to treatment and to facilitate the therapeutic process."<sup>[357]</sup>

160. Mr. Appleman's psychological evaluation report of Client #20 on July 22, 1994, did not contain any discussion of Client #20's history of family psychosocial dynamics, and the medical history only covered his three work-related injuries. Moreover, there was only a very brief psychological history which indicated that

“[p]atient has no prior history of psychological problems, no pre-existing emotional difficulties may be inferred.”<sup>[358]</sup> The raw notes of Mr. Appleman’s July 22, 1994, evaluation indicate that Client #20 had no prior outpatient psychotherapy.<sup>[359]</sup> On the other hand, Mr. Appleman also reported that “[p]atient had participated in the chronic pain program at Abbott-Northwestern.”<sup>[360]</sup>

161. The pain clinic at Abbott-Northwestern Hospital has an extensive psychological component, and every participant has an assigned psychotherapist.<sup>[361]</sup>

162. It was Dr. Cohen’s opinion that the history that Mr. Appleman recorded for Client #20 did not meet minimum community standards of acceptable and prevailing practice in the early to mid-1990s because it lacked any discussion of Client #20’s history of family psychosocial dynamics, its medical history only covered his three work-related injuries, and it contained inaccurate information about Client #20’s psychological history.<sup>[362]</sup>

**Charge of failing to document interpretations of tests administered to Client 1 (Claim 1-6)**

163. In his psychological evaluation report on Client #1 of November 15, 1993, Mr. Appleman reported the following as “TESTS USED:”

WAIS-R (Weschler Adult Intelligence Scale Revised); Bender-Gestalt; House-Tree-Person; Wide-Range Achievement Test; Trails A & B (Neuropsychological Screening Test); Sentence Completion; Beck’s Depression Inventory; Goldberg’s Stress Test; . . . <sup>[363]</sup>

164. In that November 15, 1993, report on Client #1, Mr. Appleman recorded no written interpretations by name of the Bender-Gestalt test, House-Tree-Person test, Wide-Range Achievement Test, Beck’s Depression Inventory, and Goldberg Stress Test. <sup>[364]</sup>

165. It was Dr. Cohen’s opinion that Mr. Appleman’s failure to record written interpretations of the tests described in Finding of Fact No. 164, above, failed to conform to community standards for psychological testing and interpretation in the mid 1990s and early 1990s. <sup>[365]</sup> Neither Mr. Appleman nor Dr. Wohl specifically addressed the absence of written interpretations for those tests.

**Charge of failing to document interpretations of tests administered to Client 2 (Claim 2-6)**

166. In his psychological evaluation report on Client #2 of August 23, 1994, Mr. Appleman reported the following as “TESTS USED:”

WAIS-R (Weschler Adult Intelligence Scale Revised); Bender-Gestalt; House-Tree-Person; Wide-Range Achievement Test; Trails A & B (Neuropsychological Screening Test); Sentence Completion; Goldberg’s Stress Inventory; Beck’s Depression Scale;. . . <sup>[366]</sup>

167. In that August 23, 1994, report on Client #2, Mr. Appleman recorded no written interpretations by name of the Bender-Gestalt test, House-Tree-Person test, Wide-Range Achievement Test, Sentence Completion Test, Beck’s Depression Inventory, and Goldberg Stress Test. <sup>[367]</sup>

168. It was Dr. Cohen’s opinion that Mr. Appleman’s failure to record written interpretations of the tests described in Finding of Fact No. 167, above, failed to conform to community standards for psychological testing and interpretation in the mid 1990s and early 1990s. <sup>[368]</sup> Dr. Wohl did not specifically address the absence of written interpretations for those tests. It was Mr. Appleman’s opinion that his written diagnoses reflected the test results, and that those diagnoses were sufficient written test interpretations. <sup>[369]</sup>

**Charge of failing to document interpretations of tests administered to Client 3 (Claim 3-3)**

169. In his psychological evaluation report on Client #3 of January 25, 1994, Mr. Appleman reported the following as “TESTS USED:”

WAIS-R (Weschler Adult Intelligence Scale Revised); Bender-Gestalt; House-Tree-Person; Wide-Range Achievement Test; Trails A & B (Neuropsychological Screening Test); Sentence Completion; . . . Goldberg’s Stress Test; and Beck’s Depression Scale; . . .<sup>[370]</sup>

170. In that January 25, 1994, report on Client #3, Mr. Appleman recorded no written interpretations by name of the House-Tree-Person test, Wide-Range Achievement Test, Sentence Completion Test, Goldberg Stress Test and Beck’s Depression Scale.<sup>[371]</sup>

171. Dr. Cohen not give a specific opinion on the absence in Mr. Appleman’s report on Client #3 of interpretations of the tests described in Finding of Fact No. 170, above. But it was Dr. Cohen’s general opinion that there was

the absolute community standard that if you administer a test to an individual that you name the test in your interpretation and discuss what the results and your interpretation of those results are.<sup>[372]</sup>

Dr. Wohl did not specifically address the absence of written interpretations for those tests. It was Mr. Appleman’s opinion that the findings in the body of his report reflected the test results, even though those tests were not mentioned by name.<sup>[373]</sup>

#### **Charge of failing to document interpretations of tests administered to Client 4 (Claim 4-7)**

172. In his psychological evaluation report on Client #4 of October 5, 1994, Mr. Appleman reported the following as “TESTS USED:”

WAIS-R (Weschler Adult Intelligence Scale Revised); Bender-Gestalt; House-Tree-Person; Wide-Range Achievement Test; Trails A & B (Neuropsychological Screening Test); Sentence Completion; Beck’s Depression Inventory; Goldberg’s Stress Test; . . .<sup>[374]</sup>

173. In that October 5, 1994, report on Client #4, Mr. Appleman recorded no written interpretations by name of the House-Tree-Person test, Wide-Range Achievement Test, Sentence Completion Test, Goldberg Stress Test and Beck’s Depression Scale.<sup>[375]</sup>

174. It was Dr. Cohen’s opinion that Mr. Appleman’s failure to record written interpretations of the tests described in Finding of Fact No. 173, above, failed to conform to community standards for psychological testing and interpretation in the mid 1990s and early 1990s.<sup>[376]</sup> Dr. Wohl did not specifically address the absence of written interpretations for those tests. Mr. Appleman suggests that the findings in the body of his report reflected the test results, even though those tests were not mentioned by name.<sup>[377]</sup>

**Charge of failing to document interpretations of tests administered to Client 6 (Claim 6-6)**

175. In his psychological evaluation report on Client #6 of February 21, 1996, Mr. Appleman reported the following as “TESTS USED:”

WAIS-R (Weschler Adult Intelligence Scale Revised); Bender-Gestalt; House-Tree-Person; Wide-Range Achievement Test; Trails A & B (Neuropsychological Screening Test); Sentence Completion; Beck’s Depression Inventory; Goldberg’s Stress Test;. . . [\[378\]](#)

176. In that February 21, 1996, report on Client #6, Mr. Appleman recorded no written interpretations by name of the WRAT and the Goldberg Stress Test. [\[379\]](#)

177. It was Dr. Cohen’s opinion that Mr. Appleman’s failure to record written interpretations of the tests described in Finding of Fact No. 176, above, failed to conform to community standards for psychological testing and interpretation in the mid 1990s and early 1990s. [\[380\]](#) Dr. Wohl did not specifically address the absence of written interpretations for those tests. Mr. Appleman suggests that the findings in the body of his report reflected the test results, even though those tests were not mentioned by name. [\[381\]](#)

**Charge of failing to document interpretations of tests administered to Client 20 (Claim 20-10)**

178. In his psychological evaluation report on Client #20 of July 22, 1994, Mr. Appleman reported the following as “TESTS USED:”

WAIS-R (Weschler Adult Intelligence Scale Revised); Bender-Gestalt; House-Tree-Person; Wide-Range Achievement Test; Trails A & B (Neuropsychological Screening Test); Sentence Completion; Beck’s Depression Inventory; Goldberg’s Stress Test;. . . [\[382\]](#)

179. In that July 22, 1994, report on Client #20, Mr. Appleman recorded no written interpretations by name of the Bender-Gestalt test, Wide-Range Achievement Test, and Goldberg Stress Test. [\[383\]](#)

180. It was Dr. Cohen’s opinion that Mr. Appleman’s failure to record written interpretations of the tests described in Finding of Fact No. 182, above, failed to conform to community standards for psychological testing and interpretation in the mid 1990s and early 1990s. [\[384\]](#) Neither Dr. Wohl nor Mr. Appleman specifically addressed the absence of written interpretations for those tests.

**Charge of failing to document interpretations of tests administered to Client 21 [\[385\]](#) (Claim 21-1)**

181. It was Dr. Cohen’s opinion that Mr. Appleman’s failure to issue a report with written interpretations of the Beck’s Depression Inventory and Sentence

Completion Test that he administered to Client #21 failed to conform to community standards for psychological testing and interpretation in the mid 1990s and early 1990s.<sup>[386]</sup> Neither Dr. Wohl nor Mr. Appleman specifically addressed the absence of written interpretations for those tests.

**Charges of failing to maintain test protocols for Clients #7, #8, #9, and #20<sup>[387]</sup>  
(Claims 7-3, 8/9-3, and 20-11)**

182. On or about April 22, 1992, while conducting a psychological evaluation of Client #7, Mr. Appleman administered to him the House-Tree-Person and the Sentence Completion tests.<sup>[388]</sup> Thereafter, Mr. Appleman failed to keep the protocols for those two tests in Client #7's file.<sup>[389]</sup>

183. It was Dr. Cohen's opinion that Mr. Appleman's failure to maintain the test protocols for the House-Tree-Person and the Sentence Completion tests in Client #7's file failed to conform to minimum standards of acceptable and prevailing practice in the early to mid-1990s for documentation of psychometric testing.<sup>[390]</sup> Mr. Appleman did not think it was "excellent practice" to have protocols missing from his client files.<sup>[391]</sup>

184. On or about July 24, 1991, while conducting a psychological evaluation of Client #8, Mr. Appleman administered to her the House-Tree-Person and the Sentence Completion tests.<sup>[392]</sup> Thereafter, Mr. Appleman failed to keep the protocols for those two tests in Client #8's file.<sup>[393]</sup>

185. It was Dr. Cohen's opinion that Mr. Appleman's failure to maintain the test protocols for the House-Tree-Person and the Sentence Completion tests in Client #8's file failed to conform to minimum standards of acceptable and prevailing practice in the early to mid-1990s for documentation of psychometric testing.<sup>[394]</sup> Mr. Appleman was unaware of whether or not those two test protocols were missing from his files for Client #8.<sup>[395]</sup>

186. On or about April 23 and 27, 1991, while conducting psychological evaluations of Client #9, Mr. Appleman administered psychological testing to her.<sup>[396]</sup> In his psychological evaluation report of Client #9, he did not identify the psychological tests that he had administered to her on those two dates.<sup>[397]</sup> But he did identify the following tests as having been administered to Client #9 in a subsequent health insurance claim submitted to Client #8's insurer:

1. WAIS-R (1Hr) or WISC-R (1 Hr)
2. SENTENCE COMPLETION AND FAMILY DRAWING (1 Hr)
3. BENDER GESTALT (1/2 Hr)
4. HOUSE-TREE-PERSON (1/2 Hr)
5. WIDE RANGE ACHIEVEMENT TEST (1/2 Hr)
6. GRAY ORAL READING TEST (1/2 Hr) or MMPI (1/2 Hr)<sup>[398]</sup>

187. After he tested Client #9 on April 23 and 27, 1991, Mr. Appleman failed to keep in her file the protocols for the tests that he had administered to her.<sup>[399]</sup>

188. It was Dr. Cohen's opinion that Mr. Appleman's failure to maintain the protocols for the tests that had administered to Client #9 in her file failed to conform to minimum standards of acceptable and prevailing practice in the early to mid-1990s for documentation of psychometric testing.<sup>[400]</sup> Mr. Appleman was unaware of whether or not those two test protocols were missing from his files for Client #9.<sup>[401]</sup>

189. On or about July 22, 1994, while conducting a psychological evaluation of Client #20, Mr. Appleman administered to him the Wide-Range Achievement Test, among others.<sup>[402]</sup> Thereafter, Mr. Appleman failed to keep the protocols for that test in Client #20's file.<sup>[403]</sup>

190. It was Dr. Cohen's opinion that Mr. Appleman's failure to maintain the test protocols for the Wide-Range Achievement Test in Client #20's file failed to conform to minimum standards of acceptable and prevailing practice in the early to mid-1990s for documentation of psychometric testing.<sup>[404]</sup> Mr. Appleman did not express an opinion about the absence of that test protocol from Client #20's file.

#### **Charge of failing to report an incomplete test<sup>[405]</sup> (Claim 4-9)**

191. Mr. Appleman's psychological evaluation report of Client #4 states that he administered the House-Tree-Person Test to that client.<sup>[406]</sup> The protocols for that test in Client #4's record—that is, the three pieces of paper instructing the client to draw pictures of a house, a tree and a person—are blank except for the printed instructions.<sup>[407]</sup> Mr. Appleman's psychological evaluation report of Client #4 contains no report or explanation of the blank House-Tree-Person test protocol.<sup>[408]</sup>

192. Mr. Appleman attempted to administer the House-Tree-Person Test to Client #4, but the protocol is blank because Client #4 was too depressed to finish it.<sup>[409]</sup>

193. It was Dr. Cohen's opinion that Mr. Appleman's failure to include in his report of Client #4 an explanation of the blank House-Tree-Person Test protocol failed to conform to minimum standards of acceptable and prevailing practice in the early to mid-1990s for documentation of psychometric testing.<sup>[410]</sup> It was Dr. Cohen's further opinion that if a client refused a test or did not complete it, prevailing practice standards required a notation to that effect and a brief explanation of why the test was refused or not completed.<sup>[411]</sup>

#### **Charge of failing to note appropriate reservations and qualification about Client #5's test results<sup>[412]</sup> (Claim 5-9)**

194. In the psychological evaluation report that Mr. Appleman prepared for Client #5 on June 13, 1996, his diagnostic impressions were that "[Client #5] reflects symptoms of a closed Head Injury and Depression, secondary to and precipitated by the motor-vehicle accident."<sup>[413]</sup> And in interpreting Client #5's Trails A and B tests, Mr. Appleman stated:

Trails A and B (Neuropsychological Screening Test) strongly suggest organic brain damage. Patient could not follow the directions to complete Trails A nor (sic) B. <sup>[414]</sup>

195. It was Dr. Cohen's opinion that Mr. Appleman's failure to include in that report reservations or qualifications about the validity of Client #5's test results did not conform to minimum standards of acceptable and prevailing practice in the early to mid-1990s for documentation of psychometric testing, because, among other things:

a. Mr. Appleman did not discuss in his report how Client #5's cultural background may have influenced the results of the performance section of the WAIS. <sup>[415]</sup>

b. Mr. Appleman did not discuss in his report how Client #5's cultural background and minimal English proficiency may have influenced the results of the Beck's Depression Inventory, nor how using Client #5's son to translate changed the standardization of the administration of that test. <sup>[416]</sup>

c. Mr. Appleman did not discuss in his report how Client #5's cultural background and minimal English proficiency may have influenced the results of the performance section of the Sentence Completion Test, nor how using Client #5's son to translate changed the standardization of the administration of that test. <sup>[417]</sup>

d. Mr. Appleman did not discuss in his report how administering the reading recognition part of the Wide Range Achievement Test, which consists of English words, influence the results of that test, since Client #5 was not proficient in English. <sup>[418]</sup>

196. It was Mr. Appleman's opinion that he was able to communicate adequately with Client #5 during testing. <sup>[419]</sup>

### **Charge of failing to report only partial administration of the WRAT (General Claim-2)**

197. In his psychological evaluation reports for Clients #1, #2, #3, #4, #5, #6, #8, and #20, <sup>[420]</sup> Mr. Appleman reported administering the Wide Range Achievement Test (WRAT) to those ten clients. <sup>[421]</sup> Rather than administering the entire test, which consists of multiple parts, to those clients, Mr. Appleman only administered the reading part of the WRAT. <sup>[422]</sup>

198. It was Dr. Cohen's opinion that:

I think that it's also the case and it's the common practice, the standard practice in the community, that if you administer only a part of a test, that is contained in the information and the report as well. I think it's below

community standard to administer just one of the subtests to write you administered the entire test.<sup>[423]</sup>

199. Mr. Appleman did not express an opinion on the community standard for reporting administration of only one of several subtests. Rather, he expressed his belief that it was unnecessary to do so.<sup>[424]</sup>

**Charge<sup>[425]</sup> of failing to provide adequate support for professional judgments about Client #4<sup>[426]</sup> (Claim 4-5)**

200. Client #4 was involved in an automobile accident on March 24, 1994. She first saw Mr. Appleman about six months later on October 5, 1994, when he conducted an evaluation and administered a number of psychological tests.<sup>[427]</sup> In his psychological evaluation report of the same date, Mr. Appleman recorded the following Axis I diagnostic impressions for Client #4:

1. Panic Attacks, secondary to Motor Vehicle Accident, DSM IV - 300.01
2. Post-Traumatic Stress Disorder, Severe, DSM IV 309.89
3. Major Depression, DSM IV - 296.3
4. Closed Head Injury (Provisional), DSM IV - 310.10<sup>[428]</sup>

The report further stated that “[t]his was one of the most severe cases of Panic Attacks, which I have seen in several years.”<sup>[429]</sup>

201. Mr. Appleman’s evaluation report included written test interpretations in his report for the WAIS-R, Bender-Gestalt test, and the Trails A and B tests.<sup>[430]</sup> It did not include written test interpretations for the House-Tree-Person test, the WRAT, the Sentence Completion Test, the Beck’s Depression Inventory, and the Goldberg’s Stress Test.<sup>[431]</sup> There were completed protocols for the WAIS-R, the Sentence Completion Test, the Beck’s Depression Inventory, and the Goldberg’s Stress Test,<sup>[432]</sup> but no protocols or raw data in the file for the WRAT, Bender-Gestalt, and Trails A and B tests.<sup>[433]</sup> The protocol for the House-Tree-Person test was blank because Client #4 was too depressed to complete the test.<sup>[434]</sup>

202. No expert opinion testimony was presented by either party on this charge.<sup>[435]</sup>

**Charge of substandard documentation of other potential causes for Client #6’s diagnoses<sup>[436]</sup> (Claim 6-2)**

203. On April 1, 1996, Mr. Appleman’s colleague, Dr. Beth Harrington, performed a psychological evaluation of Client #6 “to evaluate psychiatric symptoms.”<sup>[437]</sup> Mr. Appleman’s records for Client #6 contain a Psychological Evaluation report by Dr. Harrington, dated April 26, 1996. Client history information elicited by Dr. Harrington and documented in her report includes the following:

a. Client #6 separated from her husband two days after the car accident and “described the relationship as emotionally and physically abusive.”<sup>[438]</sup>

b. Client #6 used marijuana since high school and last used one month before Dr. Harrington’s evaluation.<sup>[439]</sup>

c. Client #6 reported a family history of alcoholism and a family history of manic depression.<sup>[440]</sup>

d. Client #6 “recalls being depressed in the 10th grade though did not receive professional help.”<sup>[441]</sup>

e. Client #6’s medical history includes asthma since childhood for which she uses an inhaler and laser surgery for endometriosis and an ovarian cyst.<sup>[442]</sup>

### **Charges of substandard documentation of treatment plans (general considerations)**

204. In addition to expressing opinions about Mr. Appleman’s treatment plans for individual clients, Dr. Cohen provided some more general opinions about what the usual and customary prevailing standards of practice were for the content of treatment plans:

a. Prevailing and acceptable community standards for psychological documentation, require, among other things:

. . . [a] treatment plan, usually with very specific goals. I prefer to write both short and long-term goals. I have seen other people write a goal section, and typically that involves specific recommendations and referrals and the like.<sup>[443]</sup>

b. Minimal community standards of acceptable and prevailing practice in the mid-1990s required psychologists to place the following information into treatment plans for their clients:

My opinion of the community standard was that you would have a type of treatment or treatments, there are often many different kinds of treatment, anticipated length of treatment, and treatment goals, specific often objectifiable treatment goals that you were working towards, and often, though not always, short-term intermediate goals that were steps upon the path of longer-term treatment goals.

It was Dr. Cohen’s further general opinion that if those particular general categories were not addressed in a psychologist’s records or reports, that would have deviated from practice standards.<sup>[444]</sup>

c. And concerning documenting frequency and duration of treatment, it was Dr. Cohen's opinion,

that there is a treatment plan that includes what you're going to do as in individual psychotherapy and then say one hour per week, anticipated duration of treatment is say six months, one year, whatever it is, with some representation of goals of therapy.<sup>[445]</sup>

205. Dr. Wohl also provided some more general opinions about what the usual and customary prevailing standards of practice were for the content of treatment plans:

a. There are no official documents issued by national organizations, such as the American Psychological Association that specify that psychologists should have a plan of treatment, but teaching institutions may teach that having one is desirable.<sup>[446]</sup>

b. Concerning the specificity of treatment plans:

I would have to say consistent with what I've said in the past, that each case requires a different plan and treatment. \* \* \* But I do reiterate the fact that you do not rigidly have to follow the same format in evaluating every patient. Much of it depends on what you have available and your other knowledge that's available to you and to others.<sup>[447]</sup>

c. Concerning the frequency of preparing or revising clients' treatment plans:

Well, treatment plans certainly serve a purpose. They may serve a purpose in that they provide a guidance or a certain directionality for what you do or where you are going or what sort of approaches you're using that will best showcase a certain pattern or set of facts. So I'm not directly arguing against treatment plans. But, again, . . . whether they need to show up in every single session of the progress notes is another thing. I think that's counter-productive and it doesn't help anything. It's just merely repetition for the sake of repetition.<sup>[448]</sup>

d. Dr. Wohl did not provide any opinions about whether Mr. Appleman's treatment plans for the clients at issue in this proceeding met usual and customary prevailing standards.

206. In testimony, Mr. Appleman did not provide any general opinions about usual and customary prevailing practice standards for preparing and documenting treatment plans. He also did not provide any opinions about whether his own treatment plans for the clients at issue in this proceeding met usual and customary prevailing standards. But he did offer some more general opinions about his own treatment planning in an earlier affidavit and in a pre-hearing deposition:

a. It was Mr. Appleman's opinion that he did complete written treatment plans for all of the clients covered by this proceeding, and that his initial treatment plan was the psychological evaluation report that he prepared following his initial interview and testing of a client:

[A] treatment plan consists of symptoms, prognosis, discussion of medication, discussion of treatment frequency, and the type of treatment. \* \* \* This criteria is found in psychological evaluations.<sup>[449]</sup>

A treatment plan is comprised of statements of clinical symptoms and a method to control or diminish those clinical symptoms. Respondent, as a matter of protocol and consistent practice, completes a treatment plan in the form of a psychological evaluation. The psychological evaluation involved a diagnostic interview of the patient to determine a history and career problems, and a list of other stressors that have contributed to the patient's problems.

The second part of the treatment plan, or psychological evaluation, is administering and interpreting the tests. The Respondent typically gives an IQ test, reading test, brain damage screening test, and other personality tests.<sup>[450]</sup>

## **Charges of inadequate documentation of treatment plans (Claims 1-14, 2-9, 3-11, 4-8, 5-10, and 6-9)**

207. Mr. Appleman's treatment Plan for Client #1 is contained in the psychological evaluation report that he prepared for Client #1 on November 15, 1993.<sup>[451]</sup> That treatment plan does not discuss frequency of psychotherapy, duration of psychotherapy, goals of psychotherapy, or method of psychotherapy.<sup>[452]</sup>

208. It was Dr. Cohen's opinion that Mr. Appleman's treatment plan for Client #1 failed to meet prevailing practice standards because it fails to address frequency and duration of psychotherapy and goals.<sup>[453]</sup>

209. Mr. Appleman's treatment plan for Client #2 is contained in the psychological evaluation report that he prepared for Client #2 on August 23, 1994.<sup>[454]</sup> That treatment plan does not discuss whether proposed therapy is individual or group, the length of therapy sessions, the duration of psychotherapy, goals of psychotherapy, or referral of Client #2 for neuropsychological assessment.<sup>[455]</sup>

210. It was Dr. Cohen's opinion that Mr. Appleman's treatment plan for Client #2 failed to meet prevailing practice standards because it fails to address whether proposed therapy is individual or group, the length of therapy sessions, the duration of psychotherapy, goals of psychotherapy, or referral of Client #2 for neuropsychological assessment.<sup>[456]</sup>

211. Mr. Appleman's treatment plan for Client #3 is contained in the psychological evaluation report that he prepared for Client #3 on January 25, 1994.<sup>[457]</sup> That treatment plan does not discuss, among other things, a complete description of what treatment is planned, what goals are intended and when those goals are likely to be reached.<sup>[458]</sup>

212. It was Dr. Cohen's opinion that Mr. Appleman's treatment plan for Client #3 failed to meet prevailing practice standards because it fails to "include certainly enough to understand completely what treatment is planned, what goals are intended and when those goal (sic) might be expected to be reached."<sup>[459]</sup>

213. Mr. Appleman's treatment plan for Client #4 is contained in the psychological evaluation report that he prepared for Client #4 on October 5, 1994.<sup>[460]</sup> That treatment plan does not discuss, among other things, frequency or duration of treatment or intermediate or long-term goals.<sup>[461]</sup>

214. It was Dr. Cohen's opinion that Mr. Appleman's treatment plan for Client #4 failed to meet prevailing practice standards because it fails to "include several necessary elements, such as specific time of modality, anticipated length of treatment and both intermediate and long-term goals."<sup>[462]</sup>

215. Mr. Appleman's treatment plan for Client #5 is contained in the psychological evaluation report that he prepared for Client #5 on June 13, 1996.<sup>[463]</sup> That treatment plan does not discuss the frequency and length of psychotherapy

sessions, duration of psychotherapy, and short and long-term treatment goals or referral to a therapist who was familiar with Client #5's culture and proficient in his native language.<sup>[464]</sup>

216. It was Dr. Cohen's opinion that Mr. Appleman's treatment plan for Client #5 failed to meet prevailing practice standards because it fails to include a discussion of the frequency and length of psychotherapy sessions, duration of psychotherapy, and short and long-term treatment goals. There was also no plan for referral to a therapist who was familiar with Client #5's culture and proficient in his native language.<sup>[465]</sup>

217. Mr. Appleman's treatment plan for Client #6 is contained in the psychological evaluation report that he prepared for Client #6 on February 21, 1996.<sup>[466]</sup> That treatment plan does not discuss the frequency and length of psychotherapy sessions, duration of psychotherapy, and treatment goals.<sup>[467]</sup> A portion of an MMPI-2 Clinical Interpretive Report on Client #6, which Mr. Appleman received from an outside vendor, comprises part of his treatment plan for Client #6.<sup>[468]</sup> That document contains suggestions about the kinds of therapeutic interventions that Mr. Appleman might attempt with that client. It does not discuss the frequency and length of treatment, duration of treatment, or treatment goals.

218. It was Dr. Cohen's opinion that Mr. Appleman's treatment plan for Client #6 failed to meet prevailing practice standards because it fails to include a discussion of the frequency and length of psychotherapy sessions, duration of psychotherapy, and treatment goals.<sup>[469]</sup>

### **Charges of substandard documentation of sex offender treatment plans (Claim OF-1)**

219. Mr. Rusinoff provided the following opinions about prevailing practice standards in the mid-1990s for documenting treatment plans for sex offender clients:

a. Concerning the community standard for preparing individual, written treatment plans for sex offenders:

My opinion is that a treatment plan should be its own document that outline [sic] what are the problems, what are the problems and/or diagnosis, what are the methods to deal with it, what modality will be used. Some kind of estimated time length which obviously can change because the information that comes out during the therapy changes the treatment sometimes. And I believe that treatment plans need to be signed by the client so that you have evidence that the client understands it and that the psychologist has presented it to the client.<sup>[470]</sup>

b. And concerning the prevailing practice standards for the documenting other matters in a written sex offender treatment plans:

The main goal [of sex offender treatment] is to reduce as much as possible the likelihood of the offender reoffending overall. That's basically what it's about with sex offender treatment. The goals that would be delineated on a treatment plan might be things like producing — well, taking responsibility for the offense, discussing the offense or offenses, figuring out for the person why they offended in the first place. Coming up with a — I call it a reoffense prevention plan that would document all the things I just said. Depending on the offenders, this is why an individual treatment plan would be necessary because each individual offender is different. So if the offender has deficits in empathy skills, then that's related to their offending, that would be on the treatment plan to reiterate the deficit in their empathy skills. \* \* \* So in that person's treatment plan the lack of — the deficit in their empathy would be caring about others. That would be document that this person needs to care about others. He needs to learn how to care about others or needs to learn how to respect others even if they don't care about them and needs to deal with their anger in a different way. So often times anger management might be a specific goal. Interpersonal or social skills might be a goal. Intimacy deficits in intimacy skills might be a goal to work on. And then it really depends on the individual because there are other problems.<sup>[471]</sup>

220. Mr. Appleman's opinions about documenting treatment plans for sex offenders did not differ from his opinion about documenting treatment plans for other clients.

221. Neither Mr. Rusinoff nor Mr. Appleman gave specific opinions about whether Mr. Appleman's files for Clients #10, #11, #13, and #15 contained treatment plans that conformed to usual and customary prevailing standards for documenting treatment plans for sex offenders.

222. Client #10 was an adjudicated sex offender referred by the Dakota County District Court to Mr. Appleman for sex offender treatment.<sup>[472]</sup> Mr. Appleman prepared neither a psychological evaluation report for Client #10 nor an individual, written treatment plan signed by both Mr. Appleman and Client #10.<sup>[473]</sup> Nowhere do Mr. Appleman's files for Client #10 contain a statement of treatment goals for Client #10, including goals for addressing empathy deficits, anger management, interpersonal or social skills, intimacy deficits, or addressing any of Client #10's more individual sex offender problems. Nor do his records contain a written statement of the methods he proposes to use to address those issues.

223. Client #11 was an adjudicated sex offender referred by his attorney to Mr. Appleman for sex offender treatment.<sup>[474]</sup> On October 30, 1992, Mr. Appleman prepared a psychological evaluation report for Client #11.<sup>[475]</sup> He did not prepare an individual, written treatment plan signed by both Mr. Appleman and Client #11.<sup>[476]</sup> And nowhere

do Mr. Appleman's files for Client #11 contain a statement of treatment goals for Client #11, including goals for addressing empathy deficits, anger management, interpersonal or social skills, intimacy deficits, or addressing any of Client #11's more individual sex offender problems. Nor do his records contain a written statement of the methods he proposes to use to address those issues.

224. Client #13 was an adjudicated sex offender referred to Mr. Appleman for sex offender treatment.<sup>[477]</sup> On April 17, 1991, Mr. Appleman prepared a psychological evaluation report for Client #13.<sup>[478]</sup> He did not prepare an individual, written treatment plan signed by both Mr. Appleman and Client #13.<sup>[479]</sup> And nowhere do Mr. Appleman's files for Client #13 contain a statement of treatment goals for Client #10, including goals for addressing empathy deficits, anger management, interpersonal or social skills, intimacy deficits, or addressing any of Client #13's more individual sex offender problems. Nor do his records contain a written statement of the methods he proposes to use to address those issues.

225. Client #15 was an adjudicated sex offender referred by the Dakota County District Court to Mr. Appleman for sex offender treatment.<sup>[480]</sup> On January 4, 1993, Mr. Appleman prepared a psychological evaluation report for Client #15.<sup>[481]</sup> He did not prepare an individual, written treatment plan signed by both Mr. Appleman and Client #15.<sup>[482]</sup> And nowhere do Mr. Appleman's files for Client #15 contain a statement of treatment goals for Client #15, including goals for addressing empathy deficits, anger management, interpersonal or social skills, intimacy deficits, or addressing any of Client #15's more individual sex offender problems. Nor do his records contain a written statement of the methods he proposes to use to address those issues.

### **Charge of failing to keep relevant client correspondence (Claim OF-16)**

226. Mr. Appleman failed to keep in the file he maintained for Client #13 copies of six letters that he or Client #13 generated that were relevant to evaluating and treating that client, specifically:

a. A letter dated May 23, 1991, from Mr. Appleman to Client #13's attorney enclosing a copy of Mr. Appleman's psychological evaluation report on Client #13;<sup>[483]</sup>

b. A letter dated August 6, 1991, from Mr. Appleman to Client #13's probation officer enclosing a copy of Mr. Appleman's psychological evaluation report on Client #13, together with a treatment update report;<sup>[484]</sup>

c. A letter dated November 5, 1992, from Mr. Appleman to Client #13's probation officer about safeguards that should be employed when allowing Client #13 to participate in various activities;<sup>[485]</sup>

d. A letter dated December 23, 1992, from Mr. Appleman to Client #13's probation officer summarizing Client #13's treatment issues;<sup>[486]</sup>

e. A letter dated October 12, 1993, from Client #13 to Mr. Appleman stating that Client #13 would no longer be attending Mr. Appleman's sex offender treatment program,<sup>[487]</sup> and

f. A letter dated April 25, 1994, from Mr. Appleman to Client #13's probation officer forwarding a copy of a psychological evaluation report on Client #13 by Dr. Beth Harrington.<sup>[488]</sup>

227. The file that Mr. Appleman maintained for Client #13 contained none of the correspondence described in Finding of Fact No. 226.<sup>[489]</sup>

228. It was Mr. Appleman's opinion that the usual and customary prevailing practice among psychologists relating to file maintenance was that:

[t]he general standard of record keeping is one should have all correspondence and all relevant material in one's file, in particular material that relates to the client's treatment, and that is the basis for the ability from one therapist or another therapist to communicate to the court.<sup>[490]</sup>

### **Charge of maintaining inadequate documentation of services provided to Client #20<sup>[491]</sup> (Claim 20-1)**

229. On or about July 22, 1994, Mr. Appleman prepared a psychological evaluation report on Client #2, that included the following diagnostic impressions:

- Axis I.
1. Somatoform pain disorder, DSM III 307.80
  2. Major Depression, DSM III 296.3<sup>[492]</sup>

And his recommendations for Client #20 were:

1. Referral for antidepressant medication to Dr. Keith Chilgren.
2. Referral to Dr. David Stussy, Chiropractor.
3. Vocational testing.

Coordination of job seeking behavior with treatment for depression, with Tom Saby, QRC. Mr. Saby has been alerted that the depression is currently impairing [Client #20's] functioning. It is hoped that through treatment that his level of functioning will be raised and job seeking behavior will be increased.<sup>[493]</sup>

### **Charges of inadequate documentation to substantiate billings (general considerations)**

230. Dr. Cohen offered the following opinion about practice standards for documenting psychotherapy sessions:

I think the community — I know the community standard for that was the name of the client, the date of the service, the service provided, for example, one hour of individual psychotherapy or an hour and a half of

group psychotherapy, and some description of the content of the therapeutic session.<sup>[494]</sup>

And he also gave an opinion about practice standards for maintaining documentation to substantiate charges billed:

My opinion is it is the community standard that you must have a note, some written documentation, of each visit for which you bill.<sup>[495]</sup>

231. Regarding documentation of sex offender group therapy sessions, Mr. Rusinoff gave the following opinion:

Each and every therapy session that a treatment professional has with a sex offender needs to be documented in a case note in the client file.<sup>[496]</sup>

Mr. Rusinoff did not offer a further opinion about whether usual and customary prevailing practice standards required that documentation to be present before billing for a sex offender therapy session.

232. Mr. Appleman gave the following explanation of how he customarily documented therapy sessions:

Q. Doesn't acceptable and prevailing practice in the State of Minnesota require that you make a chart entry for each time you see a patient?

A. I would support that, but I don't think the rule requires it. I would agree it would be prevailing practice. I think it is a good practice.<sup>[497]</sup>

And it was his further opinion that:

For one or two or three or four records to be missing is not, I think, below standards. If you don't have anything in your records when you do take of clinical instance (sic), that would be below standards.<sup>[498]</sup>

But at the same time, Mr. Appleman conceded that he did not always follow that practice:

At times, I took group notes and made an entry, and at times I did not. Most of the times I did.<sup>[499]</sup>

233. Mr. Klane gave his expert opinion that billing for client therapy sessions for which there were no progress notes does not comport with usual and customary accounting standards.<sup>[500]</sup>

### **Charges of inadequate documentation to substantiate billings for group therapy (Claims 1-10, 3-6, and OF-5)**

234. Mr. Appleman billed Client #1's insurer the following amounts for group therapy provided on the following dates:

12-08-93	\$190.00 <sup>[501]</sup>
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03-05-94	\$250.00 <sup>[502]</sup>
03-19-94	\$250.00 <sup>[503]</sup>
04-09-94	\$250.00 <sup>[504]</sup>
04-27-94	\$250.00 <sup>[505]</sup>
05-10-94	\$250.00 <sup>[506]</sup>
05-25-94	\$250.00 <sup>[507]</sup>
06-01-94	\$250.00 <sup>[508]</sup>

235. Mr. Appleman prepared and maintained a set of group therapy notes for his accident and trauma group.<sup>[509]</sup> In preparing group notes, Mr. Appleman normally recorded the names of the group members attending a session.<sup>[510]</sup>

236. Between December 8, 1993, and June 1, 1994, Client #1 was a member of Mr. Appleman's accident and trauma group. But Mr. Appleman's group notes for the dates indicated in Finding of Fact No. 234 do not list Client #1 as having attended those group sessions.<sup>[511]</sup>

237. Mr. Appleman billed Client #1's insurer the following amounts for group therapy that he provided on the following dates:

11-17-93	\$190.00 <sup>[512]</sup>
01-29-94	\$225.00 <sup>[513]</sup>
03-12-94	\$250.00 <sup>[514]</sup>
04-28-94	\$215.00 <sup>[515]</sup>

238. The notes for Mr. Appleman's accident and trauma group contain no group notes for the dates specified in Finding of Fact No. 237.<sup>[516]</sup>

239. Mr. Appleman billed Client #3's insurer the following amounts for group therapy provided on the following dates:

01-29-94	\$250.00 <sup>[517]</sup>
02-05-94	\$200.00 <sup>[518]</sup>
02-11-94	\$200.00 <sup>[519]</sup>
03-05-94	\$250.00 <sup>[520]</sup>

240. Between January 29, 1994, and March 5, 1994, Client #3 was a member of Mr. Appleman's accident and trauma group.

241. The notes for Mr. Appleman's accident and trauma group contain no group notes for January 29, February 5, and February 11, 1994.<sup>[521]</sup> Also, Mr. Appleman's group notes for March 5, 1994, do not list Client #3 as having attended that group session.<sup>[522]</sup>

242. Mr. Appleman billed Client #11's insurer \$380.00 for group therapy provided on January 1, 1993.<sup>[523]</sup> Mr. Appleman's files for Client #11 contain no group notes or other documentation for that therapy session.<sup>[524]</sup>

243. Mr. Appleman billed Client #13's insurer a total \$1,580.00 for fifteen group therapy sessions provided between March 30, 1992, and February 4, 1995.<sup>[525]</sup> Mr. Appleman's files for Client #13 contain no group notes or other documentation for any of those therapy sessions.<sup>[526]</sup>

244. Mr. Appleman billed Client #14's insurer a total \$1,120.00 for fourteen group therapy sessions provided between July 13, 1992, and February 2, 1995.<sup>[527]</sup> Mr. Appleman's files for Client #14 contain no group notes or other documentation for any of those therapy sessions.<sup>[528]</sup>

245. Mr. Appleman billed Client #15's insurer a total \$10,758.00 for forty group therapy sessions provided between January 11, 1993, and January 27, 1994.<sup>[529]</sup> Mr. Appleman's files for Client #15 contain no group notes or other documentation for any of those therapy sessions.<sup>[530]</sup>

246. Mr. Appleman billed Client #16's insurer a total \$1,557.50 for seven group therapy sessions provided between November 18, 1993, and January 27, 1994.<sup>[531]</sup> Mr. Appleman's files for Client #16 contain no group notes or other documentation for any of those therapy sessions.<sup>[532]</sup>

### **Charges of inadequate documentation to substantiate billings for individual therapy (Claims 1-11, OF-5, 20-6, and 21-5)**

247. Mr. Appleman billed Client #1's insurer \$200.00 each for individual psychotherapy sessions on February 4 and 10, 1995.<sup>[533]</sup> But Mr. Appleman's progress notes for Client #1 end on January 6, 1995,<sup>[534]</sup> and his records contain no progress notes for Client #1 on February 4 and 10, 1995.<sup>[535]</sup>

248. Mr. Appleman billed Client #11's insurer \$1,385.00 for seven individual therapy sessions from October 31, 1992, to January 26, 1993.<sup>[536]</sup> Mr. Appleman's files for Client #11 contain no progress notes or other documentation for those individual therapy sessions.<sup>[537]</sup>

249. Mr. Appleman billed Client #12's insurer \$187.50 for an individual therapy session on January 16, 1993.<sup>[538]</sup> Mr. Appleman's files for Client #12 contain no progress note or other documentation for that individual therapy session.<sup>[539]</sup>

250. Mr. Appleman billed Client #13's insurer a total \$2,890.00 for thirty-one individual therapy sessions provided between February 14, 1992, and January 14, 1995.<sup>[540]</sup> Mr. Appleman's files for Client #13 contain no progress notes or other documentation for any of those individual therapy sessions.<sup>[541]</sup>

251. Mr. Appleman billed Client #14's insurer a total \$2,295.00 for twenty-one individual therapy sessions provided between April 25, 1992, and January 5, 1995.<sup>[542]</sup>

Mr. Appleman's files for Client #14 contain no progress notes or other documentation for any of those individual therapy sessions.<sup>[543]</sup>

252. Mr. Appleman billed Client #15's insurer a total \$2,322.50 for thirteen individual therapy sessions provided between January 14, 1993, and January 26, 1994.<sup>[544]</sup> Mr. Appleman's files for Client #15 contain no group notes or other documentation for any of those therapy sessions.<sup>[545]</sup>

253. Mr. Appleman billed Client #20's insurer \$200.00 for an individual therapy session on August 9, 1994.<sup>[546]</sup> Mr. Appleman's billing summaries for Client #20 indicate the date of service is August 8, 1994.<sup>[547]</sup> Mr. Appleman's files for Client #20 contain no progress note or other documentation for an individual therapy session on either August 8 or 9, 1994.<sup>[548]</sup>

254. Mr. Appleman billed Client #21's insurer \$300.00 for an individual therapy session on September 13, 1995.<sup>[549]</sup> But Mr. Appleman saw Client #21 for the third and last time on September 6, 1995.<sup>[550]</sup>

### **Charge of inadequate documentation to substantiate billings for family therapy (Claim OF-6)**

255. Mr. Appleman billed the insurer for Client #15, #16, #17, #18, and #19, who were all family members, \$142.50 for each of those clients for a family therapy session on December 22, 1993.<sup>[551]</sup> Mr. Appleman's files for Client #15, #16, #17, #18, and #19, contain no progress notes or other documentation for that family therapy session.<sup>[552]</sup>

### **Charge of maintaining inaccurate billing information for Client #20 (Claim 20-5)<sup>[553]</sup>**

256. On January 3, 1995, Mr. Appleman prepared a billing summary for Client #20's account.<sup>[554]</sup> That billing summary contained charges for administering the Campbell's Interest and Career Assessments on July 25, 1994.

257. It was Dr. Cohen's opinion that billing for tests that were not completed or scored fails to meet minimal community standards of accepted and prevailing practice for psychologists in the mid-1990s.<sup>[555]</sup>

### **Other findings**

258. These Findings are based on all of the evidence in the record. Citations to portions of the record are not intended to be exclusive references.

259. The Memorandum that follows both amplifies and explains the reasons for these Findings, and, to that extent, the Administrative Law Judge incorporates that Memorandum into these Findings.

260. The Administrative Law Judge adopts as Findings any Conclusions, which are more appropriately described as Findings.

Based upon the Findings of Fact, the Administrative Law Judge makes the following:

## CONCLUSIONS

1. Minnesota law<sup>[556]</sup> give the Administrative Law Judge and the Board authority to conduct this contested case proceeding to consider whether Mr. Appleman has violated provisions of the Psychology Practice Act<sup>[557]</sup> or licensure rules duly adopted by the Board,<sup>[558]</sup> and to make findings, conclusions, and either recommendations or orders on those subjects, as the case may be.

2. The Committee gave Mr. Appleman proper and timely notice of the hearing in this matter, and the Committee has complied with all of Minnesota law's substantive and procedural requirements for maintaining this proceeding.

3. The Committee has the burden of proof in this proceeding and must establish the facts at issue by a preponderance of the evidence.<sup>[559]</sup>

4. The Psychology Practice Act provides, in part,<sup>[560]</sup> that:

(b) If grounds for disciplinary action exist under paragraph (a), the board may take one or more of the following actions:

(1) refuse to grant or renew a license;

(2) revoke a license;

(3) suspend a license;

(4) impose limitations or conditions on a licensee's practice of psychology, including, but not limited to, limiting the scope of practice to designated competencies, imposing retraining or rehabilitation requirements, requiring the licensee to practice under supervision, or conditioning continued practice on the demonstration of knowledge or skill by appropriate examination or other review of skill and competence;

(5) censure or reprimand the licensee;

(6) refuse to permit an applicant to take the licensure examination or refuse to release an applicant's examination grade if the board finds that it is in the public interest; or

(7) impose a civil penalty not exceeding \$5,000 for each separate violation. The amount of the penalty shall be fixed so as to deprive the applicant or licensee of any economic advantage gained by reason of the violation charged, or to discourage repeated violations.

(c) In lieu of or in addition to paragraph (b), the board may require, as a condition of continued licensure, termination of suspension,

reinstatement of license, examination, or release of examination grades, that the applicant or licensee:

(1) submit to a quality review, as specified by the board, of the applicant's or licensee's ability, skills, or quality of work; and

(2) complete to the satisfaction of the board educational courses specified by the board.

(d) Service of the order is effective if the order is served on the applicant, licensee, or counsel of record personally or by mail to the most recent address provided to the board for the licensee, applicant, or counsel of record. The order shall state the reasons for the entry of the order.

5. The Psychology Practice Act further provides that the following acts or omissions, among others, are grounds for discipline.<sup>[561]</sup>

**Subd. 2. Grounds for disciplinary action; forms of disciplinary action.** (a) The board may impose disciplinary action as described in paragraph (b) against an applicant or licensee whom the board, by a preponderance of the evidence, determines:

(1) has violated a statute, rule, or order that the board issued or is empowered to enforce;

(2) has engaged in fraudulent, deceptive, or dishonest conduct, whether or not the conduct relates to the practice of psychology, that adversely affects the person's ability or fitness to practice psychology;

(3) has engaged in unprofessional conduct or any other conduct which has the potential for causing harm to the public, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice without actual injury having to be established;

\* \* \* \* \*

6. In addition statutory grounds for disciplinary action, the Board has duly adopted Rules of Conduct that also govern the professional behavior and practices of persons licensed to practice psychology in the State of Minnesota.<sup>[562]</sup> Among those rules of conduct is one that prohibits psychologists from engaging in unprofessional conduct:

A psychologist must not engage in any unprofessional conduct. Unprofessional conduct is any conduct violating parts 7200.4600 to 7200.5600 or violating those standards of professional behavior that have become established by consensus of the expert opinion of psychologists as reasonably necessary for the protection of the public interest.<sup>[563]</sup>

7. For purposes of Minnesota Statutes, section 148.941, subdivision 2(a)(3) and Minnesota Rules, part 7200.5700 , the term “unprofessional conduct” is defined in the same way in which the Minnesota Supreme Court defined it in *Reyburn v. Minnesota State Bd. of Optometry*,<sup>[564]</sup> namely:

'Unprofessional conduct' is conduct which violates those standards of professional behavior which through professional experience have become established, by the consensus of the expert opinion of the members, as reasonably necessary for the protection of the public interest. In establishing the necessity for and the existence of such standards, every member of the profession should be regarded as an expert.

\* \* \* There is a moral dereliction in failure by any member of a profession to apply in professional practice the standards which, by consensus of opinion in the profession, are necessary.

What constitutes unprofessional conduct by an optometrist may be determined by those standards which are commonly accepted by those practicing the profession in the same territory.<sup>[565]</sup>

8. The charges that the Committee is asserting against Mr. Appleman in this proceeding are summarily described in Appendix I to this report, which is hereby incorporated by reference into these Conclusions. The particular paragraphs in the Notice of Hearing where each of the charges in Appendix I are more specifically alleged, if at all, are identified by appropriate references in Part III of the Memorandum that follows. Wherever appropriate, those paragraphs of the Notice of Hearing are also incorporated by reference into these Conclusions.

9. The Board has already granted summary disposition in the Committee’s favor of the following charges that are identified in Appendix I:

Claim 7-5	Claim 8/9-7	Claim 8/9-8
Claim OF-2	Claim OF-3	Claim OF-7
Claim OF-8	Claim OF-12	Claim OF-13
Claim OF-14	Claim 20-7	Claim 22-1
Claim 23-1		

10. The Committee has withdrawn the following charges that are identified on Appendix I, and the Board should therefore dismiss them:

Claim 1-3	Claim 1-8	Claim 1-9
Claim 1-12	Claim 2-1	Claim 2-4
Claim 2-5	Claim 3-1	Claim 3-2
Claim 3-7	Claim 4-1	Claim 4-4

Claim 5-1	Claim 5-2	Claim 5-4
Claim 5-7	Claim 6-1	Claim 6-4
Claim 6-5	Claim 6-7	Claim 7-1
Claim 7-2	Claim 7-6	Claim 8/9-2
Claim 8/9-5	Claim 8/9-6	Claim 8/9-9
Claim 8/9-10	Claim OF-4	Claim 20-3
Claim 20-4		

11. Principles of due process of law preclude the Board from considering charges or allegations of which Mr. Appleman did not receive fair notice in the Notice of Hearing or an amendment thereof made in accordance with the rules governing contested case proceedings.<sup>[566]</sup> The test of adequacy of notice of a charge is whether the Committee's failure to disclose the facts underlying a particular charge would have prohibited Mr. Appleman from effectively responding to that charge.<sup>[567]</sup>

12. Mr. Appleman did not receive fair and adequate notice in the Notice of Hearing or an amendment thereof of the following claims that the Committee is asserting against him, and the Board should therefore them:

Claim 1-15	Claim 1-16	Claim 2-3
Claim 2-8	Claim 3-8	Claim 3-9
Claim 4-10	Claim 5-6	Claim 5-11 <sup>[568]</sup>
Claim 7-4	Claim 7-7	Claim 7-8
Claim 7-9	Claim 8/9-4	Claim OF-15
Claim 21-2	Claim 21-4	General Claim-1

13. The Board has not previously established as the law of this case the proposition that the prohibition in Minn. Stat. § 148.98(a) and in Minn. R. pt. 7200.5700 against "unprofessional conduct" by psychologists does not extend to substandard documentation practices.<sup>[569]</sup> Rather, the ALJ concludes that both the legislature and the Board intended that the term "unprofessional conduct" include documentation practices by psychologists that fail to meet usual and customary prevailing standards of professional practice by psychologists in Minnesota.<sup>[570]</sup>

14. For the reasons stated in the Memorandum that follows,<sup>[571]</sup> the doctrine of collateral estoppel does not preclude Mr. Appleman from litigating the issues raised in Claims 20-1, 20-8, and 20-13.

15. For the reasons stated in the Memorandum that follows,<sup>[572]</sup> Claim 20-2 fails to allege a violation of the Psychology Practice Act or the Board's licensing rules, and that claim should therefore be dismissed.

16. With regard to Claim 1-13, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated a licensing statute or rule by submitting altered documents to an insurance company in order to obtain reimbursement.

17. With regard to Claim 1-13.1, the Committee established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rule, part 7200.4900, subpart 1a, on four occasions between November 23, 1993, and October 3, 1994, by transmitting inaccurate progress notes to Client #1's insurer in the course of seeking reimbursement for services provided to Client #1. The Committee also established by a preponderance of the evidence that Mr. Appleman failed to conform to the usual and customary prevailing standards of professional practice and behavior<sup>[573]</sup> for by subsequently altering or amending Client #1's progress notes without specifically noting the subsequent amendments or alterations and providing explanations for those amendments or alterations. Mr. Appleman therefore violated the provisions in statute and rule prohibiting psychologists from engaging in unprofessional conduct.<sup>[574]</sup>

18. In all subsequent Conclusion, whenever the ALJ concludes that the Committee has established by a preponderance of the evidence that Mr. Appleman has failed to conform to usual and customary prevailing standards of practice or behavior, the ALJ hereby incorporates the further conclusion that Mr. Appleman has therefore committed unprofessional conduct in violation of Minnesota Statutes § 148.98(a) and Minnesota Rules pt. 7200.5700.

19. With regard to Claim OF-17, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated a Board rule<sup>[575]</sup> by engaging in conduct harmful or potentially harmful to Client #15 by writing false statements about Client #15 in a letter to his probation officer and in a report to the Board.

20. With regard to Claim OF-20, the Committee established by a preponderance of the evidence that Mr. Appleman made false and misleading statements about Client #11 either to a probation officer or to the Board and therefore violated a Board rule by engaging in "conduct likely to deceive or defraud the public or the board."<sup>[576]</sup>

21. With regard to Claim 20-8, the Committee established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules, part 7200.5200, subpart 3, by billing a workers' compensation insurer for vocational testing for Client #20 that was never completed or interpreted.

22. With regard to Claim 3-4, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated Minnesota Statutes, section 148.975, by failing to provide warnings concerning Client #3's responses to the Sentence Completion Test and other similar remarks made during therapy. Moreover, the Committee also failed to establish by a preponderance of the evidence that Mr. Appleman failed to conform to the usual and customary prevailing standards of professional practice and behavior by failing to make a written assessment of what

Client #3 had verbalized and by failing to explain in writing why he did not consider those expressions to be specific, serious threats.

23. With regard to General Claim-3, the Committee established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules, part 7200.5000, subpart 1, by using and billing for the Goldberg's Stress Test in his practice, since it is a psychological test that lacks a manual or other published information which fully describes the development of the test, the rationale for the test, the validity and reliability of the test, and normative data. Additionally, the Committee also established by a preponderance of the evidence that Mr. Appleman's use of the Goldberg's Stress Test failed to conform to the usual and customary prevailing standards of professional practice.

24. With regard to Claim OF-11, the Committee established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules, part 7200.4900, subp. 9, by failing to coordinate Client #10 services with a new provider when Mr. Appleman did not forward to that provider with all of Client #10's chemical dependency assessment and testing records and also when Mr. Appleman attempted to mislead that provider by stating that he had not administered any tests to Client #10.

25. With regard to Claim OF-10, the Committee established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules, part 7200.4700, subpart 1, and part 7200.4900, subpart 1a, by releasing private information about Client #15 to that client's attorney, his probation officer, and to at least three other therapists, without having any written consents to release or while having only expired releases on file in that client's records.

26. With regard to Claim 1-1, the Committee established by a preponderance of the evidence that in diagnosing Client #1 with Post-Traumatic Stress Syndrome (PTSD),<sup>[577]</sup> Mr. Appleman failed to conform to usual and customary standards of professional practice and behavior by failing to provide in his Psychological Evaluation Report dated December 9, 1993, an explanation of why he had made that diagnosis when Client #1 did not meet all of the diagnostic criteria contained in DSM-III-R for PTSD. The Committee also established by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of professional behavior when he sought reimbursement from a third-party payor for that diagnosis without offering such an explanation. Mr. Appleman therefore violated the provisions in statute and rule prohibiting psychologists from engaging in unprofessional conduct.<sup>[578]</sup>

27. With regard to Claims 1-2 and 1-4, the Committee established by a preponderance of the evidence that Mr. Appleman's diagnosis of Client #1 as having somatoform pain disorder failed to conform to usual and customary prevailing standards of professional practice.

28. With regard to Claim 8/9-1, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of professional practice and behavior when he

concluded that Client #9's post-traumatic stress disorder was caused by an automobile accident on December 31, 1990. <sup>[579]</sup>

29. With regard to Claim 1-7, the Committee established by a preponderance of the evidence that Mr. Appleman did make a written interpretation of Client #1's MMPI, and that the interpretation he made failed to conform to the usual and customary prevailing standards of professional practice. The Committee also established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules, part 7200.5000, subpart 3C, by failing to make a written notation in Client #1's records that the results of the MMPI conflicted with his diagnosis of depression.

30. With regard to Claim 2-7, the Committee established by a preponderance of the evidence that Mr. Appleman's written interpretations of Client #2's WAIS-R and Trails A and B tests failed to conform to the usual and customary prevailing standards of professional practice.

31. With regard to Claim 4-3, the Committee established by a preponderance of the evidence that Mr. Appleman's written interpretations of Client #4's WAIS-R test failed to conform to the usual and customary prevailing standards of professional practice.

32. With regard to Claim 5-5, the Committee established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules, part 7200.5000, subpart 3B, by failing to include in his report of tests administered to Client #5 several significant factors relating to the conditions under which that testing was carried out that were likely to affect the validity or reliability of the conclusions that Mr. Appleman formulated from that testing.

33. With regard to Claim 5-8, The Committee established by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of practice by administering the WRAT to Client #5 when that client only had minimal proficiency in English.

34. With regard to Claim 6-8, the Committee established by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of practice in interpreting the WAIS-R and Bender Gestalt tests that he had administered to Client #6.

35. With regard to Claim 20-12, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of practice in the way he administered the Strong-Campbell's Interest Test and the Career Assessment Test to Client #20.

36. For the reasons stated in the Memorandum that follows, <sup>[580]</sup> Claim 21-3 fails to state a charge that is separate from the charges included in Claim 21-1 and Claim 21-3, and the Board should dismiss them.

37. With regard to Claim OF-9, the Committee established by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of practice when he frequently used profanity during group treatment of sex offenders in the mid-1990s.

38. With regard to Claim OF-18, the Committee established by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of practice when he frequently used confrontational therapy techniques during group treatment of sex offenders in the mid-1990s.

39. With regard to Claim OF-19, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated Minnesota Statutes, Section 148.941, Subdivision 2(a)(2), when he told sex offender clients that their probation would be revoked if they failed to complete sex offender treatment.

40. With regard to Claim 20-13, the Committee failed to establish by a preponderance of the evidence any violation of a licensing statute or rule.

41. With regard to Claim 3-10, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman failed to elicit client history from Client #3 in a way that conformed to usual and customary prevailing standards of practice.

42. With regard to Claims 6-3 and 6-10, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman failed to elicit client history from Client #6 or assessed that client in a way that conformed to usual and customary prevailing standards of practice.

43. With regard to Claim 8/9-1.1, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman failed to conform to usual and customary prevailing standards of practice by attributing Client #8's symptoms to her automobile accident without eliciting further information or considering other factors that might have accounted for those symptoms.

44. In addition to the Board's specific rules about documentation, Minnesota Rules, part 7200.5700, and Minnesota Statutes, Section 148.98(a), both of which prohibit unprofessional conduct, also require that documentation by licensed psychologists conform to the usual and customary prevailing standards of practice that are accepted by Minnesota psychologists.

45. With regard to Claim 1-5, the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #1 failed to conform to usual and customary prevailing standards of practice.

46. With regard to Claim 2-2, the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #2 failed to conform to usual and customary prevailing standards of practice.

47. With regard to Claim 3-5, the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #3 failed to conform to usual and customary prevailing standards of practice.

48. With regard to Claim 4-6, the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #3 failed to conform to usual and customary prevailing standards of practice and also violated Minnesota Rules, part 7200.5000, subpart 3C.

49. With regard to Claim 5-3, the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #5 failed to conform to usual and customary prevailing standards of practice and also violated Minnesota Rules, part 7200.5000, subpart 3B.

50. With regard to Claims 8/9-1.1 and 8/9-11, the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #8 failed to conform to usual and customary prevailing standards of practice and also violated Minnesota Rules, part 7200.5000, subpart 3B and 3C.

51. With regard to Claim 20-9, the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #20 failed to conform to usual and customary prevailing standards of practice.

52. With regard to Claims 1-6, 2-6, 3-3, 4-7, 6-6, 20-10, and 21-1, the Committee established by a preponderance of the evidence that the Mr. Appleman's documentation of test interpretations, if any, for Clients #1, #2, #3, #4, #6, #20, and #21 failed to conform to usual and customary prevailing standards of practice.

53. With regard to Claims 7-3, 8/9-3, and 20-11, the Committee established by a preponderance of the evidence that Mr. Appleman's failure to keep some of the protocols for the tests he administered to Clients #7, #8, #9, and #20 failed to conform to usual and customary prevailing standards of practice.

54. With regard to Claim 4-9, the Committee established by a preponderance of the evidence that Mr. Appleman's failure to note that Client #4 failed to complete a test that Mr. Appleman attempted to administer, along with an explanation of why, failed to conform to usual and customary prevailing standard of practice.

55. With regard to Claim 5-9, the Committee established by a preponderance of the evidence that Mr. Appleman failed to include reservations and qualifications disclosing Client #5's limited English proficiency and the assistance of a relative to translate for him during testing in the report containing the testing results. The Committee therefore established by a preponderance of the evidence that Mr. Appleman's testing report for Client #5 failed to conform to usual and customary prevailing standards of practice and also violated Minnesota Rules, part 7200.5000, subpart 3B.

56. With regard to General Claim-2, the Committee established by a preponderance of the evidence that Mr. Appleman failed to include reservations and qualifications in his reports of testing on Clients #1, #2, #3, #4, #5, #6, #8, and #20 disclosing that he had only administered one of three WRAT sub-tests to them. The Committee therefore established by a preponderance of the evidence that Mr. Appleman's testing reports for those ten clients failed to conform to usual and customary prevailing standards of practice and also violated Minnesota Rules, part 7200.5000, subpart 3B.

57. With regard to Claim 4-5, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules, Part 7200.5000, subpart 3A by failing to provide adequate support for the professional judgments that he made.

58. With regard to Claim 6-2, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated any licensing statute or rule by reporting his conclusions about what caused Client #6's symptoms and diagnoses without reporting information relating to other potential causes.

59. With regard to Claims 1-14, 2-9, 3-11, 4-8, 5-10, and 6-9, the Committee established by a preponderance of the evidence that the treatment plans that Mr. Appleman documented for Clients #1, #2, #3, #4, #5, and #6 failed to conform to usual and customary prevailing standards of practice.

60. With regard to Claim OF-1, the Committee established by a preponderance of the evidence that the treatment plans that Mr. Appleman documented for Clients #10, #11, #13, and #15 failed to conform to usual and customary prevailing standards of practice.

61. With regard to Claim OF-16, the Committee established by a preponderance of the evidence that Mr. Appleman failed to include six pieces of relevant correspondence about Client #13 in the file he maintained for that client. The Committee therefore established by a preponderance of the evidence that Mr. Appleman's client file for Client #13 failed to conform to usual and customary prevailing standards of practice and also violated Minnesota Rules, part 7200.4900, subpart 1aB.

62. With regard to Claim 20-1, to the extent that its charges are not embraced by other charges pertaining to Client #20,<sup>[581]</sup> the Committee failed to establish by a preponderance of the evidence that Mr. Appleman failed to meet usual and customary prevailing practice standards by failing to document objective findings, specific treatment provided, or the treatment benefit in the file he maintained for Client #20.

63. With regard to Claims 1-10, 3-6, and OF-5, the Committee established by a preponderance of the evidence that in some instances Mr. Appleman failed to meet usual and customary prevailing practice standards by billing the insurers of Clients #1, #3, #11, #13, and #15 for group therapy sessions for which there were no supporting group progress notes. The Committee also established by a preponderance of the

evidence that in some instances Mr. Appleman failed to meet usual and customary prevailing practice standards by billing the insurers of Clients #1 and #3 for group therapy sessions where existing group progress notes failed to document the presence of the client being billed.

64. With regard to Claims 1-11, OF-5, and 20-6, the Committee established by a preponderance of the evidence that Mr. Appleman failed to meet usual and customary prevailing practice standards by billing the insurers of Clients #1, #11, #12, #13, #14, #15, and #20 for individual therapy sessions for which there were no supporting progress notes or other written documentation.

65. With regard to Claim 21-5, the Committee established by a preponderance of the evidence that Mr. Appleman violated Minnesota Rules part 7200.5200, subpart 3, by billing Client #21's insurer for services that Mr. Appleman did not perform.

66. With regard to Claim OF-6, the Committee established by a preponderance of the evidence that Mr. Appleman failed to meet usual and customary prevailing practice standards by billing the insurers of Clients #15, #16, #17, #18, and #19 for a family therapy session for which there were no supporting progress notes or other written documentation.

67. With regard to Claim 4-2 and General Claim-4, the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated any licensing law by billing the insurers of Clients #1, #2, #4, #5, #8, #9, #11, #20, and #21 for certain tests without having the protocols for or written interpretations of those tests in client files. <sup>[582]</sup>

68. With regard to Claim 20-5, the Committee established by a preponderance of the evidence that the billing summary that Mr. Appleman prepared for Client #20's account on January 3, 1995, failed to meet usual and customary prevailing practice standards because it contained billings for tests that were not completed or scored.

69. These Conclusions are made for the reasons set out in the Memorandum which follows and which is hereby incorporated by reference in these Conclusions.

70. The Administrative Law Judge adopts as Conclusions any Findings, which are more appropriately described as Conclusions.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

### **RECOMMENDATION**

The Administrative Law Judge RESPECTFULLY RECOMMENDS that the Board of Psychology take disciplinary action against Michael Appleman, M.A., L.P., that is

consistent with the Conclusions indicated above and with the Board's previous Order on the Committee's Motion for Partial Summary Disposition.

Dated this 28<sup>th</sup> day of June, 2001

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BRUCE H. JOHNSON  
Administrative Law Judge

Reported: Kirby A. Kennedy & Associates  
(612) 922-1955  
Thirteen Volumes

## NOTICE

Under Minnesota law, [\[583\]](#) the Board must serve its final decision upon each party and the Administrative Law Judge by first-class mail.

## MEMORANDUM

### I.

#### **Whether or Not the Committee Has Effectively Amended Its Notice of Hearing**

The Notice of Hearing that the Committee filed in this proceeding contained 201 separately numbered factual allegations and twenty-six specifically alleged violations of psychology licensing laws.<sup>[584]</sup> On May 28, 1999, the Committee moved to amend its notice of hearing to include one additional factual allegation.<sup>[585]</sup> The ALJ subsequently granted the Committee's motion to amend,<sup>[586]</sup> and the Committee filed its amendment on June 8, 1999.<sup>[587]</sup> The Committee filed no other amendments to its Notice of Hearing before the evidentiary hearing in this matter ended on November 8, 2000.

In its Memorandum in Support of Motion for Partial Summary Disposition, the Committee described what appeared to be ninety-one separately identifiable charges of licensure violations by Mr. Appleman.<sup>[588]</sup> On October 14, 1999, in his recommendation to the Board on the Committee's motion for summary disposition,<sup>[589]</sup> the ALJ for purposes of analysis attempted to describe briefly what each of those ninety-one apparent violations encompassed. The ALJ characterized each one of those apparent violations as a separate "claim" and assigned a reference number to each to facilitate his and the Board's ability to address issues raised by the motion for summary disposition.<sup>[590]</sup> The Board itself used the reference system devised by the ALJ when it subsequently entered its order on the Committee's motion for partial summary disposition.<sup>[591]</sup> In its March 30, 2000, order on that motion, the Board granted summary disposition in the Committee's favor on thirteen of the claims identified by the ALJ.<sup>[592]</sup> And it remanded all other issues raised in the Notice of Hearing back to the ALJ for an evidentiary hearing on the merits. In any event, none of the thirteen claims and supporting factual allegations for which the Board granted summary disposition were at issue during the evidentiary hearing and do not need to be addressed by the ALJ at this stage of these proceedings.

During the hearing the Committee stated for the record from time to time that it was withdrawing some of its specific claims of licensure violations by Mr. Appleman. So, near the end of the hearing the ALJ placed into the hearing record the reference list of claims that he had previously compiled for the Board.<sup>[593]</sup> The ALJ then requested counsel for the Committee to update the list so that all concerned would have a current list of claims that needed to be adjudicated.<sup>[594]</sup> Counsel were requested to submit any amended versions of the claim reference list on or before December 6, 2000.<sup>[595]</sup> While the hearing was in progress, the Committee made no motion to amend its Notice of Hearings to include new factual allegations or to assert violations of licensing laws that were not raised in the original Notice of Hearing or in the amendment that the Committee had filed in 1999.

On December 6, 2000, the Committee filed its version of a claim reference list to the ALJ and to Mr. Appleman.<sup>[596]</sup> In that document the Committee indicated that off the

ninety-one “claims,” or separate instances of licensure violations that the ALJ had identified in October 1999, the Board had already disposed of thirteen by summary disposition; and the Committee had withdrawn twenty-seven during the course of the hearing.<sup>[597]</sup> The Committee characterized two claims as having been “withdrawn and replaced”<sup>[598]</sup> sixteen as “amended,”<sup>[599]</sup> with the remaining thirty-three in effect as originally asserted.<sup>[600]</sup> It then proceeded to list forty-one of what it identified as “new” claims.<sup>[601]</sup> The ALJ’s original list only pertained to charges that the Committee has submitted for summary disposition. So that list did not preclude the Committee from pursuing at the evidentiary hearing charges that it believed earlier were not susceptible of summary disposition

In any event, the parties agree that neither the licensure violations that the Board previously adjudicated on summary disposition nor those that the Committee has subsequently withdrawn are presently at issue in this proceeding. That accounts for forty of the previously-described ninety-one alleged violations. What Mr. Appleman further contends is that the other alleged licensure violations that the Committee described in Exhibit 86 as having been “withdrawn and replaced,” “amended,” or “new” — are also not properly at issue in this proceeding.

Mr. Appleman raises three objections to how the Committee has characterized its claims against him in Exhibit 86. First, he argues that the Committee is asserting new charges against him and that principles of procedural due process prevent the Board from considering charges or allegations of which he did not have fair notice prior to the hearing.<sup>[602]</sup> Second, he argues that maintaining some of the assertions that the Committee makes in Exhibit 86 violates applicable state statutes and rules. And third, he argues more generally and largely on equitable grounds that the Committee should be precluded from asserting any charge that the ALJ did not characterize as a claim when considering the Committee’s motion for summary disposition.

As Mr. Appleman points out, a license to practice a profession “is a property right deserving of constitutional protection, including due process.”<sup>[603]</sup> And among other things, due process requires reasonable notice of charges that may result in loss of such a license.<sup>[604]</sup> Reasonable notice includes “fair notice as to the reach of the grievance procedure and the precise nature of the charges.”<sup>[605]</sup> More specifically, the focus of the inquiry into adequacy of notice is whether the failure of the agency to disclose facts underlying its case prohibits the respondent from being able to effectively respond.<sup>[606]</sup> As the Minnesota Supreme Court has indicated, a licensed professional “cannot be found to have violated disciplinary rules by certain actions which were not the subject of formal charges.”<sup>[607]</sup> So the fundamental question that must be addressed here is whether or not the Committee is now asserting charges against Mr. Appleman of which he did not receive fair notice in the Notice of Hearing.<sup>[608]</sup>

Mr. Appleman also argues that the Committee’s identification of “new” or “amended” claims violates the reasonable notice requirement of the Minnesota Administrative Procedure Act<sup>[609]</sup> and the provision of OAH rules requiring a “statement of the allegations or issues to be determined” in a notice of hearing.<sup>[610]</sup> It is his position that the Committee’s failure to specifically discuss those claims in the Notice of Hearing

violates both Minn. Stat. § 14.58 and Minn. R. pt. 1400.5600, subp. 2D. However, the ALJ concludes that another OAH rule addresses the situation here more directly than the authority Mr. Appleman has cited. In recognition of due process principles OAH rules establish strict and specific requirements for amending a notice of hearing after a contested case hearing has begun:

**Amendment.** At any time prior to the close of the hearing, the agency may file and serve an amended notice of and order for hearing, provided that, should the amended notice and order raise new issues or allegations, the parties shall have a reasonable time to prepare to meet the new issues or allegations if requested.<sup>[611]</sup>

Here, the Committee neither filed nor served an amended notice of and order for hearing after filing a single amendment on June 8, 1999. Specifically, it did not ask to do so at any time while the hearing was in progress. So, the Board cannot base any disciplinary action against Mr. Appleman on any new factual allegations or charges of violating licensing laws that it did not reasonably cover in the allegations and charges in its original Notice of Hearing, as amended in June 1999. But this leaves unresolved the question of whether or not Exhibit 86 actually raises new factual allegations or alleged violations of statute or rule that are not reasonably covered by what is in the Notice of Hearing.

Finally, in advancing its theories of the case, the Committee is clearly not bound by how the ALJ earlier characterized them in Exhibit 84. As the record indicates, the ALJ's earlier listing of claims<sup>[612]</sup> was never intended to be evidence, a pleading, or a complete adjudication of what the Committee's claims against Mr. Appleman might be. Rather, it represented the ALJ's understanding of the Committee's theories of its case for the purpose of addressing its motion for summary disposition. In Exhibit 83 the ALJ simply attempted to describe summarily all of the charges for which the Committee appeared to be seeking summary disposition. Due process does not require an agency to commit itself in a notice of hearing to particular theories of its case. It is only required to set out facts and legal authority that support any theory of the case that it ultimately seeks to argue. Put another way, the underlying problem here is to determine what the terms "amended," "withdrawn and replaced," and "new" claims mean, as they are used in Exhibit 86. If they refer to facts and laws that the Committee did not fairly identify in the Notice of Hearing, then they represent ineffective amendments to that Notice of Hearing and must be disregarded. But the outcome is different if they simply raise other matters covered in the Notice of Hearing or merely relate facts and laws that the Committee has specifically addressed in the Notice of Hearing differently from the ways in which the ALJ previously characterized their relationships. The "new" and "amended" claims are merely an expression of the Committee's theories of the case and are not truly amendments to the notice of hearing.

In summary, the ALJ agrees with Mr. Appleman's view that principles of due process preclude "a disciplinary board from considering charges or allegations of which the accused has not had *fair notice* prior to the commencement of the hearing."<sup>[613]</sup> But the underlying question is whether or not the Notice of Hearing does provide fair notice

of some or all of what the Committee described as “amended” or “new” claims in Exhibit 86, as well as of claims originally described by the ALJ in Exhibit 83. The ALJ addresses these issues specifically in Part III, below.

## II.

### **Application of *Res Judicata* and Collateral Estoppel**

#### **A. The doctrine of *res judicata* does not preclude further consideration of charges of improper record keeping as instances of unprofessional conduct.**

Mr. Appleman argues that in denying summary disposition of one of the Committee’s claims against him, the Board arrived at a conclusion of law which became the law of this case and which now effectively precludes consideration of many of the Committee’s charges of inadequate documentation. Mr. Appleman correctly states that the doctrine *res judicata*, or “law of the case,” applies to administrative contested case proceedings.<sup>[614]</sup> And in denying summary disposition of Claim 3-6, it appears that the Board definitively arrived at a conclusion of law. But questions remain about the breadth of the Board’s legal conclusion and which charges, if any, that conclusion may now affect.

In denying the Committee’s motion for partial summary disposition, the Board made the following ruling:

**Claim 3-6.** Client #3 purportedly participated in four group therapy sessions with Licensee between January and March, 1994, for which Licensee billed the client’s insurer. [Record citations omitted.] The Committee claims that the charges are not substantiated due to the absence of group therapy or progress notes to indicate that Client #3 received the therapy. [Record citations omitted.] Licensee has produced no notes relative to the sessions. [Record citations omitted.] The ALJ determined that the apparent absence of notes for the four sessions constitutes a violation of Minn. R. 7200.4900, subp. 1a, which requires psychologists to “maintain an accurate record for each client.” [Record citations omitted.] As Licensee correctly points out, however, the rule does not expressly require the maintenance of therapy or progress notes. [Record citations omitted.] In most relevant part, the rule merely requires a “chronological listing of all client visits, together with fees charged.” [Record citations omitted.] Under the circumstances, we are not persuaded that Licensee violated the rule in question. We therefore do not adopt the ALJ’s recommendation and deny the Committee’s motion for summary disposition in connection with Claim 3-6.<sup>[615]</sup>

From the outset of this contested case proceeding, Mr. Appleman has consistently made the legal argument that by adopting several specific rules relating to record

keeping by psychologists, the Board intended to limit potential licensing violations involving record keeping to what was expressly indicated in those rules.<sup>[616]</sup> As a consequence, Mr. Appleman argues that record keeping practices that are not expressly prohibited by the Board's rules may not result in licensure violations, even though those practices may fall short of the "standards of professional behavior that have been established by a consensus of the expert opinion of psychologists"<sup>[617]</sup> or may "fail to meet usual and customary professional standards."<sup>[618]</sup> Mr. Appleman argues that by deciding earlier to reject the ALJ's recommendation and to deny the Committee's request for summary disposition of Claim 3-6, the Board implicitly adopted his legal position on which record keeping practices may constitute licensure violations. Mr. Appleman then contends that this then became the law of the case in this proceeding.<sup>[619]</sup> In other words, Mr. Appleman argues that the Board has already arrived at a conclusion of law that the legislature's and the Board's prohibition against "unprofessional conduct" do not extend to substandard documentation practices.<sup>[620]</sup>

For its part, the Committee argues that all the Board did in its earlier ruling on Claim 3-6 was to decide, as a matter of law, that the facts presented in the Committee's motion for summary disposition did not specifically establish a violation of Minn. R. 7200.4900, subp. 1a. The Committee therefore contends that it is still an open question whether or not the statute and rule prohibiting "unprofessional conduct" by psychologists extends to substandard documentation practices. The Committee then goes on to propose an affirmative answer to that question.

Since the Board's earlier ruling on Claim 3-6 specifically rejected the ALJ's recommendation on that claim, the scope of that claim and of that recommendation is important in determining the legal scope and effect of the Board's ruling. First of all, what the ALJ previously characterized as Claim 3-6 was based on an allegation in paragraph 22 of the Notice of Hearing:

22) Respondent billed for group psychotherapy sessions for client #3 on January 29, 1994, February 5, 1994, February 11, 1994, and March 5, 1994. Respondent has no group progress notes to support his charges for group therapy.

In making his recommendation on the Committee's motion for summary disposition, the ALJ characterized Claim 3-6 as "[f]ailing to have documentation supporting charges for group therapy."<sup>[621]</sup> In characterizing the nature of the claim, the ALJ made no recommendation about which provisions of the licensing laws that failure to have supporting documentation might violate. Thereafter, the ALJ recommended that the Board concluded the Committee had "established a *prima facie* case that Mr. Appleman violated the Board rule [citing Minn. R. 7200.4900, subp. 1a] requiring psychologists to "maintain an accurate record for each client."<sup>[622]</sup> In making that recommendation, the ALJ neither stated nor implied that Minn. R. 7200.4900, subp. 1a was the only licensing requirement that Mr. Appleman may have violated by not having documentation to support charges for group therapy.<sup>[623]</sup>

In acting on the ALJ's recommendation, the Board concluded that ". . . the rule does not expressly require the maintenance of therapy or progress notes. In most relevant part, the rule merely requires a 'chronological listing of all client visits, together with fees charged.'"<sup>[624]</sup> There is nothing in the ALJ's recommendation to suggest that he was addressing the broader issue of whether unprofessional conduct could embrace substandard documentation practices. And there is nothing in the Board's response to that recommendation that it was addressing issues that were broader than what the ALJ had presented to them. The ALJ therefore concludes that the Board has not established as the law of this case the proposition that the prohibition in Minn. Stat. § 148.98(a) and in Minn. R. pt. 7200.5700 against "unprofessional conduct" by psychologists does not extend to substandard documentation practices.<sup>[625]</sup> So, whether Mr. Appleman's failure to have documentation to support charges for group therapy sessions for Client #3 represents substandard documentation practice and, therefore, unprofessional conduct is still an open question that needs to be adjudicated in this proceeding.

**B. The doctrine of collateral estoppel does not preclude litigation of the propriety of the services that Mr. Appleman provided to Client #20.**

Client #20 had been injured on the job and had made claims for workers' compensation benefits. Client #20's Qualified Rehabilitation Consultant (QRC), who was coordinating Client #20's care, referred him to Mr. Appleman to address his adjustment reaction to work-related injuries and his subsequent stress and depression.<sup>[626]</sup> Mr. Appleman evaluated and treated Client #20 and thereafter made a request for reimbursement for those services with the Minnesota Department of Labor and Industry.<sup>[627]</sup> After the Commissioner allowed Mr. Appleman's claim for reimbursement,<sup>[628]</sup> the employer's workers' compensation insurance carrier requested a hearing before a workers' compensation judge.<sup>[629]</sup> Mr. Appleman provided the compensation judge with his treatment records for Client #20, but he did not appear at the hearing to testify in support of his request for reimbursement.<sup>[630]</sup> The workers' compensation judge made the following findings, among others, regarding Mr. Appleman's evaluation and treatment of Client #20:

14. At no time prior to July 22, 1994, did Mr. Appleman attempt to contact QRC Saby or the claims person for pre-authorization to provide any psychological or vocational services to the employee.

15. At the time of the referral to Mr. Appleman, the employee was actively involved in a rehabilitation plan with agreed upon vocational goals. No evidence exists that the employee was specifically referred to Mr. Appleman for vocational, skills, aptitude or interest testing. The services performed by Mr. Appleman were not included in the rehabilitation plan or subsequent amendments. Mr. Appleman's services are not payable pursuant to the rehabilitation statute and rules.

\* \* \*

17. Neither Dr. Pettus nor Dr. Carlson referred the employee for medical (psychological) care/treatment to Mr. Appleman. Mr. Appleman did not obtain approval from the insurer to provide medical services to the employee prior to beginning treatment. This treatment is therefore not authorized. This represents an unauthorized change in doctors and pursuant to Minn. Rule 5221.0500 is excessive.

18. A provider has the burden to show that medical services are reasonable and necessary. Mr. Appleman has not met that burden of proof as his records submitted at the hearing do not document a treatment plan, objective findings, specific treatment provided, or the benefits to the employee from treatment provided.<sup>[631]</sup>

On the basis of these findings, the workers' compensation judge held that "the psychological services provided by Mr. Michael Appleman, M.A., Licensed Psychologist, from July 22, 1994, through August 9, 1994, were excessive as not authorized and also not reasonable nor necessary to cure and/or relieve the employee's work-related conditions."<sup>[632]</sup>

The Committee argues that the doctrine of collateral estoppel precludes litigation at the hearing of "the issues regarding the propriety, reasonableness, and necessity of the testing, procedures, and psychological services provided by Respondent to client #20."<sup>[633]</sup> First of all, the Committee has asserted thirteen separate charges against Mr. Appleman that are related to his evaluation and treatment of Client #20.<sup>[634]</sup> The workers' compensation judge's findings and order reasonably embrace only four of those charges, namely:

Claim 20-1 Failing to document a treatment plan, objective findings, specific treatment provided, or the treatment benefit for Client #20.

Claim 20-2 Violating workers' compensation laws by failing to obtain an approval from Client #20's employer for the services being provided to Client #20.

Claim 20-8 Conducting vocational testing without being engaged to do so (alternatively, billing for vocational testing that was not provided).

Claim 20-13 Providing psychological services which were not reasonable or necessary for the relief or treatment of Client #20's injuries or conditions.<sup>[635]</sup>

The Committee's position is that although Mr. Appleman did not actually appear at the workers' compensation hearing to pursue his claim for reimbursement, he had notice and an opportunity to be heard. The Committee therefore argues that under the

doctrine of collateral estoppel requires, the findings of the workers' compensation judge establish these four charges as a matter of law.

Collateral estoppel prevents identical parties or those in privity with them from relitigating identical issues in a subsequent, distinct proceeding.<sup>[636]</sup> In *Graham v. Special School Dist. No. 1*,<sup>[637]</sup> the Minnesota Supreme Court held that the doctrine of collateral estoppel may be applied in appropriate instances to agency decisions. In order for collateral estoppel to be applied to an agency decision, five factors must be met:

(1) the issue to be precluded must be identical to the issue raised in the prior agency adjudication; (2) the issue must have been necessary to the agency adjudication and properly before the agency; (3) the agency determination must be a final adjudication subject to judicial review; (4) the estopped party was a party or in privity with a party to the prior agency determination; and (5) the estopped party was given a full and fair opportunity to be heard on the adjudicated issues.<sup>[638]</sup>

Collateral estoppel should not be rigidly applied.<sup>[639]</sup> As a flexible doctrine, the focus is on whether its application would work an injustice on the party against whom the estoppel is urged.<sup>[640]</sup> And both collateral estoppel and *res judicata* are qualified or rejected when their application would contravene an overriding public policy.<sup>[641]</sup>

Here, the ALJ concludes that collateral estoppel should not be applied to preclude Mr. Appleman from litigating any of the issues raised in the Notice of Hearing with reference to Client #20. Claim No. 20-1 alleges that Mr. Appleman's documentation of the services provided to Client #20 was substandard. That claim, therefore, necessarily relates to the Board rule prohibiting psychologists from engaging in "unprofessional conduct."<sup>[642]</sup> Standards of documentation, like other professional standards, must be "established by a consensus of the expert opinion of psychologists."<sup>[643]</sup> The workers' compensation judge's decision clearly indicates that in finding Mr. Appleman's documentation inadequate, she was interpreting the standard established in Minnesota's Workers' Compensation Act<sup>[644]</sup> and not the standards established by a consensus of the expert opinion of psychologists.<sup>[645]</sup> In fact, there is nothing to suggest that any expert opinion was offered or considered in the workers' compensation proceeding to establish that Mr. Appleman's documentation practices were substandard. So, with regard to Claim 20-1, the Committee has failed to meet the first two prerequisites set forth in *Graham* — namely, that the issue here is identical to the issue raised in the workers' compensation proceeding, and that prevailing standards of psychological documentation were necessary to the workers' compensation judge's adjudication and therefore properly before her.

For similar reasons, collateral estoppel does not preclude Mr. Appleman from litigating the issue raised in Claim 20-13. The workers' compensation judge only had jurisdiction to consider whether Mr. Appleman's services were reasonable or necessary for the relief or treatment of Client #20's *work related* injuries or conditions for purposes of the Workers' Compensation Act, and that is all she did decide. She lacked

jurisdiction to hear whether those services were unreasonable or unnecessary when measured against prevailing practice standards, nor did she purport to make such a determination.<sup>[646]</sup>

As for Claim 20-2, the Workers' Compensation Act does not prohibit providers of medical or psychological services from providing such services to an injured worker without the employer's approval. It provides if that they do so, the employer or its insurance carrier are not obliged to pay for the services.<sup>[647]</sup> In other words, Mr. Appleman did not violate the Worker's Compensation Act by providing services to Client #20 without the employer's approval. Lack of that approval simply made him ineligible for reimbursement from the employer. In short, as a matter of law, Claim 20-2 fails to describe a violation of the psychology licensing laws, and the ALJ recommends that the Board dismiss that claim.

Finally, concerning Claim 20-8, the workers' compensation judge did not find that Mr. Appleman conducted vocational testing without being engaged by anyone to do so. She only found that Client #20's employer did not directly or indirectly engage him to do such testing. Whether or not Client #20, or someone else acting on his behalf, engaged Mr. Appleman to conduct vocational testing is an issue that the workers' compensation clearly did not consider, nor was she empowered to rule on that issue.

In conclusion, for the reasons stated above, the ALJ recommends that the Board not apply the doctrine of collateral estoppel to preclude Mr. Appleman from litigating any claims relating to Client #20 in this contested case proceeding.

### **III. Recommendation on Charges to be Adjudicated**

At the ALJ's request, on December 6, 2000, the Committee submitted a Revised Claims List for inclusion in the record<sup>[648]</sup> as its expression of the charges that are currently pending against Mr. Appleman. The ALJ has evaluated the Committee representations in its Revised Claims List, together with the Board's March 30, 2000, order on the Committee's Motion for Partial Summary Disposition and the allegations contained in the Committee's Notice of Hearing, as amended. As a result of that analysis, the ALJ makes the following recommendations to the Board concerning the charges that are now ripe for adjudication:

**Client No. 1:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the following charges which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily: Claim 1-1,<sup>[649]</sup> Claim 1-2,<sup>[650]</sup> Claim 1- 4,<sup>[651]</sup> and Claim 1-5,<sup>[652]</sup>. Those claims are therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified the following charges as having been "amended" or "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing, as amended: Claim 1-6 (amended)<sup>[653]</sup>, Claim 1-7 (amended)<sup>[654]</sup>, Claim 1-10 (amended)<sup>[655]</sup>, Claim 1-11 (amended)<sup>[656]</sup>, and Claim 1-13 (amended)<sup>[657]</sup>, Claim 1-13.1 (new claim #)<sup>[658]</sup>, and Claim 1-14 (new claim #).<sup>[659]</sup> In

summary, the ALJ concludes that the foregoing eleven charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn the following charges, and they are no longer at issue in this proceeding: Claim 1-3, Claim 1-8, Claim 1-9, and Claim 1-12.<sup>[660]</sup> Moreover, the ALJ has concluded that what the Committee has identified as Claim 1-15 is simply a more detailed restatement of charges that are already set out in Claim 1-6 and therefore should not be considered a separate charge.<sup>[661]</sup> Finally, the ALJ concludes that Mr. Appleman did not have fair notice of Claim No. 1-16 because there are no allegations in the Notice of Hearing that fairly state its substance.<sup>[662]</sup> The ALJ therefore recommends that the Board dismiss Claims Nos. 1-3, 1-8, 1-9, 1-12, 1-15, and 1-16.

**Client No. 2:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the charges in Claim 2-2,<sup>[663]</sup> which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily: That claim is therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified the following charges as having been "amended" or "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations set out in the Notice of Hearing, as amended: Claim 2-6 (amended)<sup>[664]</sup>, Claim 2-7 (amended)<sup>[665]</sup>, and Claim 2-9 (new claim #)<sup>[666]</sup>. In summary, the ALJ concludes that the foregoing four charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn the following charges, and they are no longer at issue in this proceeding: Claim 2-1, Claim 2-4, and Claim 2-5.<sup>[667]</sup> Moreover, the ALJ concludes that Mr. Appleman did not have fair notice of either Claim No. 2-3 (amended) or Claim 2-8 (new claim #) because there are no allegations in the Notice of Hearing that fairly state their substance.<sup>[668]</sup> The ALJ therefore recommends that the Board dismiss Claims Nos. 2-1, 2-3, 2-4, 2-5, and 2-8.

**Client No. 3:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the charges contained in Claim 3-5<sup>[669]</sup> and Claim 3-6,<sup>[670]</sup> which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily. Those claims are therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified the following charges as having been "amended" or "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing, as amended: Claim 3-3 (amended)<sup>[671]</sup>, Claim 3-4 (amended)<sup>[672]</sup>, 3-10 (new claim)<sup>[673]</sup> and Claim 3-11 (new claim #).<sup>[674]</sup> In summary, the ALJ concludes that the foregoing six charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn the following charges, and they are no longer at issue in this proceeding: Claim 3-1, Claim 3-2, and Claim 3-7.<sup>[675]</sup>

Moreover, the ALJ concludes that Mr. Appleman did not have fair notice of Claims Nos. 3-8<sup>[676]</sup> and 3-9 (new claim #)<sup>[677]</sup> because there are no allegations in the Notice of Hearing that fairly state their substance. The ALJ therefore recommends that the Board dismiss Claims Nos. 3-1, 3-2, 3-7, 3-8, and 3-9.

**Client No. 4:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the following charges which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily: Claim 4-3,<sup>[678]</sup> Claim 4-5,<sup>[679]</sup> and Claim 4-6.<sup>[680]</sup> Those claims are therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified the following charges as having been "amended" or "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing, as amended: Claim 4-7 (new claim #)<sup>[681]</sup>, Claim 4-8 (new claim #)<sup>[682]</sup>, and Claim 4-9 (new claim #).<sup>[683]</sup> In summary, the ALJ concludes that the foregoing eleven charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn the charges asserted in Claims 4-1 and 4-4, and they are no longer at issue in this proceeding.<sup>[684]</sup> Moreover, the ALJ concludes that Mr. Appleman did not have fair notice of Claim No. 4-10 because there are no allegations in the Notice of Hearing that fairly state its substance.<sup>[685]</sup> The ALJ therefore recommends that the Board dismiss Claims Nos. 4-1, 4-4, and 4-10.

**Client No. 5:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the charges contained in Claim 5-3<sup>[686]</sup> and Claim 5-5,<sup>[687]</sup> which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily. Those claims are therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified the following charges as having been "amended" or "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing, as amended: Claim 5-8 (new claim #)<sup>[688]</sup>, Claim 5-9 (new claim #)<sup>[689]</sup>, and Claim 5-10 (new claim #).<sup>[690]</sup> In summary, the ALJ concludes that the foregoing five charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn the charges asserted in Claims 5-1, 5-2, 5-4, and 5-7, and they are no longer at issue in this proceeding.<sup>[691]</sup> Additionally, the ALJ concludes that Claim 5-6 (amended) raises no charges that are not already included within Claim 5-5 and is therefore redundant. He further concludes that Mr. Appleman did not have fair notice of Claim 5-11 (amended) because there are no allegations in the Notice of Hearing that fairly state the substance of that charge.<sup>[692]</sup> The ALJ therefore recommends that the Board dismiss Claims Nos. 5-1, 5-2, 5-4, 5-6, 5-7, and 5-11.

**Client No. 6:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the charges contained in Claim 6-3,<sup>[693]</sup> which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily. That claim is therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified the following charges as having been "amended" or "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing, as amended: Claim 6-2 (amended claim #)<sup>[694]</sup>, Claim 6-6 (amended claim #)<sup>[695]</sup>, Claim 6-8 (new claim),<sup>[696]</sup> and Claim 6-9 (new claim),<sup>[697]</sup> and Claim 6-10 (new claim #).<sup>[698]</sup> In summary, the ALJ concludes that the foregoing six charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn the charges asserted in Claims 6-1, 6-4, 6-5, and 6-7, and they are no longer at issue in this proceeding.<sup>[699]</sup> The ALJ therefore recommends that the Board dismiss Claims Nos. 6-1, 6-4, 6-5, and 6-7.

**Client No. 7:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting Claim 7-3,<sup>[700]</sup> which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily.<sup>[701]</sup> That claim is therefore still at issue and ripe for adjudication.

On the other hand, the Committee has withdrawn the following charges, and they are no longer at issue in this proceeding: Claim 7-1, Claim 7-2, and Claim 7-6.<sup>[702]</sup> Moreover, the ALJ concludes that Mr. Appleman did not have fair notice of Claim No. 7-4<sup>[703]</sup> or of 7-7 (new claim), 7-8 (new claim #)<sup>[704]</sup> or 7-9 (new claim number)<sup>[705]</sup> because there are no allegations in the Notice of Hearing that fairly state their substance. The ALJ therefore recommends that the Board dismiss Claims Nos. 7-1, 7-2, 7-4, 7-6, 7-7, 7-8, and 7-9.

**Client No. 8:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for Claim 8/9-3<sup>[706]</sup> and Claim 8/9-11<sup>[707]</sup>, which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily. Those claims are therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified Claim 8/9-1<sup>[708]</sup> and Claim 8/9-1.1 as having been "amended" or "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing. In summary, the ALJ concludes that the foregoing four charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn the following charges, and they are no longer at issue in this proceeding: Claim 8/9-2,<sup>[709]</sup> Claim 8/9-5, Claim 8/9-6, Claim 8/9-9, and Claim 8/9-10.<sup>[710]</sup> Moreover, the ALJ has concluded that Claim 8/9-4 should be dismissed because it either duplicates the matters alleged in Claim 8/9-3<sup>[711]</sup>

or, if not, it alleges matters of which Mr. Appleman did not receive fair notice in the Notice of Hearing.<sup>[712]</sup> The ALJ therefore recommends that the Board dismiss Claims Nos. 8/9-2, 8/9-4, 8/9-5, 8/9-6, 8/9-9, and 8/9-10.

**Sex Offender Claims:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the following charges which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily: Claim OF-1,<sup>[713]</sup> Claim OF-5,<sup>[714]</sup> Claim OF-10,<sup>[715]</sup> and Claim OF-11<sup>[716]</sup>. Those claims are therefore still at issue and ripe for adjudication. Additionally, even though the Committee has identified the following charges as having been "amended," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing, as amended: Claim OF-6 (amended)<sup>[717]</sup> and Claim OF-9 (amended),<sup>[718]</sup> OF-16 (new claim #),<sup>[719]</sup> OF-17 (new claim #),<sup>[720]</sup> OF-18 (new claim #),<sup>[721]</sup> OF-19 (new claim #),<sup>[722]</sup> and OF-20 (new claim #)<sup>[723]</sup>. In summary, the ALJ concludes that the foregoing eleven charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn Claim OF-4, and it therefore no longer at issue in this proceeding.<sup>[724]</sup> Moreover, the ALJ concludes that Mr. Appleman did not have fair notice of Claim No. OF-15 (new claim #) because there are no allegations in the Notice of Hearing that fairly state its substance:<sup>[725]</sup> So the ALJ recommends that the Board dismiss Claims Nos. OF-4 and OF-15.

**Client No. 20:** The Notice of Hearing, as amended, provides reasonable notice to Mr. Appleman and an adequate basis for asserting the following charges which the ALJ earlier identified in connection with the Committee's motion for partial summary disposition but which the Board did not dispose of summarily: 20-1,<sup>[726]</sup> Claim 20-5,<sup>[727]</sup> Claim 20-6,<sup>[728]</sup> Claim 20-8,<sup>[729]</sup> Claim 20-9,<sup>[730]</sup> and Claim 20-10,<sup>[731]</sup>. Those claims are therefore still at issue and ripe for adjudication.<sup>[732]</sup> Next, even though the Committee has identified the following charges as being "new," they do not actually raise "new" matters because Mr. Appleman had fair notice of their substance in the allegations contained in the Notice of Hearing, as amended: Claim 20-11 (new claim #),<sup>[733]</sup> Claim 20-12 (new claim #),<sup>[734]</sup> and Claim 20-13 (new claim #).<sup>[735]</sup> In summary, the ALJ concludes that the nine charges are currently at issue in this proceeding and are therefore ripe for final adjudication.

On the other hand, the Committee has withdrawn Claims 20-3 and 20-4,<sup>[736]</sup> and they are no longer at issue in this proceeding.<sup>[737]</sup> And for the reasons discussed in Part II-B, above, the ALJ recommends that the Board dismiss Claim 20-2. The ALJ therefore recommends that the Board dismiss those three claims.

**Client No. 21:** The Committee did not place any claims concerning Client #21 at issue in its earlier motion for summary disposition. Because of that, neither the ALJ nor the Board have previously attempted to identify or to characterize any charges that the Notice of Hearing might contain concerning services that Mr. Appleman provided to Client #21. So the issue with respect to Client #21 is simply whether or not the Notice

of Hearing, as amended, provided an adequate basis for and reasonable notice to Mr. Appleman of the claims that the Committee is now asserting with reference to Client #21. After evaluating the allegations in the Notice of Hearing, the ALJ concludes that the Notice of Hearing does provide Mr. Appleman with reasonable notice of the following charges: Claim 21-1,<sup>[738]</sup> Claim 21-3,<sup>[739]</sup> and Claim 21-5.<sup>[740]</sup> Those three claims are therefore at issue and ripe for adjudication.

On the other hand, the ALJ concludes that the Notice of Hearing does not provide Mr. Appleman with fair and reasonable notice of the charges described in Claim 21-2<sup>[741]</sup> or Claim 21-4<sup>[742]</sup> because there are no allegations in the Notice of Hearing that fairly state their substance. The ALJ therefore recommends that the Board dismiss Claims Nos. 21-2 and 21-4.

**Clients Nos. 22 and 23:** In its motion for summary disposition, the Committee only included one charge each relating to Clients #22 and #23.<sup>[743]</sup> Since the Board granted summary disposition of both claims, neither is currently at issue. The Committee has asserted no other charges against Mr. Appleman with reference to those two clients.

**General Claims:** In its earlier motion for partial summary disposition,<sup>[744]</sup> the Committee did not assert any generalized charges of licensure violations that involved more than one client or that did not directly involve any client. But in Exhibit 86, which the Committee filed after the hearing, it has asserted four such claims. Whether or not the Committee may assert those claims depends on whether the Notice of Hearing, as amended, provided an adequate basis for and reasonable notice to Mr. Appleman of those claims. After evaluating the allegations in the Notice of Hearing, the ALJ concludes that the Notice of Hearing does provide Mr. Appleman with reasonable notice of the following charges: General Claim 2,<sup>[745]</sup> General Claim 3,<sup>[746]</sup> and General Claim 4.<sup>[747]</sup> Those three claims are therefore at issue, within the limitations described in the accompanying footnotes, and ripe for adjudication to that extent.

But the Committee did not amend the Notice of Hearing to include any allegations of misconduct occurring after this proceeding began. The ALJ therefore concludes that the Notice of Hearing does not provide Mr. Appleman with fair and reasonable notice of the charges described in General Claim 1,<sup>[748]</sup> which alleges misconduct that occurred after the Board initiated this licensing proceeding against Mr. Appleman.<sup>[749]</sup> The ALJ therefore recommends that the Board dismiss General Claim 1.

#### **IV. Burden and Standard of Proof**

In a proceeding affecting a professional license, the licensing body normally has the burden of establishing the facts required to support each of its claims by a preponderance of the evidence.<sup>[750]</sup> Moreover, in Minnesota administrative practice, the standard of proof is preponderance of the evidence unless substantive law establishes a different standard.<sup>[751]</sup> Neither the Psychology Practice Act<sup>[752]</sup> nor any other statute specifically addresses the standard of proof in psychologist disciplinary proceedings. So, as the Court of Appeals recently confirmed, the standard of proof in a proceeding

such as this is preponderance of the evidence.<sup>[753]</sup> But in the earlier case of *In the Matter of Wang*,<sup>[754]</sup> the Minnesota Supreme Court indicated that even though the preponderance standard applies,

. . . proceedings brought on behalf of the state, attacking a person's professional and personal reputation and character and seeking to impose disciplinary sanctions, are no ordinary proceedings. We trust that in all professional disciplinary matters, the finder of fact, bearing in mind the gravity of the decision to be made, *will be persuaded only by evidence with heft*. The reputation of a profession, and the reputation of a professional as well as the public's trust are at stake.

\* \* \*

In a disciplinary proceeding, if reasonable minds are to accept as adequate findings made under a preponderance standard, it is this court's view these findings must be reasonable in the context of the record as a whole, having in mind, as a reasonable person would, the seriousness of the matter under review.<sup>[755]</sup> [Emphasis supplied.]

Here, there is no apparent disagreement among the parties about what effect the language in *Wang* has on the standard of proof in this matter. Rather than establishing an upward departure from the preponderance standard, the Minnesota Supreme Court was addressing the *quality* of the evidence that should comprise a preponderance in professional disciplinary proceedings. In other words, in deciding whether a preponderance exists, the finder of fact must assess the quality, as well as the quantity, of the evidence, and determinations of whether the licensing authority has established a preponderance must be based on evidence of good quality that takes into account "the gravity of the decision to be made" and the fact that "reputation of a profession, and the reputation of a professional as well as the public's trust are at stake."<sup>[756]</sup>

## V.

### Applicable Professional Practice Standards

#### A. The legislature's approach to practice standards

The legislature has chosen to regulate the practice of psychology in Minnesota by enacting a system of professional licensure that is administered by the Board. Unlicensed persons may not engage in that profession,<sup>[757]</sup> and licensed professionals are obliged to conduct themselves in certain ways or face limitations on or loss of their licenses.<sup>[758]</sup> In professional licensure systems such as this, professional practice standards — that is, standards for exercising professional skill, judgment, and methods — may come from one of two sources.<sup>[759]</sup> In some cases the legislature has enacted statutory practice standards while in other cases it has primarily relied on the licensing authority to establish practice standards by rule.

In the case of the medical profession, the legislature has assumed primary responsibility for establishing professional practice standards by enacting them in statute.<sup>[760]</sup> So in its disciplinary proceedings, the Board of Medical Practice interprets and applies the legislature's statutory practice standards to the facts of the case. As a consequence, its rules are mainly concerned with licensure process.<sup>[761]</sup> On the other hand, the legislature has taken a somewhat different approach in establishing practice standards for psychologists. When the legislature first enacted the Psychology Practice Act<sup>[762]</sup>, it chose to give the Board primary responsibility for establishing ethical and practice standards for the profession by

adopt[ing] a code of ethics to govern appropriate practices or behavior, as referred to in section 148.89. The board shall file such a code with the secretary of state at least 30 days prior to the effective date of such code.<sup>[763]</sup>

And the legislature initially limited its role to expressing some broad principles to guide the Board in fashioning rules to establish practice standards for psychologists:

(1) The psychologist recognizes the boundaries of his competence and the limitation of his techniques and does not offer services or use techniques that *fail to meet professional standards established in particular fields*.

(2) The psychologist who engages in practice assists his client in obtaining professional help for all important aspects of his problem that fall outside the boundaries of the psychologist's competence.

(3) A psychologist does not claim either directly or indirectly or by implication professional qualifications that differ from actual qualifications, nor does he misrepresent his affiliation with any institution, organization, or individual, nor lead others to assume that he has affiliations that he does not have.<sup>[764]</sup> [Emphasis supplied.]

Except for technical changes to reflect gender neutrality,<sup>[765]</sup> those legislative governing principles have remained unchanged over the years.

## **B. Psychology practice standards established by rule**

In establishing professional practice standards by rule, licensing authorities may take one of two general approaches — either spelling practice standards out in the rules or incorporating practice standards established elsewhere by reference. Initially, the Board of Psychology responded to the legislature's directive by adopting rules containing explicit practice standards and a code of ethics. Those ethical rules consisted solely of a series of specific obligations,<sup>[766]</sup> and they did not attempt to incorporate by reference any professional standards that the rules did not expressly describe. But that approach changed in 1989 when the Board amended its rules by adding the following provision to the code of conduct for psychologists:

A psychologist must not engage in any unprofessional conduct. *Unprofessional conduct is any conduct violating parts 7200.4600 to 7200.5600 or violating those standards of professional behavior that have become established by consensus of the expert opinion of psychologists as reasonably necessary for the protection of the public interest.* <sup>[767]</sup> [Emphasis supplied.]

In other words, in addition to being subject to standards of conduct and practice that were expressly stated in the Board's rules, the professional behavior of Minnesota psychologists would thereafter also be governed by the standards that were commonly accepted by practicing psychologists as reasonably necessary to protect the public. The very language of the 1989 rule amendment indicated that the Board intended to adopt the Minnesota Supreme Court's definition of "unprofessional conduct," in *Reyburn v. Minnesota State Bd. of Optometry*, <sup>[768]</sup> namely:

'Unprofessional conduct' is conduct which violates those standards of professional behavior which through professional experience have become established, by the consensus of the expert opinion of the members, as reasonably necessary for the protection of the public interest. In establishing the necessity for and the existence of such standards, every member of the profession should be regarded as an expert.

'\* \* \* There is a moral dereliction in failure by any member of a profession to apply in professional practice the standards which, by consensus of opinion in the profession, are necessary.'

What constitutes unprofessional conduct by an optometrist may be determined by those standards which are commonly accepted by those practicing the profession in the same territory.

\* \* \*

*The board is thereby empowered to declare as 'unprofessional' only such conduct as fails to conform to those standards of professional behavior which are recognized by a consensus of expert opinion as necessary for the public's protection.* It follows that the board is not determining when and upon whom the delegated discretionary power is to take effect but is simply ascertaining the existence of a member's acts or omissions which, if they violate the accepted standards of professional behavior, automatically bring the law into operation by its own terms. <sup>[769]</sup> [Emphasis supplied.]

The definition of "unprofessional conduct" in the 1989 rule amendment is identical to first part of the Court's definition in *Reyburn*. The ALJ further concludes that the Minnesota Supreme Court did not intend the subsequent descriptor, "those standards which are commonly accepted by those practicing the profession in the same territory,"

to be yet another or different standard but rather just another way of describing its initial definition.

In 1991 there was a major overhaul of the Psychology Practice Act<sup>[770]</sup> in which the legislature enacted much of its current version. In that revision the legislature added a declaration of policy to the Psychology Practice Act<sup>[771]</sup> that indicated approval of the Board's 1989 decision to incorporate the *Reyburn* definition of unprofessional conduct into its rules:

The practice of psychology in Minnesota affects the public health, safety, and welfare. The regulations in sections 148.88 to 148.98 protect the public from the practice of psychology by unqualified persons and from unethical or *unprofessional conduct* by persons licensed to practice psychology.<sup>[772]</sup> [Emphasis supplied.]

In summary, the ALJ concludes that the standards for assessing Mr. Appleman's professional and ethical practices prior to May 15, 1993, are the specific practice and ethical obligations listed in the rules that were then in effect, as well as the *Reyburn* test, which the Board had incorporated into its rules in 1989.

### **C. Psychology practice standards enacted by the legislature in 1993**

Effective May 15, 1993, the legislature supplemented the practice standards in the Board's rules by specifically enumerating ten kinds of behavior for which the "[B]oard may impose disciplinary action . . . against an applicant or licensee."<sup>[773]</sup> Among the legislatively enumerated grounds for discipline was engaging in

*unprofessional conduct or any other conduct which has the potential for causing harm to the public, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice without actual injury having to be established;*<sup>[774]</sup> [Emphasis supplied.]

Although the legislature worded its definition of unprofessional conduct slightly different from the *Reyburn* test, the import of the two tests is the same. And there is no evidence that the legislature meant the standard to be anything different from what the Board had previously incorporated into its rules. What the legislature did clearly intend by making this particular statutory change was to make it unnecessary for the Board to establish that unprofessional conduct resulted in actual injury to a client in order to impose disciplinary action.<sup>[775]</sup>

In summary, the incidents giving rise to the Committee's charges of unprofessional conduct by Mr. Appleman occurred both before and after May 15, 1993. And the ALJ concludes that both before and after that date the Board had the authority to discipline a psychologist for engaging in unprofessional conduct. The ALJ further concludes that there was no essential difference in the legal definition of unprofessional conduct before or after May 15, 1993. The essence of unprofessional conduct in both

time periods was conduct that fell short of those standards which were commonly accepted in the State of Minnesota by practicing psychologists.<sup>[776]</sup> And in determining whether commonly accepted standards exist, one must look to those standards of professional behavior which are recognized by a consensus of expert opinion as necessary for the public's protection.<sup>[777]</sup> Finally, during neither time period is actual injury to a client a precondition to disciplinary action.

#### **D. The function of the APA's Ethical Principles in establishing practice standards**

Since 1982 the Board's disciplinary rules have made reference to the American Psychological Association's (APA) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethical Principles):<sup>[778]</sup>

Subp. 4. **Aid to interpretation.** The Ethical Principles of Psychologists and Code of Conduct shall be used as an aid in resolving any ambiguity which may arise in the interpretation of the rules of conduct. However, in a conflict between the rules of conduct and the ethical principles, the rules of conduct shall prevail. The Ethical Principles of Psychologists and Code of Conduct, published in *American Psychologist* by the American Psychological Association, December 1992, is incorporated by reference and is available at the state law library. It is not subject to frequent change.<sup>[779]</sup>

The parties and their expert witnesses have had somewhat different views of what "an aid in resolving any ambiguity which may arise in the interpretation" means. When it moved earlier for partial summary disposition, the Committee took the position that the Board had effectively incorporated the APA Ethical Principles by reference into its disciplinary rules as substantive standards.<sup>[780]</sup> On the other hand, Mr. Appleman's counsel and his expert witness, Dr. Wohl, expressed a very different view of the role that should play in disciplinary proceedings. They argued that the Board only intended the APA Ethical Principles to be expressions of aspirations — that is, idealized expressions of standards toward which psychologists should strive but not necessarily reflective of what commonly occurs in actual practice.<sup>[781]</sup>

The ALJ concludes that neither view is entirely correct. First, if the Board had intended the APA Ethical Principles to be substantive practice standards, it could simply have incorporated them into the rules as such, something that the Board clearly chose not to do. On the other hand, the introduction to the APA's Ethical Principles clearly indicates that although the Preamble and General Principles express aspirational concepts, the specific ethical standards that follow do reflect a consensus among practicing psychologists about what actual practice standards are:

The Preamble and General Principles are *aspirational* goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course

of action and may be considered by ethics bodies in interpreting the Ethical Standards. The Ethical Standards set forth *enforceable* rules for conduct as psychologists.<sup>[782]</sup>

The ALJ concludes that the Board's language in Minn. R. pt. 7200. 4500, subp. 4, should be taken at face value. In other words, the Board intended that the APA's specific Ethical Standards be taken as guidelines for determining what actual practice standards are whenever provisions of the Code of Ethics in the rules<sup>[783]</sup> were not sufficiently explicit to establish concrete standards in actual practice situations. Most of the ethical standards set out in the rules are very explicit and do not require much interpretation when applying them to actual practice situations. But a notable exception is Minn. R. 7200.5700 prohibiting psychologists from engaging in "any unprofessional conduct, which the rule further defines as "violating those standards of professional behavior that have become established by consensus of the expert opinion of psychologists as reasonably necessary for the protection of the public interest." In applying this rule to actual practice situations, interpretation is clearly necessary to establish what the applicable standards of professional behavior are. And in this regard, the specific Ethical Standards contained in the APA's Ethical Principles can be very helpful in defining the applicable practice standards more clearly and explicitly. So in summary, the ALJ concludes that in applying the rule prohibiting unprofessional conduct, the Board intended to rely on the APA's Ethical Principles as guidelines for determining the applicable practice standards.

## VI. Expert Testimony

### A. The role of expert testimony in professional disciplinary proceedings

The OAH rules that govern contested case proceedings such as this provide that:

The judge shall give effect to the rules of privilege recognized by law. *Evidence which is incompetent, irrelevant, immaterial, or unduly repetitious shall be excluded.*<sup>[784]</sup> [Emphasis supplied.]

The requirement of competence addresses, among other things, the admissibility of opinion evidence, including expert opinion, in administrative contested case proceedings. So it is appropriate for an ALJ to seek guidance about the weight and admissibility of expert opinion in the larger corpus of Minnesota law. The first and perhaps most important source of such guidance are the opinion rules in the Minnesota Rules of Evidence. Minn. R. Evid. 702 provides:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact at issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify thereto in the form of opinion or otherwise.

This test for admissibility of expert opinion only requires that the trier of fact be *aided* by the testimony. In other words, the rule clearly contemplates that the role of trier of fact

not be supplanted or pre-empted by experts. So under normal circumstances, the trier of fact need only consider expert opinion evidence or accord weight to the extent that it is found to be helpful.

But to some extent, *Reyburn* places expert opinion in professional disciplinary proceedings on a different and higher footing. Where there are charges of unprofessional conduct, the complaining party must first establish the practice standards that have been breached — that is, some “standards of professional behavior which through professional experience have become established, by the consensus of the expert opinion of the members.”<sup>[785]</sup> And “in establishing the necessity for and the existence of such standards, every member of the profession should be regarded as an expert.”<sup>[786]</sup> In other words, in addressing claims of unprofessional conduct in a proceeding like this, the ALJ must base findings about applicable practice standards and whether or not the licensee violated those standards on expert opinions expressed by members of the profession, including the licensee.

Here, both parties tendered expert opinions about which professional practice standards applied to Mr. Appleman in a variety of contexts and about whether or not Mr. Appleman violated those standards. The Committee presented testimony from Dr. Cohen and Mr. Rusinoff, and Mr. Appleman presented testimony from Dr. Wohl and Mr. Klane, as well as his own testimony. And more often than not the opinions offered by the two parties differed. First of all, in evaluating that expert testimony the issue is not what any one of those experts personally believes a practice standard to be. Rather, according to *Reyburn* the issue is what an expert concludes the *consensus* of expert opinion among psychologists is concerning the standard of professional behavior that is at issue. In weighing those opinions about what consensus in the field is, the ALJ has also considered traditional factors affecting witness credibility, such as interest, consistency of the opinions with the other evidence, etc.

## **B. There is a single set of standards for all practicing psychologists.**

Mr. Appleman suggests that because Dr. Cohen’s professional experience has primarily been as a specialist in neuropsychology in academic and other institutional settings, his opinions should be accorded less weight than those of other expert witnesses. He argues that psychologists who are subjected to the pressures of private general practice should not be expected to “dot every ‘i’ and cross every ‘t’.”<sup>[787]</sup> There is, however, no evidence in the record suggesting that practice standards differ depending on a psychologist’s practice setting and educational background. In weighing the value of expert opinion on an issue, important considerations should be whether or not the expert has knowledge of the applicable standards, whether there is a sufficient basis for that knowledge, and whether the opinion is consistent with other expressions of consensus within the field.

**C. The APA's ethical principles represent an expression of professional consensus about practice standards.**

The APA's *Ethical Principles* concedes that many of its specific ethical standards do not necessarily establish standards of professional behavior in specific situations:

Many of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context.<sup>[788]</sup>

And the APA also did not intend that an apparent violation of an ethical standard, taken alone, should be the basis for legal consequences to a psychologist:

Whether or not a psychologist has violated the Ethics Code does not by itself determine whether he or she is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur. However, compliance with or violation of the Ethics Code may be admissible as evidence in some legal proceedings, depending on the circumstances.<sup>[789]</sup>

In preparing this report, the ALJ has considered the role of expert testimony that *Reyburn* contemplates, the Board's characterization of the *APA Principles* as an aid to interpretation, and the qualifications that the APA itself has imposed on the *Principles*. And it appears to the ALJ that it is appropriate to use the *APA Principles* as a yardstick for assessing which of two or more differing expert opinions about practice standards most accurately reflect the consensus of experts within the field of psychology. In other words, if an expert opinion appears to be at variance with APA ethical principles or standards, then it might appropriately be accorded less weight as evidence of prevailing practice standards than an opinion that is more consistent with those principles and standards.

**D. The expert witnesses did not necessarily have to interview Mr. Appleman's clients to give opinions on whether he met prevailing practice standards.**

Mr. Appleman also argues that the opinions of Dr. Cohen and Mr. Rusinoff about whether he has met prevailing practice standards should be accorded less weight than his own opinions because neither of them interviewed or performed their own assessments of the clients at issue here.<sup>[790]</sup> First, it appears that such a criticism is only potentially meritorious where a practitioner's clinical judgment has been brought into question or where there is an underlying dispute over facts on which a client could shed light. But interview and assessment appears unnecessary with charges of improper billing or record keeping where the issue is simply whether records conform to a standard. It would also appear to be unnecessary with charges of failure to follow a customary and accepted procedure where the client can shed no light on the procedures that the psychologist followed. Nonetheless, it was appropriate for Mr. Appleman to caution the trier of fact to inquire whether failure of an expert to conduct an

independent evaluation of a client might affect the reliability of the expert's opinion about a particular charge.

## VII.

### **Charges of Substandard Clinical and Other Professional Judgment**

It is the Board's role, and not the ALJ's, to determine the relative seriousness of any of the Committee's charges that are established by a preponderance. But for convenience of analysis, the ALJ has grouped the charges for which he is not recommending dismissal on legal grounds into two broad categories. The first group is discussed in this section and consists of pending charges that raise issues about Mr. Appleman's clinical and other professional judgment. The second group, discussed in the following section, consist of pending charges that raise issues about Mr. Appleman's record keeping practices. It is the ALJ's view that the Minnesota Supreme Court's decision in *Wang* should be of greater concern in addressing the first group of charges, since they essentially bring Mr. Appleman's professional competence and moral character into question.

#### **A. Charge of altering client records (Claims 1-13 and 1-13.1):**

In Claim 1-13 the Committee charged Mr. Appleman with submitting altered documents to an insurance company to obtain reimbursement, and in Claim 1-13.1 it charged him with altering or adding material to Client #1's clinical records without appropriately identifying that the records were being amended. A preponderance of the evidence established that on four occasions between November 23, 1993, and October 3, 1994, Mr. Appleman made subsequent alterations to progress notes that he had prepared for Client #1. The evidence also established that he had transmitted both the unaltered and altered versions of those progress notes to Client #1's insurer in the course of seeking reimbursement for services provided to that client.<sup>[791]</sup> And at no time did he ever specifically note that the amendments or alterations were such nor did he provide any explanation for why the progress notes were being amended or altered.<sup>[792]</sup>

The Board's rules specifically provide that "[a] psychologist must maintain an accurate record for each client. Each record must minimally contain . . . an accurate chronological listing of all client visits, together with fees charged to the client or a third-party payor . . . ."<sup>[793]</sup> As an aid to interpreting that rule, APA Ethical Standard 1.26 provides:

In reports to payors for services or sources of research funding, psychologist accurately state the nature of the research or service provided, the fees or charges, and where applicable the identity of the provider, the findings, and the diagnosis.

Whether it was the altered or the unaltered sets of progress notes that were inaccurate is immaterial. One of the sets was necessarily inaccurate. So, Mr. Appleman

transmitted inaccurate documents to a third-party payor in connection with his requests for reimbursement and therefore violated the rule. Additionally, both Dr. Cohen and Dr. Wohl agreed that prevailing practice standards for psychologists required that they specifically note any subsequent amendments or alterations of progress notes and provide explanations for any such amendments or alterations.<sup>[794]</sup> Mr. Appleman did neither. He therefore violated the prohibitions in both statute and rule against engaging in unprofessional conduct, since his own documentation practices in these instances failed to conform to those standards. The ALJ therefore is recommending that the Board conclude that charges in Claim 1-13.1 have been established by a preponderance of the evidence.

However, Claim 1-13 is a different matter. It suggests that Mr. Appleman fraudulently altered records in order to receive reimbursement for services not performed. Although that *inference* may also be drawn from the evidence, any such inference is clearly insufficient to meet the standard in *Wang*. For example, the possibility at least exists here that Mr. Appleman erred in preparing the progress notes in the first instance, that the altered versions correctly reflected what had occurred, and that he simply failed to explain why he had amended them. In order to establish fraudulent conduct here, it is the ALJ's view that the Committee was obliged to negate that possibility by some evidence "with heft," and not simply with an inference. The ALJ is therefore recommending that the Board dismiss the charges described in Claim 1-13.

#### **B. Charges of unprofessional conduct in interactions with sex offender clients (Claims OF-17 and OF-20):**

The Committee is asserting two charges of unprofessional conduct arising out of Mr. Appleman's interactions with Clients #15 and #11. In Claim OF-17, the Committee asserts that he engaged in conduct harmful or potentially harmful to Client #15 by writing false statements about Client #15 in a letter to his probation officer and in a report to the Board. This charge is based primarily on apparently contradictory statements that Mr. Appleman made about Client #15's amenability to treatment.<sup>[795]</sup> In order to establish the charge, it is necessary to infer from the surrounding facts that the shift in Mr. Appleman's opinion about Client #15's attitude was disingenuous and intended to inflict harm on that client, rather than being a legitimate change in opinion. That is a very serious charge, and in the ALJ's view *Wang* requires more hefty evidence than mere inferences. The contrary views of two of Client #15's other therapists about his attitude toward therapy elevate the evidence to the required qualitative standards. Psychologists often express contrary opinions. Moreover, the opinions here were introduced as hearsay, with no opportunity for Mr. Appleman to cross-examine the proponents.<sup>[796]</sup> Finally, the Committee did pose a lengthy hypothetical question to its expert Mr. Rusinoff about Mr. Appleman's behavior toward Client #15. Although that hypothetical question did include some assumptions relating the shift in Mr. Appleman's opinion about Client #15's attitude, Mr. Rusinoff's opinion seemed primarily based on the assumption that Mr. Appleman had accused Client #15 of lying to his probation officer. In other words, the relevance of Mr. Rusinoff's opinion to the unobjectionable

portion of Claim OF-17 was ambiguous at best. For these reasons, the ALJ is recommending that the Board dismiss the charges embraced by Claim OF-17.

Claim OF-20 also challenges the accuracy of one of Mr. Appleman's assessments of a client's amenability to treatment — this time, Client #11. There, the Committee charged that Mr. Appleman made false and misleading statements to the Board about Client #11's willingness to participate in chemical dependency and sex offender treatment.<sup>[797]</sup> In December 1992 Mr. Appleman submitted a report as part of Client #11's pre-sentence investigation that stated that Client #11 acknowledged having a problem with alcohol dependence, was participating in chemical dependency treatment, and was "unequivocally, amenable" to sex offender treatment.<sup>[798]</sup> About a month and a half later, at Client #15's request, his probation officer transferred him from Mr. Appleman's program to another sex offender treatment program. The record indicates that Mr. Appleman did not change his original assessment of Client #11's willingness to participate in treatment at any time before Client #15 left the program.<sup>[799]</sup> But two years later, in contrast to the assessment that he had made of Client #11 during treatment, Mr. Appleman prepared a case analysis for the Board in which he characterized Client #11 as resistive to both sex offender and chemical dependency treatment, manipulative, and deceitful.<sup>[800]</sup> And it is on this basis that the Committee charges that Mr. Appleman made false or misleading statements about Client #11

The evidence supporting Claim OF-17 differed materially from the evidence supporting Claim OF-20. In the former case, the possibility existed that Client #15's attitude and Mr. Appleman's opinion about that attitude could have changed during the course of treatment. But in Claim OF-20, involving Client #11, the Committee failed to produce evidence that effectively ruled that possibility out. There is no evidence in the record that even suggests that Client #11's attitude and Mr. Appleman's opinion about that attitude changed during the relatively brief when Mr. Appleman was treating him. So either his statement during the pre-sentence investigation or his statement to the Board was misleading. One of the Board's rules prohibits psychologists from engaging "in any conduct likely to deceive or defraud the public or the board."<sup>[801]</sup> So it does not really matter which of the two statements was misleading.<sup>[802]</sup> Additionally, Mr. Appleman presented no evidence at the hearing to deny or explain the discrepancy. In fact, there was evidence that he admitted the existence of the discrepancy.<sup>[803]</sup> The ALJ therefore is recommending that the Board conclude that charges in Claim OF-20 have been established by a preponderance of the evidence.

### **C. Charge of billing for services not provided (Claim 20-8):**

In Claim 20-8, the Committee charged, among other things, that Mr. Appleman billed Client #20's workers' compensation insurer for vocational testing that was never provided. Mr. Appleman admitted that he billed the workers' compensation insurer for vocational testing that he never completed or interpreted.<sup>[804]</sup> Minnesota Rules part 7200.5200, subpart 3, provides that

[a] psychologist shall not directly or by implication misrepresent to the client or to a third party billed for services the nature of the services, the extent to which the psychologist has provided the services, or the individual who is professionally responsible for the services provided.

By his own admission, Mr. Appleman violated that rule.

### **D. Charge of failure to give required warnings. (Claim 3-4)**

In Claim 3-4, the Committee charges Mr. Appleman with failure to give required warnings of Client #3's homicidal ideation or, alternatively, failure to document an assessment and explanation for not giving those warnings. The legislature has imposed a duty to warn on psychologists in certain circumstances:

The duty to predict, warn of, or take reasonable precautions to provide protection from, violent behavior arises only when a client or other person has communicated to the licensee a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim. If a duty to warn arises, the duty is discharged by the licensee if reasonable efforts, as defined in subdivision 1, paragraph (c), are made to communicate the threat.<sup>[805]</sup>

Although *Culberson v. Chapman*<sup>[806]</sup> actually deals with the reverse situation — that is, a client challenging a clinician's decision to give a warning, one of the court of appeals' conclusions is germane here, namely that in assessing the seriousness of threats verbalized by their clients,

[p]ractitioners must be given a wide degree of discretion in determining what type of action will best ensure the safety of the individuals involved.<sup>[807]</sup>

It is therefore the ALJ's view that Mr. Appleman's conclusion that Client #3 was not verbalizing homicidal thoughts about another person and his decision not to warn that other person were within the scope of his clinical discretion under the statute. The ALJ therefore concludes that Mr. Appleman did not violate the statute.

However, a separate issue is whether Mr. Appleman failed to conform to prevailing practice standards by not recording both a written assessment of what Client #3 had verbalized and an explanation of why he did not consider Client #3's statements

to be homicidal ideation. Dr. Cohen's views certainly represent the more cautious approach for clinicians. On the other hand, *Culberson v. Chapman* tends to lend some support to Mr. Appleman's view on the duty to document in this instance. The court of appeals indicated that it had undertaken a thorough review of the legislative history of Minnesota Statutes, section 148.975, including listening to tapes of committee hearings and floor debate.<sup>[808]</sup> This at least suggests that the legislature took account of prevailing practice standards when it enacted the statute, as did the court of appeals when it interpreted it. Additionally, Dr. Cohen's opinion is based solely on a records review and without any personal contact with Client #3, and in the ALJ's view this is one situation where those facts diminish the weight of his opinion. In other words, the ALJ is not convinced that the standard that Dr. Cohen expressed is an absolute prevailing practice standard. Rather Mr. Appleman's view that there is room for clinical judgment in deciding what to place in a client's chart more closely approximates prevailing practice. For these reasons, the ALJ recommends that the Board dismiss the charges in Claim 3-4.

**E. Charge of administering and billing for a non-standard test without identifying it as such. (General Claim 3)**

In General Claim-3, the Committee charges that Mr. Appleman administered a non-standard psychological test — namely, the Goldberg Stress test — to eight of his clients and charged them for that test without commenting in his reports on limitations on its efficacy and the fact that it is not a test that psychologists commonly use in their practices. One of the Board's rules provides that in order for a psychologist to use any psychological tests in his or her practice, those

...psychological tests *used* by psychologists must include a manual or other published information which fully describes the development of the test, the rationale for the test, the validity and reliability of the test, and normative data.<sup>[809]</sup> [Emphasis supplied.]

A clear preponderance of the evidence established that Mr. Appleman used and billed for the Goldberg's Stress Test in connection with the services that he provided to several of his clients,<sup>[810]</sup> and that the Goldberg's Stress test lacks a manual or other published information which fully describes the development of the test, the rationale for the test, the validity and reliability of the test, and normative data.<sup>[811]</sup> The ALJ therefore concludes that Mr. Appleman's use of the Goldberg's Stress Test violated a Board rule.<sup>[812]</sup> It was also Dr. Cohen's opinion that Mr. Appleman's use of the Goldberg's Stress Test failed to meet the usual and customary prevailing standards of professional practice by psychologists in Minnesota in the mid-1990s.<sup>[813]</sup> Mr. Appleman disagreed,<sup>[814]</sup> and Dr. Wohl expressed no opinion on that subject because he had personally never encountered the test.<sup>[815]</sup> The fact that Dr. Wohl had never personally encountered the test in his long career tends to support Dr. Cohen's opinion. So the ALJ is recommending that the Board conclude that a preponderance of the evidence establishes that Mr. Appleman's use of the Goldberg's Stress Test failed to meet prevailing professional practice standards.

## F. Charge of failure to coordinate services (Claim OF-11):

In Claim OF-11, the Committee charges that Mr. Appleman violated Board rules by failing to release Client #10's treatment records to a subsequent provider.<sup>[816]</sup> The Board's rules provide:

**Coordinating services with other professionals.** A psychologist shall ask a client whether the client has had or continues to have a professional relationship with another mental health professional. If it is determined that the client had or has a professional relationship with another mental health professional, the psychologist shall, to the extent possible and consistent with the wishes and best interests of the client, coordinate services for that client with the other mental health professional.

As an aid to interpreting the phrase "coordinate services," APA Ethical Standard 4.09(d) indicates that a psychologist should take "reasonable steps to facilitate transfer of responsibility to another provider if the patient or client needs one immediately."<sup>[817]</sup> Dr. Cohen testified that an important purpose for documentation of psychology services is:

to provide a permanent and accurate record of all that's taken place, both in terms of whatever assessments you have done with a client, or in the case of therapy, the treatment you have done with the client, and so that you have a record available to yourself and so other practitioners who see the record are able to determine what has been going on, what you have done and what is to be done.<sup>[818]</sup>

It was Mr. Rusinoff's opinion that transmitting only three pages to a new provider when a psychologist has developed sixty pages of records in caring for a client is substandard practice. In short, coordinating care clearly involves providing client records to a new provider in order to facilitate continuity of care.

Even though Mr. Appleman testified at the hearing that he provided Client #10's records to Mr. Johnson "at some reasonable time,"<sup>[819]</sup> a preponderance of the evidence established that he did not. Although Mr. Appleman had previously agreed orally and in writing to send "all reports and records" to Client #10's new provider, there is no record of Mr. Appleman ever having sent any record to Mr. Johnson other than the chemical dependency assessment of February 26, 1993.<sup>[820]</sup> Mr. Appleman gave a somewhat contradictory version of what happened in a pre-hearing deposition, where he suggested that Mr. Johnson may not have received the other chemical dependency assessment and testing records because of "clerical error."<sup>[821]</sup> In fact, both of those versions are directly contradicted by Mr. Johnson's testimony that in a telephone conversation on April 6, 1993, Mr. Appleman told him that "that there was no testing that had been done..."<sup>[822]</sup> Mr. Johnson's testimony is corroborated by progress notes that he made in Client #10's chart on the date that the conversation with Mr. Appleman occurred.<sup>[823]</sup> Mr. Johnson's version of the facts is more credible than Mr. Appleman's. The ALJ therefore concludes that Mr. Appleman violated the rule requiring coordination

of care not only by failing to provide Mr. Johnson with all of Client #10's chemical dependency assessment and testing records, but also by attempting to mislead Mr. Johnson into believing that no other testing of Client #10 had been done.

### **G. Charge of releasing confidential information (Claim OF-10):**

The Board's rule on protecting the privacy of clients provides, in part:

**In general.** A psychologist shall safeguard the private information obtained in the course of practice, teaching, or research. With the exceptions listed in subparts 2, 4, 5, 10, and 12, private information is disclosed to others only with the informed written consent of the client.<sup>[824]</sup>

Another Board rule requires that client records "minimally contain," among other things, "copies of all client authorizations for release of information and any other legal forms pertaining to the client."<sup>[825]</sup> A preponderance of the evidence established that Mr. Appleman released private information about Client #15 to that client's attorney, his probation officer, and to at least three other therapists without having any written consents to release or with only expired releases on file. Asserting that releases may have been misfiled is no defense to the rule that prescribes the minimal contents of a client's file. And the rule on disclosure goes on to negate Mr. Appleman's opinion that releases are unnecessary to disclose private information to a client's attorney or probation officer:

**Disclosure without written consent.** Private information may be disclosed without the informed written consent of the client when disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by the client on the client or another individual. *In such case the private information is to be disclosed only to appropriate professional workers, public authorities, the potential victim, or the family of the client.*<sup>[826]</sup> [Emphasis supplied.]

Here, Mr. Appleman made no showing that disclosure was necessary to protect against such a clear and present risk.

### **H. Charges of substandard assessment and diagnosis.**

In its list of charges, the Committee asserted four charges that bring Mr. Appleman's clinical judgment into question by alleging diagnoses that fail to conform to prevailing practice standards — namely, Claims 1-1, 1-2, 1-4, and 8/9-1. The Committee withdrew several other charges of substandard diagnoses.

#### **1. Claim 1-1: Misdiagnosing Client #1 as having PTSD.**

Three of the Committee's charges relating to Mr. Appleman's care of Client #1 bring Mr. Appleman's clinical judgment directly into question by alleging that Mr. Appleman made substandard diagnoses.<sup>[827]</sup> Claim 1-1 charges that Mr. Appleman

inappropriately diagnosed Client #1 with Post-Traumatic Stress Disorder (PTSD).<sup>[828]</sup> Neither Dr. Cohen nor Dr. Wohl made an independent assessment of Client #1 in arriving at their respective opinions about whether or not Mr. Appleman's diagnoses were substandard. Rather, resolution of this charge turns on the legal status to be accorded the diagnostic criteria contained in DSM-III-R.<sup>[829]</sup>

That document's diagnostic criteria specify that in order to diagnose a client as having PTSD, there must be a "[d]uration of the disturbance (symptoms in B, C and D) of at least one month."<sup>[830]</sup> Mr. Appleman's records indicated, and he himself admitted, that he made the diagnosis only about *two weeks* after Client #1 experienced a traumatic event.<sup>[831]</sup> In effect, the Committee takes the position that making a diagnosis that does not meet all of the pertinent diagnostic criteria in DSM-III-R is substandard practice *per se*.<sup>[832]</sup> On the other hand, Mr. Appleman argues that DSM-III-R is not "a bible" and its diagnostic criteria do not have to be taken literally in all cases. Rather, it is merely a guideline that leaves room for an individual clinician's clinical judgment.<sup>[833]</sup>

However, the opinions of the parties' respective expert witnesses do not appear to support a view of prevailing practice standards that is as extreme as either party proposes. It was Dr. Cohen's opinion that prevailing practice standards required that all diagnostic criteria in DSM-III-R be met, "unless one clearly delineates the reasons why, in accordance with the diagnostic and statistical manual."<sup>[834]</sup> Because Mr. Appleman's diagnosis of PTSD did not meet the duration criterion of DSM-III-R *and* because he did not explain why he departed from the criterion, it was Dr. Cohen's opinion that Mr. Appleman's diagnosis was substandard.<sup>[835]</sup> On the other hand, it was Dr. Wohl's opinion that DSM-III-R and DSM-IV were just guidelines and that a psychologist "can take liberties with these guidelines."<sup>[836]</sup> Nevertheless, Dr. Wohl indicated that a third party payor would be justified in withholding reimbursement from reimbursing a psychologist who departed from DSM-III-R criteria in making a diagnosis.<sup>[837]</sup> But two provisions of DSM-III-R appear helpful in resolving the apparent conflicts of expert opinion:

The impact of DSM-III has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about disorders for which they have professional responsibility.<sup>[838]</sup>

\* \* \*

. . . DSM-III and DSM-III-R provide specific diagnostic criteria as guides for making each diagnosis since such criteria enhance interjudge diagnostic reliability. It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response.<sup>[839]</sup>

After considering all of the evidence relating to this charge,<sup>[840]</sup> the ALJ concludes that the Committee failed to establish by a preponderance of the evidence that Mr. Appleman misdiagnosed Client #1 as having PTSD.<sup>[841]</sup> But the ALJ does conclude that

he failed to conform to prevailing practice standards by not explaining his departure from DSM-III-R criteria when he diagnosed Client #1 as having PTSD and when he sought reimbursement from a third party payor for that diagnosis.

## **2. Claims 1-2 and 1-4: Misdiagnosing Client #1 as having somatoform pain disorder.**

Claims 1-2 and 1-4 both relate to Mr. Appleman's diagnosis of Client #1 also having somatoform pain disorder.<sup>[842]</sup> Although previously characterized by the ALJ as being two separate charges, they are so closely connected that the ALJ will now address them as a single charge.<sup>[843]</sup> As with the claim of an inappropriate PTSD diagnosis, the crux of this charge is that the diagnosis did not meet a key diagnostic criterion in DSM-III-R for that condition — namely, that there must be a “[p]reoccupation with pain for at least six months.”<sup>[844]</sup> As in the claim involving PTSD, the outcome of this charge depends on the weight to be accorded DSM-III-R's diagnostic criteria in establishing practice standards. But for the reasons that follow, the ALJ concludes that here there was a misdiagnosis of somatoform pain disorder rather than only a failure to provide an explanation of why he departed from the diagnostic criterion in DSM-III-R.

Client #1 was involved in an automobile accident on November 1, 1993. Mr. Appleman first saw him on November 15, 1993, and diagnosed Client #1 as having somatoform pain disorder on November 24, 1993, only twenty-three days after Client #1's traumatic event.<sup>[845]</sup> It was Dr. Cohen's opinion that under prevailing practice standards, “you cannot diagnose somatoform pain disorder before the client reaches that six months criteria.”<sup>[846]</sup> Unlike his opinion on diagnosing PTSD, Dr. Cohen did not indicate that prevailing standards allowed a clinician to diagnose somatoform pain disorder where preoccupation with pain was of less than six months' duration so long as an explanation for the departure from the criterion was given. Dr. Cohen explained the reasons for his opinion that prevailing standards did recognize such an exception:

The difference, according to research, is that individuals who have had pain for six months or more typically have a constellation of symptoms that reflect not only the physical pathology, but often psychological concomitants. To translate that into English, people acutely after their injury respond one way. \* \* \* So there are very different problems at those different time periods, and the chronic pain treatment is not appropriate for people in the acute stage, but certainly would be appropriate for people in that later stage, the more chronic pain phase.<sup>[847]</sup>

In other words, twenty-three days after a traumatic event was not enough time in which to determine adequately whether or not a client was displaying chronic pain symptomology. For his part, Dr. Wohl indicated that Dr. Cohen was “correctly stating that there is an average of six months and it is down there as the cut off....”<sup>[848]</sup> But he went on to disagree with Dr. Cohen and express the opinion that:

[w]hether or not he hypothetically falls before the six months or after six months, there's nothing magic about six months. It's just a measure of central tendency or in this case an average or a mean or a mode. So the

individual patient can certainly be responded to on the basis of what your experience has found to be the best possible treatment approach whether or not they meet that six-month criteria or not.<sup>[849]</sup>

There are two primary reasons why the ALJ concluded that Dr. Wohl's opinion did not represent the consensus of psychologists about the prevailing standard for diagnosing somatoform pain disorder. First, DSM-III-R itself represents strong evidence of prevailing diagnostic standards. In describing the duration criterion, it frames it as "at least six months." Nowhere does it even suggest that six months represents an average or mean. So it appears to the ALJ that Dr. Cohen's opinion is more consistent with DSM-III-R than Dr. Wohl's. Second, this is not a case where the time of diagnosis was even close to DSM-III-R's duration criterion. It was made only about three weeks after the traumatic event when it was more probable than not Client #1 was still in an acute stage of pain. For these reasons, the ALJ concludes that the Committee did establish by a preponderance of the evidence that Mr. Appleman misdiagnosed Client #1 as having somatoform pain disorder.

### **3. Claims 8/9-1: Inappropriately attributing Client #9's PTSD to a recent automobile accident.**

In Claim 8/9-1 charges Mr. Appleman with inappropriately attributing Client #9's PTSD to a recent automobile accident. Client #9 was involved in an automobile accident on December 31, 1990, and Mr. Appleman first evaluated her on April 23, 1991.<sup>[850]</sup> One of his diagnoses was "Post-Traumatic Stress Disorder due to a car accident."<sup>[851]</sup> Documentation that Mr. Appleman received from other health care providers indicated that Client #9 had also been involved in earlier automobile accidents, and that she also had a history of "nervous breakdowns" before her most recent automobile accident.<sup>[852]</sup> Neither the Committee nor its expert, Dr. Cohen, appear to take issue with the appropriateness of diagnosing Client #9 with PTSD.<sup>[853]</sup> Rather, in Claim 8/9-1 the Committee charges that it was a substandard clinical judgment for Mr. Appleman's to conclude that her PTSD *was caused by* the December 31, 1990, automobile accident. It was Dr. Cohen's opinion that that Mr. Appleman's conclusion about Client #9's PTSD did not meet prevailing standards because

"[i]ts certainly the case that this woman had tremendous other stressors in her life, had a history of chemical dependency, and none of that is included in the information of formulation of this case."<sup>[854]</sup>

Dr. Wohl was not asked for any opinions about Mr. Appleman's diagnoses of Client #9.<sup>[855]</sup> On direct examination, Mr. Appleman reiterated his conclusion that Client #9's PTSD was related to the most recent automobile accident.<sup>[856]</sup> So whether this charge has been substantiated turns on the relative weight to be accorded Dr. Cohen's opinion and Mr. Appleman's own opinion. Mr. Appleman's testimony did not specifically address or explain what is at issue here, namely, causation. His opinions also shed no light on any prevailing standards that might apply to his finding of causation.<sup>[857]</sup> On the other hand, although Dr. Cohen's testimony was framed in terms of prevailing standards, the subject of his opinion is somewhat ambiguous. He suggested other causes but offered no opinion of his own about what caused Client #9's PTSD. So, it is

unclear what Dr. Cohen was considering to be substandard — Mr. Appleman’s conclusion about causation or his case formulation.<sup>[858]</sup> It is the ALJ’s opinion that in deciding *Wang* the Minnesota Supreme Court was requiring something “more hefty” than an ambiguous expert opinion to establish a licensing violation. He therefore recommends that the Board dismiss Claim 8/9-1.

## I. Charges of substandard test administration and interpretation.

In its list of charges, the Committee asserted eight charges that bring Mr. Appleman’s clinical judgment into question by alleging diagnoses that fail to conform to prevailing practice standards — namely, Claims 1-7, 2-7, 4-3, 5-5, 5-8, 6-8, 20-12, and 21-3. The Committee withdrew several other charges of substandard testing.

### 1. Claim 1-7: Making a substandard interpretation of Client #1’s MMPI.

In Claim 1-7, the Committee charges that Mr. Appleman made a substandard interpretation of an MMPI that he had administered to Client #1. The charge is based on an MMPI scoring sheet,<sup>[859]</sup> a progress note that appears to document his interpretation of the test,<sup>[860]</sup> and Dr. Cohen’s opinion that the interpretation of the MMPI in the progress note was substandard.<sup>[861]</sup> Neither Mr. Appleman nor Dr. Wohl gave expert opinions at the hearing about Mr. Appleman’s interpretation of Client #1’s MMPI.<sup>[862]</sup> But in an earlier affidavit filed in opposition to the Committee’s motion for partial summary disposition,<sup>[863]</sup> Mr. Appleman offered three, somewhat contradictory criticisms of Dr. Cohen’s opinion. First, he stated that Dr. Cohen’s opinion was “totally erroneous.”<sup>[864]</sup> Second, he stated that he had never made a written interpretation of the MMPI, apparently implying that the two contiguous sentences in the progress note, “Went over MMPI. Pt. is highly depressed w/ significant physical complaints,” were, in fact, disconnected.<sup>[865]</sup> Finally, he stated that his diagnosis of depression was based on all of his testing and the results of his interview with the client, of which the MMPI results were only one element.<sup>[866]</sup>

First of all, neither Mr. Appleman nor Dr. Wohl challenged Dr. Cohen’s opinion that an interpretation of Client #1’s MMPI scoring that did conform to prevailing practice standards would not have included physical complaints and major depression. Dr. Cohen’s opinion on that issue is highly credible, since he wrote his doctoral dissertation on interpretation of the MMPI.<sup>[867]</sup> So the only issue here is whether Mr. Appleman made that interpretation. The two sentences in question in the progress note are contiguous. The most reasonable interpretation of what he wrote is that the statement that the patient “is highly depressed w/ significant physical complaints” refers to what Mr. Appleman discussed when he “went over the MMPI” with Client #1.” Because of that, because of Mr. Appleman’s interest in the outcome of this proceeding, and because he only offered that interpretation of his progress note in a context where he was not subject to cross-examination, the ALJ concludes that his interpretation of the progress note is not credible.

But even if one accepts Mr. Appleman's interpretation of his progress note, a preponderance of the evidence still establishes a violation of licensing laws. A Board rule requires psychologists to note:

any discrepancy, disagreement, or conflicting information regarding the circumstances of the case that may have a bearing on the psychologist's conclusions . . . <sup>[868]</sup>

An interpretation of the MMPI that did meet practice standards directly conflicted with his diagnosis of depression, and he was obliged to note the conflict but did not. So even if he did not interpret the MMPI as suggesting major depression and physical complaints, he still violated the rule by not noting the conflict between the MMPI results and his diagnoses.

The ALJ therefore concludes that the Committee did establish by a preponderance of the evidence that Mr. Appleman made a written interpretation of Client #1's MMPI, and that the interpretation he made did not conform to prevailing practice standards. Alternatively, it established by a preponderance of the evidence that Mr. Appleman violated a Board rule by failing to make a written notation in Client #1's records that the results of the MMPI conflicted with his diagnosis of depression.

## **2. Claim 2-7: Substandard interpretations of the WAIS-R and Trails A and B tests administered to Client #2.**

Claim 2-7 charges that Mr. Appleman with making substandard interpretations of the WAIS-R and Trails A and B tests that he had administered to Client #2. He concluded, among other things, that sub-test patterns from the WAIS-R suggested long-term memory, short-term memory, vocabulary and language problems.<sup>[869]</sup> On the other hand, it was Dr. Cohen's opinion that long- and short-term memory deficits were not discernible from the WAIS-R, so those conclusions did not conform to prevailing practice standards.<sup>[870]</sup> It was also his opinion that Client #2's scores on the WAIS-R's sub-tests were average or above average and therefore not suggestive of vocabulary and language problems.<sup>[871]</sup> Although Mr. Appleman did not offer any specific opinions about these test interpretations at the hearing, he again offered opinions in an earlier affidavit that were contrary to Dr. Cohen's.<sup>[872]</sup> There, Mr. Appleman asserted that the WAIS-R sub-tests do measure auditory and written short and long-term memory.<sup>[873]</sup> Again, this issue turns on the relative credibility of two conflicting expert opinions. The ALJ considered Dr. Cohen's opinions to be more credible for at least three reasons. First, as a neuropsychologist, Dr. Cohen has had significantly more training and experience with psychological testing than Mr. Appleman.<sup>[874]</sup> Second, Mr. Appleman did not dispute Dr. Cohen's opinion that Client #2's scores on verbally based sub-tests were average or above average and therefore not suggestive of vocabulary and language problems. Third, Mr. Appleman did not directly challenge Dr. Cohen's opinion that Client #2's scores on sub-tests assessing problem solving and perceptual organization did not support Mr. Appleman's interpretation that the WAIS-R indicated that those functions were "dramatically low." In other words, Mr. Appleman did not take

issue with the proposition that many of his other interpretations of the WAIS-R were substandard.

It was also Dr. Cohen's opinion that Mr. Appleman's interpretation of the Trails A and B tests — namely, that "Trails A & B . . . suggests that [Client #2] has difficulty tracking" — failed to conform to prevailing practice standards. The basis for his opinion was that Client #2's low-average Trailmaking scores were consistent with the results on other visual tests and Client #2's overall IQ.<sup>[875]</sup> Mr. Appleman's criticism of this opinion does not even address the issue. In his affidavit, he asserted that his conclusion about tracking was based on personal observations of Client #2 and not necessarily on the Trailmaking scores,<sup>[876]</sup> a statement that directly contradicts what he wrote in his test interpretation.

In summary, the ALJ therefore concludes that the Committee did establish by a preponderance of the evidence that Mr. Appleman's written interpretations of Client #2's WAIS-R and Trails A and B tests did not conform to prevailing practice standards.

### **3. Claim 4-3: Substandard interpretations of the WAIS-R test administered to Client #4.**

In Claim 4-3, the Committee charges that Mr. Appleman made a substandard interpretation of the WAIS-R for Client #4. This particular charge generated the most extensive expert debate of the hearing, with Dr. Cohen expressing opinions that Mr. Appleman's interpretations of the test did not conform to prevailing practice standards and with Mr. Appleman expressing opinions that he did.<sup>[877]</sup> The focal point of debate was the standard error of measurement for the WAIS-R. In substance, it was Dr. Cohen's opinion that in interpreting the test Mr. Appleman attached clinical significance to subtest scores that fell within the standard error of measurement and that that practice did not conform to prevailing practice standards.<sup>[878]</sup> In other words, in Dr. Cohen's opinion the standard error of measurement is clinically meaningful in interpreting test results. On the other hand, it was essentially Mr. Appleman's opinion that the only usual and customary practice in scoring the WAIS-R was to ensure that the scores were arithmetically correct. Otherwise, psychologists were completely free to attach clinical significance to test scores that appeared to be consistent with their clinical observations, including scores that fell within the standard error of measurement.<sup>[879]</sup> In short, in Mr. Appleman's view the standard error of measurement is not clinically meaningful in interpreting test results.

The ALJ concludes that Dr. Cohen's opinion is more credible in establishing what the prevailing practice standards are for interpreting the WAIS-R, first and foremost because that opinion is more consistent the Board's rules. The Board's rule on reports provides that a psychological "report must include," among other things:

any reservations or qualifications concerning the validity or reliability of the conclusions formulated and recommendations made, taking into account the conditions under which the procedures were

carried out, the limitations of scientific procedures and psychological descriptions, and the impossibility of absolute predictions . . . .<sup>[880]</sup>

A psychological test's standard error of measurement is clearly a limitation on a scientific procedure. The rule clearly contemplates that psychologists will customarily formulate their conclusions about testing in ways that are consistent with the scientific limitations inherent in tests. Dr. Cohen expressed the substance of the rule more directly:

I guess in summarizing, the data is what any psychologist has, and you must follow the data and what it says, not use it as a leaping off point for making things that are different from where the data is.<sup>[881]</sup>

Finally, despite Mr. Appleman's contrary opinion,<sup>[882]</sup> the ALJ also finds Dr. Cohen's opinions that the WAIS-R does not measure long-term memory and that two of Client #4's highest scores were on sub-tests that measure attention were more credible. Again, as a neuropsychologist, Dr. Cohen has had significantly more training and experience with memory testing than Mr. Appleman, a point that Mr. Appleman himself readily conceded.<sup>[883]</sup> In summary, the ALJ concludes that the Committee did establish by a preponderance of the evidence that Mr. Appleman's written interpretations of Client #4's WAIS-R test did not conform to prevailing practice standards.

#### **4. Claims 5-5 and 5-8: Substandard interpretations of the tests administered to Client #5.**

In Claim 5-5, the Committee charged Mr. Appleman with failing "to competently administer and interpret psychological tests regarding client #5,"<sup>[884]</sup> and in Claim 5-8 it more specifically charged him with "inappropriately administering the WRAT Reading Recognition subtest to a non-native English-speaking person. Addressing the second, more specific claim first, it was Dr. Cohen's opinion that administering a portion of the WRAT that involved reading words in English to a client who had minimal proficiency in English test did not conform to prevailing practice standards.<sup>[885]</sup> Neither Mr. Appleman nor Dr. Wohl even attempted to take issue with Dr. Cohen's opinion. And that opinion so comports with common sense as to be self-evident. The ALJ therefore concludes that the Committee established by a preponderance of the evidence that Mr. Appleman failed to meet usual and customary prevailing standards of practice by administering the WRAT to Client #5.

With regard to the more general claim of substandard test administration and interpretation for Client #5, the major thrust of Dr. Cohen's testimony was that testing conditions were less than optimal for the tests that Mr. Appleman administered, and that those less than optimal conditions were likely to have affected the results that Mr. Appleman obtained.<sup>[886]</sup> But in no case, was Dr. Cohen able to say definitively that Mr. Appleman's interpretations were substandard because they were erroneous. Rather, the ALJ concludes that the facts involved in Claim 5-5 are more appropriately governed by the Minnesota Rules, part 7200.5000, subpart 3B, which requires that "report must include . . . any reservations or qualifications concerning the validity or reliability of the

conclusions formulated and recommendations made, taking into account the conditions under which the procedures were carried out . . .” A preponderance of the evidence clearly established that a number of factors relating to the conditions under which the testing of Client #5 was carried were likely to affect the validity or reliability of the conclusions that Mr. Appleman formulated from that testing.<sup>[887]</sup> He therefore violated that rule in connection with his testing of Client #5 by failing to discuss in his report the many factors that Dr. Cohen noted.

**5. Claim 6-8: Substandard interpretations of the WAIS-R test administered to Client #6.**

In Claim 6-8, the Committee charged Mr. Appleman with substandard interpretations of the tests that he administered to Client #6. It was Dr. Cohen’s opinion that Mr. Appleman’s interpretations of Client #6’s WAIS-R and Bender-Gestalt tests did not conform to usual and customary prevailing practice standards, and he offered specific reasons for why they did not.<sup>[888]</sup> Neither Mr. Appleman nor Dr. Wohl challenged those opinions or offered differing opinions.<sup>[889]</sup> The ALJ therefore concludes that the Committee established by a preponderance of the evidence that Mr. Appleman failed to meet usual and customary prevailing standards of practice in his interpretations of the WAIS-R and Bender-Gestalt tests that he administered to Client #6.

**6. Claim 20-12: Charge of inappropriately administering tests to Client #20.**

In Claim 20-12, the Committee charged Mr. Appleman with improperly allowing Client #20 to take two vocational tests and the MMPI home to complete. A preponderance of the evidence established that Client #20 took the Strong-Campbell’s Interest Test and the Career Assessment Test home to complete but failed to establish that he ever took the MMPI home to complete.<sup>[890]</sup> Although Dr. Cohen clearly established that it was usual and customary prevailing practice for psychologist to adhere closely to test administration procedures or explain in writing when they did not,<sup>[891]</sup> the Committee failed to present any evidence to establish what the test administration procedures for the Strong-Campbell’s Interest Test and the Career Assessment Test were. And there was at least some evidence from Mr. Appleman that those test administration procedures did not require that a client take those tests in the psychologist’s office. The ALJ therefore concludes that the Committee failed to establish by a preponderance of the evidence that Mr. Appleman engaged in unprofessional conduct by failing to meet prevailing practice standards in the way he administered the Strong-Campbell’s Interest Test, the Career Assessment Test, and the MMPI to Client #20.

**7. Claim 21-3: Substandard interpretations of test administered to Client #20.**

In Claim 21-3, the Committee charges Mr. Appleman with failing to reconcile test results with his diagnosis of major depression. First of all, since Mr. Appleman did not prepare a written report of his testing, there is no evidence that ever interpreted the

Beck Depression Inventory and Sentence Completion test as indicating major depression. So any charge of substandard test interpretation must fail here. The essence of Dr. Cohen's expert opinions is that the results of the two tests appear to be inconsistent with the diagnoses, and that Mr. Appleman did not attempt to explain the apparent contradiction. If any charge is germane to these facts, it would seem to be a violation of the rule that requires reports to include "any reservations or qualifications concerning the validity or reliability of the conclusions formulated and recommendations made, taking into account the conditions under which the procedures were carried out...."<sup>[892]</sup> But Mr. Appleman never prepared a report of his testing of Client #21 (which is the charge being asserted in Claim 21-1). So the charge here is really failure to include reservation and qualifications in a report that does not exist. In short, the ALJ concludes that the charge of failing to reconcile testing results with the diagnosis of Client #21 should be dismissed, and that the issues are essentially inadequate documentation issues that should be considered as part of Claim 21-1.

## **J. Charges of substandard treatment.**

### **1. Claim OF-9 and OF-18: Using profanity and a confrontational therapy approach in sex offender treatment.**

In Claim OF-9, the Committee charged Mr. Appleman with unprofessional conduct for using profanity during therapy sessions with sex offender clients and in Claim OF-18 for using substandard confrontational or shaming sex offender treatment strategies. The charges are closely related, so the ALJ will discuss them together. Two programs that treated sex offenders employed Mr. Appleman the early 1980s, and he acquired sex offender treatment and training there. He relied on that experience to support the Statement of Competency in sex offender treatment that he filed with the Board.<sup>[893]</sup> In the early 1980s psychologists who treated sex offenders commonly used profanity and confrontational treatment approaches during treatment.<sup>[894]</sup>

But by the mid-1990s, the profession had abandoned the practice because therapists decided it was abusive and failed to provide clients with appropriate role modeling behavior. So it was Mr. Rusinoff's opinion that by the mid-1990s using profanity and confrontational treatment techniques with sex offenders no longer conformed to usual and customary prevailing practice standards, which by then required therapists to use the modeling behavior approach to treatment. Nevertheless, the evidence established that Mr. Appleman continued to use profanity and confrontational treatment techniques into the mid-1990s, including when he was treating the sex offenders whose care is at issue here.<sup>[895]</sup> It was Mr. Appleman's opinion that use of those techniques still conformed to usual and customary prevailing practice standards in the mid-1990s.

Mr. Rusinoff currently operates a day treatment program for sex offenders with special needs,<sup>[896]</sup> was clinical director from 1993-1998 of the Alpha House program where Mr. Appleman had previously trained, and has both received and presented an extensive amount of training in sex offender treatment throughout the 1990s.<sup>[897]</sup> He is therefore very familiar with developments and changes in standards within the field. On

the other hand, the record indicates that Mr. Appleman has either received or presented little, if any, sex offender treatment training since the early 1980s. The ALJ concludes that Mr. Rusinoff's opinion on treatment standards in the mid-1990s is more credible than Mr. Appleman's.

## **2. Claim OF-19: Threatening sex offender clients with revocation of probation.**

In Claim OF-19, the Committee charges Mr. Appleman with threatening his sex offender clients with revocation of probation as an inappropriate therapy technique. The Committee argues that practice violates Minnesota Statutes, Section 148.941, Subdivision 2(a)(2), which prohibits psychologists from engaging in fraudulent, deceptive, or dishonest conduct.<sup>[898]</sup> The evidence established that Mr. Appleman told some of his sex offender clients on occasions that they would go to prison or jail if they did not complete treatment.<sup>[899]</sup> So, in order to establish a violation of the statute in this instance, the Committee must prove that Mr. Appleman's statements were fraudulent, deceptive, or dishonest. But the evidence that the Committee presented fell far short of that.

The Committee relied primarily on testimony from Thomas Thompson, who had been Client #11's probation officer. First of all, the ALJ disregarded testimony from Mr. Thompson that Mr. Appleman's had a reputation of exploiting sex offender clients. Character evidence is not relevant to show that someone acted in a particular way on a particular occasion.<sup>[900]</sup> Second, Mr. Thompson testified that Mr. Appleman lacked authority to terminate a sex offender client's probation. But the most that can be inferred from the evidence was that Mr. Appleman would report to the court that the client failed to complete treatment, and that the court would then revoke probation. No evidence established that Mr. Appleman had ever said that he himself had the authority to revoke probation. Third, Mr. Thompson's opinion that a court would not have sent Client #11 to prison for failing to complete sex offender treatment was only a speculative guess about what a court might or might not do if Client #11 failed to complete sex offender treatment.<sup>[901]</sup> Finally, in order to establish fraud, deceit, or dishonesty, the Committee had to prove that Mr. Appleman knew his statements about probation being revoked were false. The evidence failed to establish that Mr. Appleman knew or believed that a court would not revoke probation if a client failed to complete sex offender treatment. For these reasons, the ALJ concludes that the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated Minnesota Statutes, section 148.941, subdivision 2(a)(2). by telling sex offender clients that their probation would be revoked if they failed to complete sex offender treatment. should be dismissed.

## **3. Claim 20-13: Providing services to Client #20 that were neither reasonable nor necessary.**

Claim 20-13 charges Mr. Appleman with providing services that were not reasonable or necessary for relief or treatment of Client #20's injuries or conditions. The Committee first argued that collateral estoppel precluded Mr. Appleman from

challenging a finding by a workers' compensation judge that the services he provided to Client #20 were neither reasonable nor necessary to cure or relieve the Client #20's work-related conditions.<sup>[902]</sup> But the ALJ has previously concluded that the Committee cannot rely on collateral estoppel alone to establish this claim.<sup>[903]</sup> Since psychology licensing laws do not make providing services that are not compensable under the Workers' Compensation Act a *per se* violation, the Committee had to establish that providing such services failed to conform to usual and customary prevailing practice standards. And the Committee failed to present any such evidence. Second, even if it had presented such evidence, it still would have had to rule out that Mr. Appleman's services were also neither reasonable nor necessary to cure or relieve any non-related condition. The Committee also failed to do that. For these reasons, the ALJ recommends that the Board dismiss Claim 20-13.

## **K. Charges of taking substandard client histories.**

### **1. Claims 3-10: Taking substandard client history information from Client #3**

Claim 3-10 charges Mr. Appleman with failing to follow up on history and test results indicating that Client #3 possibly had chemical dependency issues. The Committee bases Claim 3-10 on the following allegation in the Notice of Hearing: “[Mr. Appleman] failed to address issues of the client’s chemical use, abuse, or dependency.”<sup>[904]</sup> But Dr. Cohen’s testimony focuses on the fact that Mr. Appleman failed to *comment on or explain* what that might mean.<sup>[905]</sup> The implication in the charge, as framed in the Notice of Hearing, is that Mr. Appleman’s clinical judgment was substandard because he failed to follow up with Client #3 on chemical dependency issues. The problem is that Dr. Cohen was not asked to give an opinion on Mr. Appleman’s clinical judgment in eliciting history from Client #3 was substandard, he was asked whether Mr. Appleman’s *documentation* of Client #3’s history was substandard. As a result, the ALJ concludes that the Committee failed to establish by a preponderance of the evidence that Mr. Appleman’s *taking of* history from Client #3 failed to conform to the usual and customary prevailing standards of professional practice. The ALJ therefore recommends that the Committee dismiss Claim 3-10.<sup>[906]</sup>

### **2. Claims 6-2, 6-3, and 6-10: Taking substandard client history information from Client #6**

Claim 6-2 charges Mr. Appleman with stating in his report that Client #6’s symptoms resulted from her automobile accident without eliciting, considering, or reporting other information that might have accounted for the symptoms. Claim 6-3 charges that he made psychological assessments with inadequate data, and Claim 6-10 charges that he performed a substandard assessment of Client #6 by failing to inquire whether the nightmare of a friend’s suicide was an actual event.<sup>[907]</sup> All three are based on the following two allegations in the Notice of Hearing:

40) \* \* \* Respondent’s diagnoses are not supported by his records and do not comport with DSM-IV criteria.

41) In evaluating client #6, Respondent completely failed to take into account client #6’s ongoing severe marital strain and other pre-existing interpersonal difficulties, including suicide of a close male friend, as well as her history of depression and family history of bipolar illness. Respondent’s report states only that client #6 was currently separated from her husband.

The ALJ concludes that to the extent that the Board is charging Mr. Appleman with substandard clinical judgment, whether in the taking of history from Client #6 in formulating his diagnosis, or drawing conclusions on causation, these three charges suffer from the same failure of proof as Claim 3-10. The only question that the Committee posed to Dr. Cohen that touches on those three issues was framed in terms

of the sufficiency of Mr. Appleman's *documentation* of Client #6's history.<sup>[908]</sup> With the exception of a question about testing,<sup>[909]</sup> the Committee asked Dr. Cohen nothing about whether or not Mr. Appleman's clinical judgments about Client #6 failed to conform to usual and customary prevailing standards. As a result, the ALJ concludes that the Committee failed to establish by a preponderance of the evidence that Mr. Appleman's taking of history from Client #6 or his assessment of that client failed to conform to the usual and customary prevailing standards of professional practice. The ALJ therefore recommends that the Committee dismiss Claim 6-3 and 6-10. But since the Notice of Hearing can fairly be interpreted as alleging substandard documentation of Client #6's history, the ALJ will reconsider Claim 6-2, below, as a claim of inadequate documentation.

### **3. Claim 8/9-1.1: Obtaining insufficient client history information from Client #8**

Claim 8/9-1.1 charges that Mr. Appleman attributed Client #8's symptoms to a motor vehicle accident without eliciting, considering, or reporting other factors that might have accounted for the symptoms. Unlike the previous charges of substandard history, here the Committee did ask Dr. Cohen for an opinion on whether Mr. Appleman clinical judgment in eliciting history from Client #8 was substandard, and Dr. Cohen answered in the affirmative and went on to explain the basis for his opinion.<sup>[910]</sup> So, the question then turns to whether that Dr. Cohen's opinion is sufficient to establish the charge by a preponderance of the evidence.

An assumption that history not recorded is history not taken necessarily underlies Dr. Cohen's opinion on this claim. But even if that assumption is usual and customary in the profession, other evidence directly contradicts it here. Mr. Appleman had obtained much other historical information about Client #8 from other sources that suggested other causes for her symptoms.<sup>[911]</sup> He simply did not incorporate it into his own client history. Dr. Cohen conceded that was the case.<sup>[912]</sup> Mr. Appleman testified that there were two reasons why he did not attempt to obtain more information of that kind from Client #8 herself. First, he was not proficient in assessing and treating sexual abuse cases, and, second, he did not want to interfere with the treatment of other therapists who were treating Client #8 for sex abuse.<sup>[913]</sup> But more important, what the evidence established here was that Mr. Appleman was aware of information suggesting other possible causes for Client #8's symptoms, but that he made a clinical judgment that those other possibilities did not cause the symptoms for which he was treating her. As for client history that appears nowhere in Mr. Appleman's files, Dr. Wohl pointed out that the fact that Mr. Appleman did not record it does not necessarily mean that he did not obtain or consider it. In summary, the ALJ concludes that the Committee failed to prove by a preponderance of the evidence Mr. Appleman engaged in substandard practice by attributing Client #8's symptoms to her automobile accident without eliciting further information or considering other factors that might have accounted for those symptoms.<sup>[914]</sup>

## Standards of Professional Documentation

As suggested in the discussion in Part V., there appear to be three possible bases for disciplining psychologists for improperly or inadequately documenting the services they provide to clients. First, the legislature has directed the Board to adopt "rules of conduct to govern an applicant's or licensee's practices or behavior."<sup>[915]</sup> And the Board has responded by including some explicit documentation requirements in its rules. Second, the legislature has specifically directed the Board to adopt rules that prohibit applicants and licensees from offering "services or use techniques that fail to meet usual and customary professional standards."<sup>[916]</sup> The Board has also done that in Minn. R. pt. 7200.5700. Third, the legislature has explicitly and independently made psychologists subject to discipline for engaging:

"in unprofessional conduct or any other conduct which has the potential for causing harm to the public, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice without actual injury having to be established."<sup>[917]</sup>

In short, the documentation practices of psychologists arguably can result in licensure violations if those practices violate the Board's rules, if they fail to meet usual and customary professional standards, or if they fail to conform to the minimum standards of acceptable and prevailing practice.

### A. Rules establishing explicit documentation requirements

Three provisions of the Board's rules directly address documentation of services by psychologists. Minn. R. pt. 7200.4900, subp. 1a indicates what client records minimally must contain:

Subp. 1a. **Client records.** A client who is the direct recipient of psychological services has the right of access to the records relating to psychological services maintained by the psychologist on that client, as provided in Minnesota Statutes, section 144.335, subdivision 2, provided the records are not classified as confidential under Minnesota Statutes, section 13.84. A psychologist must maintain an accurate record for each client. Each record must minimally contain:

- A. an accurate chronological listing of all client visits, together with fees charged to the client or a third-party payer;
- B. copies of all correspondence relevant to the client;
- C. a client personal data sheet; and
- D. copies of all client authorizations for release of information and any other legal forms pertaining to the client.

A psychologist who is an employee of an agency or facility need not maintain client records separate from records maintained by the agency or facility.

Minn. R. 7200.5000, subp. 3 addresses what reports of psychological services must contain:

Subp. 3. **Reports.** The provision of a written or oral report, including testimony of a psychologist as an expert witness, concerning the psychological or emotional health or state of a client, is a psychological service. The report must include:

A. a description of all assessments, evaluations, or other procedures upon which the psychologist's conclusions are based;

B. any reservations or qualifications concerning the validity or reliability of the conclusions formulated and recommendations made, taking into account the conditions under which the procedures were carried out, the limitations of scientific procedures and psychological descriptions, and the impossibility of absolute predictions;

C. a notation concerning any discrepancy, disagreement, or conflicting information regarding the circumstances of the case that may have a bearing on the psychologist's conclusions; and

D. a statement as to whether the conclusions are based on direct contact between the psychologist and the client.

Finally, two provisions of Minn. R. pt. 7200.5200 address documentation of psychologists' charges to clients or third party payors:

Subp. 2. **Itemized fee statement.** A psychologist shall itemize fees for all services for which the client or a third party is billed and make the itemized statement available to the client. The statement shall identify at least the date on which the service was provided, the nature of the service, the name of the individual providing the service, and the name of the individual who is professionally responsible for the service.

Subp. 3. **No misrepresentation.** A psychologist shall not directly or by implication misrepresent to the client or to a third party billed for services the nature of the services, the extent to which the psychologist has provided the services, or the individual who is professional.

**B. Additional documentation requirements are included in prevailing standards of practice**

The legislature has directed the Board to address in its rules a requirement that licensees not "offer services or use techniques that fail to meet usual and customary professional standards."<sup>[918]</sup> The Board responded by adopting Minn. R. pt. 7200.5700, which prohibits unprofessional conduct and defined that term as "violating those standards of professional behavior that have become established by consensus of the expert opinion of psychologists as reasonably necessary for the protection of the public interest." The ALJ concludes that the "usual and customary professional standards"

that the legislature referred to in Minn. Stat. § 148.98 (a) and the "standards of professional behavior that have become established by consensus of the expert opinion of psychologists" that the Board refers to in its rule mean the same thing, and both refer to the same set of practice standards.<sup>[919]</sup> Nowhere did the legislature suggest that the Board should exclude documentation practices that violate standards of practice from the prohibition in its rules against "unprofessional conduct."

Moreover, when viewed together, the Board's rules make it clear that improper and inadequate documentation practices do constitute unprofessional conduct. As previously noted, the Board has incorporated the APA's Ethical Principles into its rules as aids to interpreting, among other things, the term "unprofessional conduct" as it appears in Minn. R. pt. 7200.5700.<sup>[920]</sup> Several of those ethical standards either directly or indirectly address documentation of psychology services and, to that extent, provide more specific insight and guidance into what practitioners generally accept as being adequate documentation. Finally, in interpreting similar rules adopted by the Board of Dentistry,<sup>[921]</sup> the Minnesota Court of Appeals upheld discipline of a dentist for "grossly deviating from the minimal standards required of a professional in maintaining adequate records."<sup>[922]</sup>

### **C. Documentation requirements are also inherent in the statutory requirement to conform to minimum standards of acceptable and prevailing practice**

In addition to directing the Board to address unprofessional conduct in its rules, the legislature has also enacted a specific prohibition against unprofessional conduct into the Psychology Practice Act. That definition of unprofessional conduct is framed in terms of a "departure from or failure to conform to the minimum standards of acceptable and prevailing practice."<sup>[923]</sup> There is nothing in statute to suggest that this prohibition excludes minimum standards of acceptable and prevailing documentation practices. And in the *Dental License of Schultz, supra*, the Minnesota Court of Appeals upheld disciplining a dentist for inadequate documentation of patient records in violation of a similar statute.<sup>[924]</sup> The ALJ therefore concludes that in enacting Minn. Stat. § 148.941, subd. 2(3), the legislature intended the stricture against unprofessional conduct to include record keeping practices that fail to conform to the minimum standards of acceptable and prevailing practice.

## **IX.**

### **Charges of Substandard Documentation**

The parties presented two very different views of the standard for documenting psychology services. In essence, it was Dr. Cohen's view that there is a consensus among psychologists about what client records should contain, and that consensus has formulated several specific and well-defined standards and requirements.<sup>[925]</sup> On the other hand, Dr. Wohl seemed to suggest that there is no consensus within the

profession about specific documentation standards, so that the only real standards are those that are explicitly stated in statute or rule.<sup>[926]</sup>

But the two sets of views were not completely irreconcilable. For example, Dr. Wohl did not reject the idea that there may be some consensus among practitioners about documentation standards. Rather, he indicated that if any exist, they have not been written down anywhere.<sup>[927]</sup> And Dr. Wohl's opinions themselves suggested some unwritten substantive standards. He indicated that the adequacy of client records must be viewed in light of the purpose for which the client was being evaluated and treated and by the needs of the audience, that is, the persons to whom the psychologist expected to communicate the results.<sup>[928]</sup> In other words, psychological documentation standards are context-dependent, so adequacy must necessarily be an *ad hoc* determination.

Since the Board has adopted APA's *Ethical Principles and Code of Conduct* as interpretive guidelines for its own rules, one should also consider whether or not documentation is consistent with the APA's ethical standards when assessing adequacy. One of the important APA ethical principles is the one providing that documentation should facilitate continuity of care.<sup>[929]</sup> Documentation practices that promote continuity of care are more likely to conform to prevailing practice standards than practices that do not, or worse, practices that impede continuity of care.

Finally, even in situations where the Board's documentation rules may not apply directly, those rules may still be helpful in determining whether or not a documentation practice conforms to prevailing standards. Because the state's rulemaking process encourages a high level of direct practitioner involvement in adopting rules, the underlying purposes and objectives of Board's practice rules can be viewed as fair expressions of the practice standards that Minnesota's psychologists recognize. So in analyzing expert opinions documentation, an important consideration is how consistent those opinions are with the Board's practice rules.

#### **A. Charges of substandard documentation of client histories.**

It was Dr. Cohen's general opinion that consensus among practitioners about documentation standards does exist and, further, that usual and customary prevailing practice in the early 1990s required practitioners to address several specific types of information in their client histories.<sup>[930]</sup> Dr. Cohen then went on to give more specific opinions about conformity with documentation standards for each individual charge of substandard documentation by Mr. Appleman. Dr. Wohl did not. Rather all his opinions about documentation standards for client history were generic. It was Dr. Wohl's general opinion that the profession recognizes no fixed criteria for determining what should be documented in a client's history, so the only standards are those which states have explicitly enacted in statute or adopted in rule.<sup>[931]</sup>

When applied to the documentation of client histories, Dr. Wohl's general views are less consistent with Minnesota law than Dr. Cohen's. In 1956, the Minnesota Supreme Court incorporated the usual and customary prevailing practices of

professionals into the legal concept of unprofessional conduct in the case of *Reyburn v. Board of Optometry*.<sup>[932]</sup> And in 1985, the Minnesota Court of Appeals held that the concept of unprofessional conduct embraces professional documentation that fails to conform to usual and customary prevailing practice standards.<sup>[933]</sup> Those decisions would have been superfluous if Minnesota's appellate courts had concluded that there was not consensus among licensed professionals about articulable documentation standards. But this conclusion does not necessarily resolve all of the Committee's claims of substandard documentation of client history in the Committee's favor. There is the further question of whether, and under what circumstances, consensus among psychologists embraces the elements of client history that Dr. Cohen described.<sup>[934]</sup> And answering that question requires addressing each claim of substandard documentation of client history in context and on its own merits.

1. **Claim 1-5** charges failure to elicit from Client #1 certain client history information that bore on Mr. Appleman's findings and conclusions. It was Dr. Cohen's opinion that the history Mr. Appleman documented for Client #1 was substandard because it lacked a family history, a history of family dynamics, a medical history, a history of medication use, a chemical dependency assessment, an assessment of school background, a psychosocial history or a systematic evaluation of psychological status.<sup>[935]</sup> This was consistent with Dr. Cohen's more general opinions about the elements of client history that prevailing practice standards require.<sup>[936]</sup> Dr. Cohen's opinion on this charge was also consistent with one of Dr. Wohl's general opinions about documentation, namely, that standards of adequacy for documentation depend, in part, on who is requesting the psychological report. Here, Client #1's attorney referred him to Mr. Appleman for evaluation and treatment.<sup>[937]</sup> And APA *Ethical Standard* 1.23(b) indicates that psychologists are held to a higher standard of accuracy and detail when they have reason to believe that records of their services will be used in legal proceedings. Mr. Appleman's opinion — that he only had to note history about Client #1 that related to the referral question and what was needed for treatment<sup>[938]</sup> — was inconsistent with Ethical Standard 1.23(a), which indicates that documentation should facilitate continuity of care by other providers.<sup>[939]</sup> Considering all of this, the ALJ concludes that the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #1 was substandard.

2. **Claim 2-2** also charges a failure to elicit certain client history information that bore on Mr. Appleman's findings and conclusions. It was Dr. Cohen's opinion that the history that Mr. Appleman documented for Client #2 was substandard because it lacked any previous mental health history, medical history, social history, family history, or discussion of past or present psychosocial stressors in Client #2's life.<sup>[940]</sup> This was again consistent with Dr. Cohen's general opinion about the elements of client history required by prevailing practice standards.<sup>[941]</sup> But more notably, Mr. Appleman testified he later learned that Client #2 had a pre-existing anxiety condition, which appears to have been agoraphobia.<sup>[942]</sup> Nevertheless, he failed to elicit pre-existing mental health history from Client #2 during his assessment and to document it in the records. Neither Mr. Appleman nor Dr. Wohl offered any specific opinion about whether the history that Mr. Appleman documented for Client #2 conformed to

prevailing practice standards. APA Ethical Standard 1.23(a) states that a psychologist's documentation should facilitate continuity of care. At a minimum, Mr. Appleman's failure to document a pre-existing mental health condition does not meet that objective and would likely tend to impede continuity of care. For all of these reasons, the ALJ found that Dr. Cohen's opinions about prevailing standards and Mr. Appleman's nonconformity with those standards to be more credible. The ALJ therefore concludes that the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #2 was substandard.

**3. Claim 3-5** specifically charges that Mr. Appleman failed to document information about Client #3's pre-existing medical and mental health history that bore on the conclusions that Mr. Appleman drew about that client's mental health status.<sup>[943]</sup> It was Dr. Cohen's opinion that the history that Mr. Appleman documented for Client #3 was substandard because it lacked any educational history, family history, prior medical history, prior mental health history of prior accidents or injuries, or psychosocial history.<sup>[944]</sup> A more serious deficiency however, was that Mr. Appleman's records indicated Client #3's alcohol use had increased since the accident but contained no information about his pre-existing alcohol use or his current potential for chemical dependency problems. Dr. Cohen's opinion that all those deficiencies had made Mr. Appleman's history for Client #3 substandard was not only credible, it was again consistent with the *APA Ethical Standards*. Failure to adequately document a potential chemical dependency problem has a strong potential for impeding continuity of care. For these reasons, the ALJ concludes that the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #3 was substandard.

**4. Claim 4-6** involves the charge that Mr. Appleman failed to note clinical information bearing on the reliability of the professional opinions he expressed about Client #4. It was Dr. Cohen's opinion that the history that Mr. Appleman documented for Client #4 was substandard because it lacked any medical history and contained only a limited psychosocial history.<sup>[945]</sup> Although Mr. Appleman stated that he relied Client #4's family practitioner, who had made the referral, for documentation of medical history, Mr. Appleman's client file contained none of that physician's medical records for Client #4.

But the most serious aspect of this charge was that Mr. Appleman attributed Client #4's symptoms to an automobile accident on March 24, 1994, while failing to document that she had been involved in an earlier automobile accident in December 1988. The Board rule governing the content of psychological reports requires that those reports contain, among other things:

a notation concerning any discrepancy, disagreement, or conflicting information regarding the circumstances of the case that may have a bearing on the psychologist's conclusions.....<sup>[946]</sup>

Dr. Cohen expressed an opinion about why Mr. Appleman's history of Client #4 failed to meet the standards established by the rule:

First, Mr. Appleman diagnosed the client with both panic attack[s] secondary to the motor vehicle accident and post-traumatic stress disorder related to the motor vehicle accident, the latter motor vehicle accident, and I believe that it would certainly be important, germane to assess how earlier accidents might have affected the client both at that time and contributed to whatever response the client was having following the second accident. Certainly, that could be a factor. Second, Mr. Appleman diagnosed the client with a provision[al] closed-head injury, and certainly there would be questions asked as to whether such an injury had been sustained in accident one, accident two or both accidents. That would be very important as well.<sup>[947]</sup>

Dr. Cohen also expressed his opinion that the absence of history on the earlier accident also failed to meet prevailing standards of documentation.<sup>[948]</sup>

In summary, the ALJ concludes that the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #3 was substandard and also that his history of Client #4 violated Minnesota Rules, part 7200.5000, subpart 3C.

**5. Claim 5-3** involves the charge that Mr. Appleman failed to elicit and note information about Client #5's pre-existing medical and mental health conditions that could have affected the conclusions he reached about Client #5's mental health status. It was Dr. Cohen's opinion that the history that Mr. Appleman documented for Client #5 was substandard because it lacked any medical history, psychological history, or educational history and only a brief social and vocational history.<sup>[949]</sup> But the most important issue that Dr. Cohen raised was Mr. Appleman's failure to note that Client #5 was a diabetic, a condition that could have significantly affected Client #5's performance on the tests that Mr. Appleman administered to him, as well as his intellectual status,<sup>[950]</sup> which Mr. Appleman considered a major issue. Mr. Appleman stated that he had asked Client #5 about his medical history, but that Client #5 failed to report the diabetes. Although Client #5 was not proficient in English, Dr. Fisher was able to elicit that information less than a month later by conducting collateral interviews with Client #5's two sons.<sup>[951]</sup> But why Mr. Appleman failed to obtain the relevant medical history is immaterial. Client #5 had a medical condition that could have materially affected his performance on the psychological tests that Mr. Appleman gave him. Minnesota Rules, part 7200.5000, subpart B, obliged Mr. Appleman to include that information in his report:

. . . The report *must* include:

\* \* \*

B. any reservations or qualifications concerning the validity or reliability of the conclusions formulated and recommendations made, taking into account the conditions under which the procedures were carried out, the limitations of scientific procedures and psychological descriptions, and the impossibility of absolute predictions.... [Emphasis supplied.]

So, Dr. Cohen's opinion that the deficiencies in Mr. Appleman's history of Client #5 made that client history substandard was credible because it was consistent with the Board's rules. The ALJ therefore concludes that the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #5 was substandard and also violated Minnesota Rules, part 7200.5000, subpart 3B.

**6. Claims 8/9-1.1 and 8/9-11** overlap. Both involve charges that Mr. Appleman failed to obtain relevant history information from Client #8. As previously noted,<sup>[952]</sup> rather than alleging and proving substandard clinical judgment by failing to take adequate history, the Notice of Hearing<sup>[953]</sup> actually alleged, and the evidence<sup>[954]</sup> actually tended to establish, failure *to document* significant history information. Mr. Appleman diagnosed Client #8 as having PTSD that was precipitated by and secondary to an automobile accident.<sup>[955]</sup> But he had in his possession a substantial amount of information from others that Client #8 had a prior history of substantial physical, sexual, and emotional abuse. It was Dr. Cohen's opinion that Mr. Appleman's history of Client #8 was substandard because it failed to include that abuse history.<sup>[956]</sup> This is another case where the Board rule governing preparation of reports is germane. The history of abuse at the very least raised issues about the validity of Mr. Appleman's conclusion that Client #8's PTSD was caused by the automobile accident. That history also represented "conflicting information regarding the circumstances of the case" that may have had a bearing on Mr. Appleman's conclusions. So failure to include that history in his report failed to meet usual and customary prevailing standards and also violated Minnesota Rules, part 7200.5000, subparts B and C.

**7. Claim 20-9** charges that Mr. Appleman failed to document information about Client #20's pre-existing medical and mental health history that bore on the conclusions that Mr. Appleman drew about that client's mental health status.<sup>[957]</sup> It was Dr. Cohen's opinion that the history Mr. Appleman documented for Client #20 was substandard because it lacked any discussion of Client #20's history of family psychosocial dynamics, and that the medical history only covered Client #20's three work-related injuries.<sup>[958]</sup> But a more serious deficiency was inaccurate information about Client #20's mental health history. Mr. Appleman's raw notes expressly stated and his report suggests that Client #20 had no prior history of psychotherapy.<sup>[959]</sup> On the other hand, Mr. Appleman documented Client #20's participation in Abbott-Northwestern's pain clinic, which requires patients to participate in psychotherapy.<sup>[960]</sup> Dr. Cohen's opinion that a report with those deficiencies, particularly inaccurate information about a client's psychological history, failed to conform to prevailing standards was credible. That opinion was consistent with the APA *Ethical Standards*, since inaccurately recording psychological history has a strong potential for impeding continuity of care. For these reasons, the ALJ concludes that the Committee established by a preponderance of the evidence that the client history that Mr. Appleman documented for Client #20 was substandard.

## **B. Charges of Substandard Documentation of Client Testing.**

**1. Claims Nos. 1-6, 2-6, 3-3, 4-7, 6-6, 20-10, and 21-1.** All seven of these claims involve the same issue of substandard documentation — that is, whether Mr. Appleman was obliged to include written interpretations by test name of psychological tests that he administered to them. In the cases of Clients #1, #2, #3, #4, #6, and #20, Mr. Appleman prepared written psychological evaluation reports that listed the psychological tests that he had administered.<sup>[961]</sup> But in six cases, he only included written interpretations by test name of some of those psychological tests while not specifically mentioning several others.<sup>[962]</sup> In the seventh case, the records of Client #21, Mr. Appleman never prepared any written psychological evaluation report and, therefore, never created written interpretations of either of the two tests that he administered to her.<sup>[963]</sup>

It was Dr. Cohen's general opinion that prevailing practice standards required psychologists to document:

the name of the test, the score for the test, some interpretation as to the meaning of that score usually in conjunction with other tests administered at the same time, and then any reservations or limitations you may have about the conditions of testing or the meaning of the test score.<sup>[964]</sup>

In fact, Dr. Cohen emphasized that opinion by stating that:

[T]here is the absolute community standard that if you administer a test to an individual that you name the test in your interpretation and discuss what the results and your interpretation of those results are.<sup>[965]</sup>

Consistent with these general opinions, Dr. Cohen expressed specific opinions that the reports of the tests that Mr. Appleman administered to Clients #1, #2, #4, #6, and #20, all failed to conform to prevailing practice standards because of the absence of specific written interpretations for many of those tests.<sup>[966]</sup>

It was Dr. Wohl's general opinion about test documentation that prevailing standards considered it:

very appropriate to flexibly pick and choose from among parts of tests and incorporate them into my clinical overview. So the presence or absence of something in the absence of any other information about the patient doesn't mean very much to me.<sup>[967]</sup>

Finally, Mr. Appleman explained the absence of specific, written test interpretations with his opinion that the findings and diagnoses that he made in the body of his reports reflected the result of his testing, even though the tests were not mentioned by name.<sup>[968]</sup>

Dr. Cohen's opinions on prevailing standards for documenting test interpretations are consistent with the principles incorporated into the Board rule governing the content of reports,<sup>[969]</sup> while Dr. Wohl's and Mr. Appleman's opinions on the same subject are not. Dr. Cohen's opinions on prevailing standards for documenting test interpretations are also consistent with APA *Ethical Standard* 1.23 (a).<sup>[970]</sup> because his approach to testing documentation promotes continuity of care. On the other hand, Dr. Wohl's and

Mr. Appleman's approaches to testing documentation are not consistent with that ethical standard because it would tend to leave subsequent providers in the dark about the results of testing. For these reasons, the ALJ concludes that the Committee established by a preponderance of the evidence that the test interpretations, if any, that Mr. Appleman documented for Clients #1, #2, #3, #4, #20, and #21 were substandard.

**2. Claims 7-3, 8/9-3, and 20-11** charge Mr. Appleman with failing to maintain in his records the protocols for the tests that he administered to Clients #7, #8, #9, and 20.<sup>[971]</sup> The charges are straightforward, and the evidence that established them virtually uncontroverted. Mr. Appleman failed to keep the protocols in his client files for some of the tests he administered to those four clients.<sup>[972]</sup> It was Dr. Cohen's opinion that failure to keep those test protocols in the client files failed to conform to usual and customary prevailing practice standards.<sup>[973]</sup> Mr. Appleman barely disagreed with Dr. Cohen. Mr. Appleman admitted that not keeping test protocols in client files was a shortcoming but minimized it with an opinion that it was simply not "excellent practice." Considering all this together, the ALJ concludes that the Committee established by a preponderance of the evidence Mr. Appleman's failure to keep some of the protocols for the tests he administered to Clients #7, #8, #9, and #20 was substandard practice.

**3. Claim 4-9** charges Mr. Appleman with failing to note in his report on Client #4 that he attempted to administer the House-Tree-Person Test, but that the client failed to complete the test. The facts underlying this claim are not in dispute: Mr. Appleman attempted to administer the test, but Client #4 was too depressed to complete it. Mr. Appleman indicated in his report that he administered the test but did not indicate that Client #4 failed to complete it or the reason why.<sup>[974]</sup> Dr. Cohen established that prevailing practice required Mr. Appleman to make a notation in his report that Client #4 failed to complete the test with a brief explanation of why.<sup>[975]</sup> Neither Mr. Appleman nor Dr. Wohl challenged Dr. Cohen's opinion about prevailing that practice. The ALJ therefore concludes that the Committee established by a preponderance of the evidence that Mr. Appleman's failure to note that Client #4 failed to complete a test that Mr. Appleman attempted to administer, along with an explanation of why, failed to conform to prevailing practice.

**4. Claim 5-9** charges Mr. Appleman with failing to include in his psychological evaluation report of Client #5 appropriate reservations or qualifications about the validity of that client's test results. Again, the underlying facts were not really in dispute. Client #5 had minimal proficiency in English. Mr. Appleman administered several psychological tests to Client #5, using Client #5's son to translate for him during evaluation and testing.<sup>[976]</sup> Many of the tests that Mr. Appleman administered to Client #5 were designed for persons whose native language was English. Moreover, using another person to help translate during testing, particularly a close relative, was a significant deviation from the standards for administering many of those tests.<sup>[977]</sup> Mr. Appleman disputed none of these facts. He also did not dispute that he had neither discussed any of these factors in his report nor even referred to them. In his testimony, Mr. Appleman simply described how he went about using a translator during the interview and testing.<sup>[978]</sup> So, the only issue is whether there was a legal duty for Mr.

Appleman to have discussed and explained in his report the facts that Client #5 had minimal proficiency in English and that his son had assisted in translation during testing.

Minnesota Rules, part 7200.5000, governs the content of psychological reports, and it states what reports “must include.” Subpart 3B of the Rule requires a report to include “any reservations or qualifications concerning the validity or reliability of the conclusions formulated and recommendations made, taking into account the conditions under which the procedures were carried out.” A preponderance of the evidence established that Client #5’s limited proficiency in English affected the validity of the results of tests that were designed for persons whose native language was English. And having an English-speaking family member assist Client #5 in taking the tests deviated significantly from the standards for administering many of the tests and also affected the validity of the results. The ALJ therefore concludes that Mr. Appleman violated the rule. Dr. Cohen also expressed his opinion that Mr. Appleman’s failure to include such reservations and qualifications in his report did not conform to prevailing standards of documentation.<sup>[979]</sup> So, for that reason, the ALJ also concludes that Mr. Appleman’s documentation of Client #5’s test results was substandard.

**5. General Claim-2** charges Mr. Appleman with stating in his reports that he administered the Wide Range Achievement Test (WRAT) to eight clients when, in fact, he only administered one of the three sub-tests to them. Again, the underlying facts<sup>[980]</sup> were not in dispute. Mr. Appleman’s psychological evaluation reports for eight clients indicated that he administered the WRAT to them, when he actually administered only one of the three sub-tests. It was Dr. Cohen’s opinion it that did not meet community standards for a psychologist to administer only one of several sub-tests while suggesting in the report that he or she had administered the entire test.<sup>[981]</sup> Mr. Appleman did not directly offer an opinion to the contrary.<sup>[982]</sup> The ALJ also concludes that administering only one of three sub-tests is a qualification to a procedure that must be reported under the Board rule that specifies the contents of psychological reports. The ALJ therefore concludes that Mr. Appleman violated Minnesota Rules, part 7200.5000, subpart 5B. Additionally, Dr. Cohen expressed his opinion that it was also substandard practice for Mr. Appleman’s to indicate in his reports that he had administered only one of the WRAT’s three sub-tests, in his test documentation for those eight clients. So the Committee also established the alternative charge that Mr. Appleman failed to conform to usual and customary prevailing standards by failing to document adequate support for his professional judgments about eight clients.

### **C. Charges of Substandard Documentation of Client Diagnoses.**

**1. Claim 4-5.** In evaluating the Committee’s motion for partial summary disposition, the ALJ characterized Claim 4-5 as “[f]ailing to provide a third-party payer with testing protocols when requested (alternatively, failure to provide adequate support for professional judgments that were made.)”<sup>[983]</sup> But the ALJ has previously concluded that the Notice of Hearing failed to give Mr. Appleman reasonable notice of any claim that he failed to give the insurer copies of test protocols, when requested.<sup>[984]</sup> What remains of the claim is the alternative charge of failing to document adequate support for professional judgments about Client #4.

The Committee elsewhere charged that Mr. Appleman failed to include in the report he prepared for Client #4 written interpretations of all the tests that his report says were administered to that client.<sup>[985]</sup> It also charged elsewhere that he failed to disclose in his report the fact that Client #4 failed to complete the House-Tree-Person test.<sup>[986]</sup> And the ALJ has previously concluded that a preponderance of the evidence established both of those charges.<sup>[987]</sup> In Claim 4-5, the essence of the charge is having insufficient test data in his files to support his diagnoses.<sup>[988]</sup>

The Committee produced no expert opinion evidence that in making his diagnoses of Client #4 with the testing information that can now be found in his files failed to conform to usual and customary prevailing practice standards. Rather, to establish this charge, the Committee relies exclusively on Minnesota Rules, Part 7200.5000, subpart 3A, which provides that a psychological report “must include . . . a description of all assessments, evaluations, or other procedures upon which the psychologist’s conclusions are based.” Mr. Appleman admitted that he obtained no data from Client #4’s House-Tree-Person test. But the rule does not require a description of test data that *did not* contribute to a psychologist’s conclusions, regardless of whether a report implies that they did. Mr. Appleman listed eight other tests that he said contributed to his conclusions, and the Committee failed to prove otherwise. It only proved that he did not include written interpretations for four of the other tests in his report. The Committee also proved that there was no raw test data or written protocols for four of the tests he said he administered to Client #4,<sup>[989]</sup> but there actually were written interpretations in the report for three of the four.<sup>[990]</sup> That substantially negates any inference that Mr. Appleman did not do the testing. In summary, the ALJ concludes that the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated on Minnesota Rules, Part 7200.5000, subpart 3A by failing to provide adequate support for the professional judgments that he made.

**2. Claim 6-2** charged Mr. Appleman with stating in a written report that Client #6’s symptoms resulted from her automobile accident without eliciting, considering, or reporting other information that might have accounted for her symptoms. In Part VII-K-2, above, the ALJ concluded that the Committee failed to prove that Mr. Appleman drew his conclusions on cause without eliciting information about or considering other potential causes, but he left open the claim that Mr. Appleman drew that conclusion without reporting information relating to other causes.

In his psychological evaluation report of Client #6, Mr. Appleman concluded that:

[s]econdary to and precipitated by the motor-vehicle accident, patient is experiencing Depression, Post-Traumatic Stress Disorder, with Panic Attacks as well as the possibility of a Closed Head Injury.<sup>[991]</sup>

But there is evidence in Client #6’s records that suggest other causes for her symptoms and diagnoses, including marital problems, an emotionally and physically abusive relationship, marijuana use, a family history of alcoholism, a family history of manic depression, the suicide of a friend, medical problems, and others.<sup>[992]</sup> And it was Dr. Cohen’s opinion that Mr. Appleman should have included discussion of these other

possible causal factors in his report.<sup>[993]</sup> Mr. Appleman evaluated and tested Client #6 on February 21, 1996. The problem is there is no evidence that he obtained information on those other possible causal factors before he received the report of Dr. Beth Harrington about six weeks later and the admission history of George Dawson, M.D. almost three months later. In other words, the Committee cannot charge Mr. Appleman with failing to record information that he did not have at the time he prepared his report. It may well be that he *should have elicited* that information when he evaluated Client #6 in February. But as discussed above, the Committee also asserted that charge but failed to prove it because Dr. Cohen was not specifically asked for an opinion on that. In any event, the ALJ concludes that the Committee failed to establish by a preponderance of the evidence that Mr. Appleman violated any licensing law by reporting his conclusions about what caused Client #6's symptoms and diagnoses without reporting information relating to other potential causes.

#### **D. Charges of Substandard Documentation of Client Treatment.**

1. **Claims 1-14, 2-9, 3-11, 4-8, 5-10, and 6-9** are similar. They charge Mr. Appleman with documenting substandard treatment plans for Clients #1, #2, #3, #4, #5, and #6.<sup>[994]</sup> It was the opinion of the Committee's expert witness, Dr. Cohen, that usual and customary prevailing practice standards required Mr. Appleman to document treatment plans for his clients (who were not sex offenders) that minimally contained: statements of the types of treatments that Mr. Appleman would be attempting, anticipated treatment length, anticipated frequency and duration of treatment sessions, and specific treatment goals.<sup>[995]</sup> It was Dr. Wohl's opinion that national psychology associations had created no written guidance for what should be in client treatment plans, and that psychologists did not have to rigidly follow the same format in preparing treatment plans for clients. Finally, it was Dr. Wohl's opinion that psychologists did not customarily prepare a new treatment plan every time they saw a client.<sup>[996]</sup> None of Dr. Wohl's opinions directly contradicted Dr. Cohen's; and, in fact, Dr. Wohl never offered an opinion about prevailing practice standards for the *content* of treatment plans. Nor did he ever expressly say there were no such practice standards. Mr. Appleman gave his opinions about practice standards for the content of treatment plans primarily by affidavit.<sup>[997]</sup> In essence, it was his opinion that a treatment plan was the same as a psychological evaluation report, and he stated that his reports were his treatment plans for the clients at issue.

It appeared to the ALJ from all of the evidence that psychological evaluation reports were not the same as treatment plans, although those reports could certainly contain the kinds of treatment plans that Dr. Cohen described. The ALJ therefore concluded that the usual and customary practice standards that prevailed at the time Mr. Appleman was treating Clients #1, #2, #3, #4, #5, and #6 minimally required documentation of the following information about treatment in client records: statements of the types of treatments, anticipated treatment length, anticipated frequency and duration of treatment sessions, and specific treatment goals. Most, if not all, of that information was missing from Mr. Appleman's psychological evaluation reports and other records for Clients #1, #2, #3, #4, #5, and #6. So the ALJ concludes that Mr.

Appleman's documentation of his treatment plans for those six clients were substandard.

**2. Claim OF-1** charges Mr. Appleman with documenting substandard treatment plans for his sex offender clients, namely, Clients #10, #11, #13, and #15. It was the opinion of Mr. Rusinoff, the Committee's expert witness on sex offender treatment, that usual and customary prevailing practice standards required Mr. Appleman to document separate, individual treatment plans for his sex offender clients. It was also Mr. Rusinoff's opinion that usual and customary prevailing practice standards required that those treatment plans minimally contain: goals for addressing empathy deficits, anger management, interpersonal or social skills, intimacy deficits, and any of the client's more individual sex offender problems, as well as a written statement of the methods the therapist proposes to use to address those issues.<sup>[998]</sup> Dr. Wohl did not specifically address the issue of documenting treatment plans for sex offender clients. And Mr. Appleman made no distinction between standards for documenting his treatment planning for sex offenders and treatment planning for his other clients. In other words, it was his opinion that a treatment plan was the same as a psychological evaluation report, and he stated that his reports were his treatment plans for the clients at issue.<sup>[999]</sup>

In assessing the relative credibility of Mr. Rusinoff's and Mr. Appleman's opinions about standards for documenting treatment planning for sex offenders, the ALJ was aided by the APA *Ethical Standards*. All of Mr. Appleman's sex offenders were under court supervision, and he was asked to make periodic progress reports to the court system. APA Ethical Standard 1.23 (b) specifically indicates that psychologists should maintain a higher standard of documentation when they have reason to believe that documentation will come under scrutiny in an adjudicative forum.<sup>[1000]</sup> But even as a practical matter, a court supervising a sex offender's release would need to know the goals that comprise the offender's sex offense prevention plan so it could determine whether or not the offender was meeting those goals. Mr. Appleman did not prepare separate, individual written treatment plans for Clients #10, #11, #13, and #15. Moreover, neither his psychological evaluation reports for those clients nor any of the other documents in those clients' files contain the information that Mr. Rusinoff specified. So the ALJ concludes that Mr. Appleman's documentation of his treatment plans for Clients #10, #11, #13, and #15 were all substandard.

#### **E. Charge of Failing to Maintain Relevant Client Correspondence.**

**1. Claim OF-16** charges Mr. Appleman with failing to maintain in his file for Client #13 six items of correspondence that he either sent to others or one case received from Client #13. The evidence tending to establish this claim is straightforward and not in dispute. Mr. Appleman generated one piece of correspondence to Client #13's attorney and four more pieces to his probation officers, all relating to Client #13's treatment. He also received correspondence from Client #13 when that client ended his participation in Mr. Appleman's sex offender treatment program.<sup>[1001]</sup> Mr. Appleman admitted that he did not have copies of any of the six letters in his own files.<sup>[1002]</sup> The Board rule governing client records is explicit and unequivocal in providing that "[a]

psychologist must maintain an accurate file for each client,” and that “[e]ach record must minimally contain . . . copies of all correspondence relevant to the client.”<sup>[1003]</sup> Moreover, Mr. Appleman himself expressed an opinion that usual and customary prevailing practice required psychologists to maintain in their client files all correspondence relevant to that client,<sup>[1004]</sup> in effect conceding that his records for Client #13 were substandard.

#### **F. Charge of Failing to Maintain Adequate Documentation for Client #20.**

**Claim 20-1** charges Mr. Appleman with failing to document a treatment plan, objective findings, specific treatment provided, or the treatment benefit for Client #20. To the extent that this claim embraces substandard documentation of client history and testing, it is duplicative of Claims 20-9 and 20-11, and those portions of this claim should not be regarded as separate from those other claims. What remains are allegations that Mr. Appleman failed to document objective findings, specific treatment provided, or the treatment benefit for Client #20. The Committee presented no expert testimony to establish that documenting those matters failed to conform to usual and customary prevailing standards. Rather, it relied on the collateral estoppel effect of workers’ compensation judge’s earlier decision to establish both a duty to document those things and a failure by Mr. Appleman to discharge that duty. But the ALJ has previously concluded that the Committee cannot rely on collateral estoppel to establish necessary elements of this charge.<sup>[1005]</sup> And both *Wang* and *Reyburn* preclude inferring such a duty and a breach of that duty without supporting expert opinion evidence. The ALJ also concludes that the Board rule governing the content of reports is not specific enough to support such an inference. The ALJ therefore concludes, to the extent not embraced by other charges pertaining to Client #20, the Committee has failed to establish by a preponderance of the evidence that Mr. Appleman engaged in substandard practice by failing to document objective findings, specific treatment provided, or the treatment benefit in the file he maintained for Client #20.

#### **G. Charges of Inadequate Documentation to Substantiate Billings.**

The last ten charges all raise the common issue<sup>[1006]</sup> of what documentation psychologists must keep in their files to support the charges they bill to clients and third-party payers. Alternatively, the Committee also suggests that these ten claims charge Mr. Appleman with billing for services that he did not provide. As support for the alternative charge, the Committee relies on expert testimony to the effect that if a service was undocumented, it did not happen.<sup>[1007]</sup> But the ALJ concludes that testimony relating to the absence of documentation, together with the inferences that can be drawn from it, are insufficient to establish the alternative charge. The Committee presented no affirmative evidence, such as a client’s testimony, that services were not provided on the dates in question.<sup>[1008]</sup> Moreover, all the evidence established was that it was prevailing practice for psychologists to have documentation in their files to support the charges that they billed.<sup>[1009]</sup> But Mr. Appleman testified that he occasionally failed to follow that practice,<sup>[1010]</sup> thereby negating any necessary inference that he provided no service whenever his files contained no documentation to

substantiate a service. In summary, evidence that Mr. Appleman billed for services that he did not provide falls well short of the *Wang* standard of evidence with heft.

Finally, the Committee argues that failing to have progress notes or other documentation in a client's records to support a bill for services on that date violates two Board rules. It first cites Minnesota Rules, part 7200.4900, subpart 1a, as authority for the general proposition that psychologists must maintain an accurate record for each client. But the portion of that rule that is germane to these charges is actually more limited in scope and application in requiring only:

A. an accurate chronological listing of all client visits, together with fees charged to the client or a third-party payer.<sup>[1011]</sup>

In other words, failing to have progress notes to substantiate charges for a client visit is not expressly covered by that rule. The Committee also cites Minnesota Rules, part 7200.5200, subpart 3, which provide that:

[a] psychologist shall not directly or by implication misrepresent to the client or to a third party billed for services the nature of the services, the extent to which the psychologist has provided the services, or the individual who is professionally responsible for the services provided.

The problem with applying that rule to these charges is that the rule requires establishing a "misrepresentation." Mr. Appleman's position is that he did not misrepresent to insurers the nature or extent of the services that he provided to their insureds — in other words, he did not bill for services that he did not provide. Rather, he merely failed to have certain kinds of documentation in his files to substantiate providing the services. And the Committee failed to establish the contrary by a preponderance of the evidence. So the ALJ also concludes that Minnesota Rules, part 7200.5200, subpart 3, does not apply to this set of charges.<sup>[1012]</sup>

In conclusion, in considering the Committee's charges concerning Mr. Appleman's documentation for billing purposes, the inquiry must now focus on what prevailing documentation standards required and whether Mr. Appleman failed to conform to those standards.

### **1. Charges of inadequate documentation to substantiate group therapy charges. (Claims 1-10, 3-6, and OF-5)**

These three claims charge Mr. Appleman with billing the insurers for Clients #1, #3, #11, #13, #14, and #15 for particular group therapy sessions without having group progress notes to document that the sessions were held or, if so, to document that the client being billed was present at the sessions. The Committee established by a preponderance of the evidence that Mr. Appleman's records for those clients lacked that documentation.<sup>[1013]</sup> It was Dr. Cohen's opinion that usual and customary prevailing standards required a psychologist to have a progress note or some other written documentation to support a billing for a therapy session.<sup>[1014]</sup> Mr. Appleman's expert accounting witness, Mr. Klane, agreed with Dr. Cohen.<sup>[1015]</sup> Even Mr. Appleman himself agreed that making a chart entry every time a psychologist sees a client was prevailing

practice.<sup>[1016]</sup> The ALJ therefore concludes that the Committee established by a preponderance of the evidence that Mr. Appleman engaged in substandard practice by billing for group therapy sessions either for which there were no supporting group notes or for which the group progress notes failed to document the presence of the client being billed.

## **2. Charges of inadequate documentation to substantiate individual therapy charges. (Claims 1-11, OF-5, 20-6, and 21-5)**

These four claims charge Mr. Appleman with billing the insurers of Clients #1, #11, #12, #13, #14, #15, #20, and #21 for particular individual therapy sessions without having progress notes to document that the sessions were held.<sup>[1017]</sup> For the most part, the issues are virtually the same as the issues raised with supporting documentation for group therapy billings. The Committee established by a preponderance of the evidence that Mr. Appleman billed the insurers for Clients #1, #11, #12, #13, #14, #15, and #20 for individual therapy sessions that were unsupported by progress notes or other written documentation in his files.<sup>[1018]</sup> The Committee also established that usual and customary prevailing practice was for psychologists to maintain written documentation for each therapy session billed.<sup>[1019]</sup> The ALJ therefore concludes that the Committee established by a preponderance of the evidence that Mr. Appleman engaged in substandard practice by billing the insurers for Clients #1, #11, #12, #13, #14, #15, and #20 for individual therapy sessions for which there were no supporting progress notes or other written documentation.

Claim 21-5 is another matter. There, the evidence established that Mr. Appleman billed Client #21's insurer for an individual therapy session on September 13, 1995.<sup>[1020]</sup> But he also admitted under oath that the last time he saw Client #21 was a week before — that is, on September 6, 1995.<sup>[1021]</sup> So, in this case a preponderance of the evidence established that Mr. Appleman billed Client #21's insurer for services that he could not have possibly performed and thereby violated the prohibition in Minnesota Rules part 7200.5200, subpart 3, against making misrepresentations to third-party payers.

## **3. Charge of inadequate documentation to substantiate billings for family therapy. (Claim OF-6)**

A preponderance of the evidence established that Mr. Appleman billed the insurer for Clients #15, #16, #17, #18, and #19, who were all family members, for a family therapy session on December 22, 1993,<sup>[1022]</sup> and that his files for Clients #15, #16, #17, #18, and #19, contain no progress notes or other documentation for that family therapy session.<sup>[1023]</sup> The Committee previously established that usual and customary prevailing practice was for psychologists to maintain written documentation for each therapy session billed.<sup>[1024]</sup> So, again, the ALJ therefore concludes that the Committee established by a preponderance of the evidence that Mr. Appleman engaged in substandard practice by billing the insurers for Clients #15, #16, #17, #18, and #19 for a family therapy session for which there were no supporting progress notes or other written documentation.

#### **4. Charge of inadequate documentation to substantiate billings for testing. (Claims 4-2 and General Claim 4)**

In Claim 4-2 and General Claim-4, the Committee charges Mr. Appleman with substandard practice by billing for certain tests that he administered to Clients #1, #2, #4, #5, #8, #9, #11, #20, and #21 without having test protocols or written test interpretations in the files that he maintained on those clients. First of all, the ALJ has already concluded that the Committee had established the charges of failing to maintain test protocols in client file as set forth in Claims 7-3, 8/9-3 and 20-11.<sup>[1025]</sup> To that extent, General Claim-4 is a duplication of those charges. Second, the ALJ also concluded that the Notice of Hearing failed to give fair notice of claims of failure to maintain test protocols in the files of other clients and has recommended dismissal for that reason.<sup>[1026]</sup> So the ALJ recommends against allowing the Committee to go forward with other parts of General Claim-4. In summary, the ALJ therefore concludes that the Board should dismiss Claim 4-2 and General Claim-4.

#### **5. Charge of maintaining inaccurate billing information for Client #20 (Claim 20-5)<sup>[1027]</sup>**

Claim 20-5 essentially charges Mr. Appleman with generally maintaining inaccurate billing information for Client #20. In attempting to establish this charge, the Committee emphasizes the disparities between a billing summary that Mr. Appleman prepared<sup>[1028]</sup> and a billing reconciliation that Mr. Klane, an expert witness engaged by Mr. Appleman, prepared for Client #20's account.<sup>[1029]</sup> Minnesota Rules, part 7200.4900, subpart 1a, requires that "[a] psychologist must maintain an accurate record for each client" and that "[e]ach record must contain . . . an accurate chronological listing of all client visits, together with fees charged to the client or a third-party payer."<sup>[1030]</sup> In assessing Claim 20-5, it is in Mr. Appleman's billing summary that the rule requires to be accurate. Mr. Klane's account reconciliation is immaterial to the inquiry unless it tends to establish inaccuracies in that billing summary. But here, the Committee appears to be arguing the reverse — i.e., that it is Mr. Klane's reconciliation that is inaccurate.<sup>[1031]</sup> Second, the rule is only concerned with the accuracy of reconciliation itself, and not whether or not Mr. Appleman lacks supporting documentation in Client #20's files. Finally, the only apparent inaccuracies in the billing summary relate to the charges for administering the Campbell's Interest and Vocational Assessment tests. The evidence established that neither test was completed or scored.<sup>[1032]</sup> But application of the rule to his situation seems inapposite. The rule only purports to require that the amount of the charge to the insurer be correct. It arguably does not require that the underlying charge be appropriate. So the ALJ concludes that a preponderance of the evidence does not establish a violation of Minnesota Rules, part 7200.4900, subpart 1a-A.

On the other hand, Dr. Cohen established that billing for tests that were not completed or scored failed to meet minimal community standards of accepted and prevailing practice for psychologists in the mid-1990s.<sup>[1033]</sup> In other words, the billing summary failed to meet prevailing practice standards because it contained charges for tests that were not completed or scored.

## B. H. J.

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<sup>[1]</sup> Minn. Stat. § 14.61. (Unless otherwise specified, all references to Minnesota Statutes are to the 2000 edition.)

<sup>[2]</sup> The ALJ is making Appendix I a part of this report for the Board's convenience in addressing the charges against Mr. Appleman. It is based on Exhibit 83, which the ALJ previously provided to the Board for the same reason as part of his recommendation on the Committee's Motion for Summary Disposition. See also note 10, *infra*.

<sup>[3]</sup> Minn. Stat. §§ 148.88 through 148.98, also known as the Minnesota Psychology Practice Act or the Psychology Practice Act. Unless otherwise specified, all references to Minnesota Statutes are to the 2000 edition.

<sup>[4]</sup> Hereinafter "Notice of Hearing." Administrative Record, Item 1.

<sup>[5]</sup> Namely, clients identified here as Client #1 through Client #23.

<sup>[6]</sup> Administrative Record, Item 6.

<sup>[7]</sup> Administrative Record, Item 13.

<sup>[8]</sup> Administrative Record, Items 69 and 70.

<sup>[9]</sup> Administrative Record, Items 62 and 63.

<sup>[10]</sup> The Committee did not list or specifically identify each of the licensure violations for which it was seeking summary disposition, nor did it correlate alleged violations with the allegations contained in the Notice of Hearing. So, in order to make a recommendation on the Committee's motion, the ALJ drew up a list of what appeared to be ninety-one separate identifiable charges of professional misconduct. (Administrative Record, Item 87 at pp. 49-53; see also Exhibit 83.) The ALJ did not at that time attempt to correlate those charges with corresponding allegations in the Notice of Hearing.

<sup>[11]</sup> Administrative Record, Item 89.

<sup>[12]</sup> Administrative Record, Item 87.

<sup>[13]</sup> *Id.*

<sup>[14]</sup> Administrative Record, Item 112.

<sup>[15]</sup> *Id.*

<sup>[16]</sup> *Id.*

<sup>[17]</sup> Tr. Vol. XII at pp. 1853-54.

<sup>[18]</sup> Exhibit 83.

<sup>[19]</sup> Letter from ALJ to parties dated November 20, 2000 (Administrative Record, Item 121); see also Tr. Vol. XII at pp. 1853-54 and Vol. XIII at pp. 2165-66.

<sup>[20]</sup> On March 19, 2001, the Committee tendered another list of its claims, identified as Exhibit 83-A. In addition to a description of the claims the Committee was asserting and their status, Exhibit 83-A also contained some record references relating to those claims. The ALJ is also including it in the record for illustrative and referential purposes only and for the Board's convenience.

<sup>[21]</sup> Exhibit B (Curriculum Vitae at p. 1).

<sup>[22]</sup> *Id.*; Tr. Vol. IX at p. 1507.

<sup>[23]</sup> Exhibit B.

<sup>[24]</sup> *Id.*; Tr. Vol. IX at p. 1507.

<sup>[25]</sup> Exhibit B (Curriculum Vitae at p. 1); Tr. Vol. IX at p. 1508-09.

<sup>[26]</sup> *Id.*

- [27] Tr. Vol. IX at p. 1508.
- [28] Tr. Vol. IX at p. 1520-22.
- [29] Exhibit B (Curriculum Vitae at p. 3).
- [30] Exhibit B (Curriculum Vitae at p. 2).
- [31] Exhibit B (Curriculum Vitae at p. 2).
- [32] *Id.*
- [33] Exhibit B (Curriculum Vitae at p. 2).
- [34] *Id.*
- [35] *Id.*
- [36] *Id.*
- [37] Exhibit 33.
- [38] Exhibit B (Curriculum Vitae at p. 2).
- [39] Tr. Vol. X at p. 1584.
- [40] Exhibit B (Curriculum Vitae at pp. 3-4).
- [41] Minn. R. pt. 7200.1000.
- [42] Exhibits 34 and B; *see generally* Tr. Vol. IX at pp. 1514-16.
- [43] Exhibits 34 and B; Tr. Vol. X at pp. 1572-74.
- [44] Exhibits 34 and B;
- [45] Minn. R. pts. 7200.3810 through 3840. *See also* Exhibit C.
- [46] Tr. Vol. X at pp. 1584-86.

[47] In addition to Mr. Appleman and the other expert witnesses described below, the Committee offered the testimony of Scott Johnson, M.A., L.P., and Thomas R. Thompson, a probation officer with Ramsey County Corrections, and Mr. Appleman offered the testimony of Steven Trobiani, M.D., and David L. Stussi, D.C. All four were offered as fact witnesses, and none of them were qualified or tendered as expert witnesses.

- [48] Exhibit 42A; Tr. Vol. IV at pp. 624-25 and 629-30.
- [49] Exhibit 42A; Tr. Vol. IV at p. 625.
- [50] Exhibit 42A; Tr. Vol. IV at pp. 633-36.
- [51] Exhibit 42A; Tr. Vol. V at p. 839.
- [52] Tr. Vol. IV at p. 630.
- [53] Tr. Vol. IV at pp. 637-38.
- [54] Exhibit 43A; Tr. Vol. VII at p. 1175.
- [55] Exhibit 43A.
- [56] *Id.*
- [57] *Id.*; Tr. Vol. VII at pp. 1177-78.
- [58] *Id.*
- [59] Exhibit 43A; Tr. Vol. VII at pp. 1178-79.
- [60] Tr. Vol. VIII at pp. 1250-54.
- [61] Exhibit 43A; Tr. Vol. VIII at pp. 1257-59,
- [62] *Id.*
- [63] Tr. Vol. VIII at p. 1262.
- [64] Tr. Vol. XI. at pp. 1678-82; Exhibit 45A.
- [65] *Id.*
- [66] Exhibit 45A; Tr. Vol. XI at p. 1681.
- [67] Exhibit 45A.

- [68] *Id.*; Tr. Vol. XI at pp. 1686-87.
- [69] Exhibit 45A.
- [70] *Id.*
- [71] Tr. Vol. XI at pp. 1687-94 and pp. 1773-1778.
- [72] *Id.*
- [73] Exhibit 46A; Tr. Vol. XIII at p. 1993.
- [74] Exhibit 46A; Tr. Vol. XIII at pp. 1994-97.
- [75] Exhibit 46A.
- [76] *Id.*; Tr. Vol. XIII at p. 1993.
- [77] Tr. Vol. XIII at p. 2023.
- [78] Exhibit 1 at pp. 007022-23.
- [79] Exhibit 1A at p. 100123.
- [80] Exhibit 1 at p. 000093; Tr. Vol. VI at pp. 909, 917, and 939.
- [81] Exhibit 1 at p. 000109 and Exhibit 1A at p. 100146.
- [82] Exhibit 1 at p. 000121; Tr. Vol. VI at pp. 943-44.
- [83] *Compare* Exhibit 1 p. 000093 *with* p. 000121; testimony of Michael Appleman (Tr. Vol. I at pp. 130-135).
- [84] Tr. Vol. I at pp. 130-135.
- [85] Exhibit 1 at pp. 007027.
- [86] Exhibit 1 at p. 000109 and Exhibit 1A at p. 100146.
- [87] Exhibit 1 at pp. 000121-22; Tr. Vol. VI at pp. 945-50.
- [88] Exhibit 1A at p. 100173.
- [89] Exhibit 1 at pp. 000193-94; Tr. Vol. VI at pp. 953-54.
- [90] *Compare* Exhibit 1 pp. 0000121-22 *with* pp. 000193-94; testimony of Michael Appleman (Tr. Vol. I at pp. 136-138); Exhibit 30 at pp. 473-77.
- [91] Tr. Vol. I at pp. 130-35.
- [92] Exhibit 1 at pp. 007042.
- [93] Exhibit 1 at p. 000109 and Exhibit 1A at p. 100146.
- [94] Exhibit 1 at pp. 000126-27; Tr. Vol. VI at pp. 956-58.
- [95] Exhibit 1A at p. 100173.
- [96] Exhibit 1 at pp. 000198-99; Tr. Vol. VI at pp. 953-54.
- [97] *Compare* Exhibit 1 pp. 0000126-27 *with* pp. 000478-479; testimony of Michael Appleman (Tr. Vol. I at pp. 139-41); Exhibit 30 at pp. 473-77.
- [98] Tr. Vol. I at pp. 140-41.
- [99] Exhibit 1 at pp. 000079 and 007046.
- [100] Exhibit 1 at p. 000109 and Exhibit 1A at p. 100146.
- [101] Exhibit 1 at p. 000128; Tr. Vol. VI at pp. 964-65.
- [102] Exhibit 1 at pp. 000163; Tr. Vol. VI at pp. 964-67.
- [103] *Compare* Exhibit 1 pp. 0000128 *with* pp. 000163; testimony of Michael Appleman (Tr. Vol. I at pp. 136-138); Exhibit 30 at pp. 473-77.
- [104] Tr. Vol. I at pp. 142-43; Exhibit 30 at pp. 480-81.
- [105] Testimony of Dr. Cohen (Tr. Vol. IV at pp. 743-45); testimony of Dr. Wohl (Tr. Vol. XI at pp. 1785-91).
- [106] Exhibit 32 at p. 37, ¶ 122.
- [107] *Id.* at ¶ 123.

- [108] Exhibit 32 at p. 39, ¶ 130.
- [109] Exhibit 19 at p. 004731.
- [110] Exhibit 32 at p. 40, ¶ 133.
- [111] *Id.* at p. 41, ¶ 135.
- [112] Exhibit 32 at p. 41, ¶ 136; Exhibit 19 at pp. 004945-46.
- [113] Exhibit 19 at p. 004997.
- [114] *Id.* at p. 004998.
- [115] Exhibit 32 at p. 28, ¶ 90.
- [116] Exhibit 12 at p. 003078.
- [117] Exhibit 12 at pp. 002915 and 3203.
- [118] Exhibit 12 at pp. 002979-80; Exhibit 32 at p. 30, ¶ 96.
- [119] Exhibit 32 at p. 44, ¶ 148.
- [120] Exhibit 32 at p. 46, ¶ 157; Exhibit 20 at p. 008202; Exhibit 29 at pp. 368-69.
- [121] Exhibit 20 at p. 005608.
- [122] Exhibit 29 at p. 368.
- [123] Exhibit 20 at p. 005574; *see also* Exhibit 32 at p. 46, ¶ 157.
- [124] Exhibit 29 at pp. 368-69.
- [125] Exhibit 3A at pp. 300000-17.
- [126] *Id.* at pp. 300004-07; Exhibit 32, p. 9 ¶ 19.
- [127] D.B. was the driver of the other car involved in Client #3's motor vehicle accident. (Tr. Vol. III at p. 392.)
- [128] Exhibit 3A at pp. 300028-29.
- [129] *Id.* at 300004-300007 and 300028-300029; Tr. Vol. III at pp.394-95.
- [130] Exhibit 3A at p. 300010.
- [131] *Id.* at p. 300013.
- [132] Exhibit 44A at pp. 30-31.
- [133] Tr. Vol. III at pp. 397-98.
- [134] Tr. Vol. IV at p. 765.
- [135] Tr. Vol. IV at p. 766.
- [136] Exhibit 44A at pp. 30-31.
- [137] *Id.* Tr. Vol. III at pp. 391-396.
- [138] *Id.*
- [139] Exhibit 1A at p. 100036; Exhibit 2A at p. 200000; Exhibit 3A at p. 300004; Exhibit 6A at p. 600008; and Exhibit 20 at p. 005512. The ALJ concluded that the Notice of Hearing did not provide fair notice of the same charge as it related to Clients #4, #5, and #21. See discussion in Section III, "General Claims," of the Memorandum that follows.
- [140] Exhibit 1 at pp. 000077 and 007020; Exhibit 2 at p. 000417; Exhibit 3 at pp. 000766 and 000779; Exhibit 4 at p. 000873; Exhibit 5 at p. 000995; Exhibit 6 at pp. 001202 and 001227; Exhibit 20 at p. 008200; and Exhibit 21 at p. 005730; *see also* Exhibit 44B at pp. 20-21. ¶ 30.
- [141] Exhibit 28 at pp. 107-08; Tr. Vol. II at pp. 252-54, Vol. IV at pp. 666-68; and Vol. XI at p. 1820.
- [142] *Id.*
- [143] Tr. Vol. IV at pp. 666-68.
- [144] Tr. Vol. XI at p. 1820.
- [145] Tr. Vol. II at pp. 252-53.
- [146] Exhibit 44B at p. 46, ¶ 91, and p. 52, ¶ 108.
- [147] Exhibit 10 at p. 2622; Exhibit 32 at p. 26, ¶ 79.

- [148] Exhibit 32 at p. 26, ¶ 80.
- [149] Exhibit 10 at pp. 2733-42.
- [150] Exhibit 10 at pp. 002756-57.
- [151] *Id.* at pp. 002760-64
- [152] Exhibit 32 at p. 27, ¶ 83.
- [153] Exhibit 10 at pp. 002752-53.
- [154] *Id.* at pp. 002545-50.
- [155] Tr. Vol. III at pp.469-70 and Vol. VI at pp. 1067-68 and 1075.
- [156] Exhibit 10 at p.002490.
- [157] *Id.* at p. 002759.
- [158] *Id.* at p. 002544; Exhibit 32 at p. 28, ¶ 88; Tr. Vol. VI at p. 1077.
- [159] Exhibit 10 at pp. 002585.
- [160] Exhibit 10 at p. 002561; Tr. Vol. VI at pp. 1075-76.
- [161] Tr. Vol. VI at pp. 1074-75;
- [162] Exhibit 19 at p. 004922.
- [163] Exhibit 19 at p. 004929.
- [164] See generally Exhibit 19 at pp. 004864-005005.
- [165] Exhibit 19 at p. 004943
- [166] Exhibit 19 at pp. 004762-63 (duplicate copy at pp. 004997-98).
- [167] *Id.*
- [168] Tr. Vol. VII at pp. 1221-22.
- [169] Exhibit 44B at pp. 115-16.
- [170] *Id.*
- [171] Exhibit 32 at pp. 3-4; Exhibit 1A at pp. 100000-04.
- [172] Exhibit 1 at pp. 000084-87; Exhibit 1A at pp. 10002-04.
- [173] Exhibit 1 at p. 000084.
- [174] *Id.* at p. 000086.
- [175] Exhibit 1 at p. 007020.
- [176] Exhibit 1 at p. 000082-93.
- [177] American Psychiatric Association: Washington, D.C. (1987) (hereinafter "DSM-III-R"). Exhibit 79 at pp. 247-51.
- [178] Hereinafter sometimes "PTSD."
- [179] Exhibit 79 at p. 251.
- [180] Tr. Vol. IV at pp. 712-13.
- [181] Tr. Vol. XI at pp. 1723-24.
- [182] *Id.* at 1736.
- [183] Exhibit 1A at p. 100007; see also Exhibit 32 at p. 3. Findings of Fact Nos. 65 through 67 are also germane to this charge.
- [184] Exhibit 1 at pp. 000082-83.
- [185] Exhibit 79 at pp. 264-66.
- [186] Tr. Vol. IV at pp. 711-12.
- [187] Tr. Vol. XI at p. 1735.
- [188] *Id.*
- [189] Exhibit 9 at pp. 002132-35.
- [190] *Id.* at pp. 002121, 002152, and 002157.

[191] See *Id.* at pp. 002132-38.

[192] *Id.* at p. 002152.

[193] See *Id.* at pp. 002132-38.

[194] *Id.* at p. 002106

[195] Tr. Vol. V at p. 824.

[196] Tr. Vol. XII at p. 1951.

[197] Exhibit 1A at p. 100044.

[198] *Id.*

[199] *Id.* at p. 100024.

[200] Tr. Vol. IV at pp. 731-32.

[201] Tr. Vol. IV at pp. 735-36.

[202] Exhibit 44A at p. 16.

[203] Exhibit 44B at p. 27.

[204] The protocol for the WAIS-R can be found in Exhibit 2A at pp. 200039-44; and the protocol for the Trails A and B can be found in Exhibit 2A at pp. 200030-33.

[205] Exhibit 2A at p. 200002.

[206] Tr. Vol. IV at pp. 731-32.

[207] Tr. Vol. IV at pp. 748-49.

[208] Exhibit 44B at p. 34.

[209] *Id.* at p. 36.

[210] The protocol for the WAIS-R can be found in Exhibit 4A at pp. 400012-17.

[211] Exhibit 4A at p. 400075.

[212] Tr. Vol. XIII at pp. 2127-28.

[213] Tr. Vol. XII at pp. 1865-66.

[214] Tr. Vol. XII at p. 1874.

[215] Tr. Vol. IV at pp. 731-32.

[216] Tr. Vol. IV at pp. 770-72.

[217] Tr. Vol. IV at pp. 731-32.

[218] Dr. Wohl did not offer a specific opinion about whether or not Mr. Appleman's interpretation of Client #4's WAIS-R met prevailing practice standards.

[219] Tr. Vol. XII at pp. 1873-74.

[220] Exhibit 5A at p. 500004.

[221] Exhibit 5A at pp. 500004 and 500010-28.

[222] *Id.* at p. 500004.

[223] *Id.* at p. 500006. The report only includes performance sub-test scores.

[224] *Id.* at p. 500005.

[225] *Id.* at p. 500007.

[226] *Id.* at pp. 500006-07.

[227] Tr. Vol. III at p. 416.

[228] Exhibit 5A at p. 500065.

[229] Tr. Vol. III at p. 417; Exhibit 5A at p. 500067.

[230] Exhibit 5A at p. 500067.

[231] Tr. Vol. V at pp. 788-89.

[232] *Id.* at p. 790.

[233] Tr. Vol. V at pp. 790-91.

- [234] *Id.* at p. 794.
- [235] Tr. Vol. XII at p. 1890.
- [236] Exhibit 6A at pp. 600008-13.
- [237] *Id.* at p. 600008.
- [238] *Id.* at p. 600011.
- [239] Tr. Vol. V at pp. 798-800.
- [240] Exhibit 44A at p. 55.
- [241] Other relevant underlying facts are set forth in Findings of Fact Nos. 41-43.
- [242] Tr. Vol. IV at pp. 725-26
- [243] Exhibit 29 at pp. 369-70.
- [244] Exhibit 32 at p. 48 ¶ 165.
- [245] *Id.* at p. 48, ¶ 166; Exhibit 21 at p. 005715.
- [246] *Id.* at pp. 49, ¶¶ 170 and 177.
- [247] Exhibit 21 at pp. 005721-27.
- [248] Exhibit 21 at p. 005723.
- [249] Exhibit 21 at p. 005727.
- [250] *Id.* at pp. 005699-005708.
- [251] American Psychiatric Association: Washington, D.C. (May 1994) (Introduced into the hearing record as Exhibit 80).
- [252] Exhibit 80 at p. 344.
- [253] *Id.* at p. 424.
- [254] Tr. Vol. V. at pp. 830-31.
- [255] Tr. Vol. XII at pp. 1976-79.
- [256] Exhibits 34 and Exhibit 67 (Curriculum Vitae) at p. 2.
- [257] Exhibit 34.
- [258] Exhibit 29 at p. 286; Exhibit 44A at p. 77.
- [259] Exhibit 27 at pp. 75-76.
- [260] Exhibit 29 at p. 285.
- [261] See *also* Exhibit 28 at pp. 177-78; Exhibit 32 at p. 26, ¶ 81; and Testimony of Client #23 (Tr. Vol. IX at pp. 1416-17).
- [262] Exhibit 29 at p. 286.
- [263] Tr. Vol. IX at pp. 1416-17.
- [264] Tr. Vol. VII at p. 1199.
- [265] Tr. Vol. VII at p. 1201.
- [266] *Id.* at p. 1200.
- [267] *Id.* at pp. 1198-99.
- [268] Exhibit 44B at p. 115; see also Exhibit 44A at pp. 76-77.
- [269] Exhibit 27 at p. 90; Exhibit 29 at p. 284.
- [270] Tr. Vol. VIII at pp. 1376-77.
- [271] *Id.*
- [272] Other relevant underlying facts are set forth in Findings of Fact Nos. 41-43.
- [273] Exhibit 20 at p. 005563
- [274] Other relevant underlying facts are set forth in Findings of Fact No. 44.
- [275] Exhibit 3A at p. 300004.
- [276] *Id.* at p. 300008.

[277] *Id.* at p. 300005.

[278] *Id.* at p. 300029.

[279] Tr. Vol. IV at pp. 760-62.

[280] Exhibit 32 at p. 14.

[281] Exhibit 6A at p. 600008.

[282] *Id.* at p. 600014.

[283] *Id.*

[284] *Id.* at p. 600016.

[285] *Id.* at pp. 600102 and 600138.

[286] Exhibit 6A at pp. 600101 and 600105. (NOTE: These pages were supposed to have been in sequence.)

[287] Tr. Vol. V at pp. 796-97.

[288] Other relevant underlying facts are included in Findings of Fact Nos. 78-83.

[289] Exhibit 8 at pp. 002075-77.

[290] *Id.* at p. 002205

[291] Exhibit 8 at p. 002074.

[292] *Id.* at pp. 002090-91.

[293] *Id.* at pp. 002092-94.

[294] *Id.* at pp. 002097-99.

[295] Tr. Vol. V at p. 812.

[296] Tr. Vol. V at pp. 811-12.

[297] Tr. Vol. XII at pp. 1935-36.

[298] Tr. Vol. XI at p. 1764.

[299] Exhibit 35.

[300] Tr. Vol. IV at p. 640.

[301] *Id.* at pp. 642-43.

[302] Tr. Vol. IV at p. 648.

[303] *Id.*

[304] *Id.* at pp. 643-45.

[305] *Id.* at p. 646

[306] *Id.* at pp. 646-47 and 650.

[307] *Id.* at pp. 648-49.

[308] *Id.* at pp. 649-50.

[309] *Id.* at p. 659-60.

[310] *Id.* at p. 733

[311] *Id.* at p. 665.

[312] *Id.* at pp. 713-14

[313] *Id.* at p. 714

[314] *Id.*

[315] *Id.* at p. 715

[316] Tr. Vol. V at pp. 881-82.

[317] Exhibit 45A, Addendum.

[318] Tr. Vol XI at pp. 1693-94.

[319] *Id.* at pp. 1694-95.

[320] *Id.* at pp. 1747-48.

[321] *Id.*

[322] *Id.* at pp. 1746-47.

[323] *Id.* at p. 1759.

[324] *Id.* at pp. 1752-53.

[325] *Id.* at p. 1757.

[326] *Id.* at p. 1750.

[327] Tr. Vol. IV at pp. 611-12.

[328] Exhibit 1A at pp. 100002-04 and 100036-39; Tr. Vol. IV at pp.728-731.

[329] Tr. Vol. IV at pp.728-731.

[330] Mr. Appleman was asked to comment on that issue but never did. (Tr. Vol. X at pp. 1614-15)

[331] Exhibit 2A at pp. 200000-04.

[332] *Id.*

[333] *Id.* at p. 200002.

[334] Tr. Vol. X at pp. 1636-37.

[335] Exhibit 2A at pp. 200000-10; Tr. Vol. IV at pp.746-47.

[336] Tr. Vol. IV at pp.746-47.

[337] Other relevant underlying facts are set forth in Findings of Fact Nos. 44 and 124.

[338] Exhibit 3A at pp. 300004-13; Tr. Vol. IV at pp. 760-62.

[339] Exhibit 3A at p. 300005.

[340] Tr. Vol. IV at pp.767-68.

[341] Tr. Vol X at pp. 1648-49.

[342] Exhibit 4A at p. 400073.

[343] Exhibit 4A at pp. 400021-25 and 400073-77; Tr. Vol. IV at pp.768-69.

[344] Exhibit 4A at pp. 400078-82.

[345] Tr. Vol. IV at p.769.

[346] Tr. Vol XII at pp. 1878.

[347] Other relevant underlying facts are set forth in Findings of Fact Nos. 96 through 101.

[348] Exhibit 5A at pp. 500004-08 and 500029-33; Tr. Vol. V at pp.786-87.

[349] Tr. Vol. V at pp.786-87.

[350] Tr. Vol III at p. 418.

[351] Most of the relevant underlying facts are set forth in Findings of Fact Nos. 130 through 135.

[352] Exhibit 8 at pp. 002075-77; Tr. Vol. V at pp. 811-12.

[353] Tr. Vol. V at pp. 811-12.

[354] Finding of Fact No. 134.

[355] Other relevant underlying facts are set forth in Finding of Fact No. 41.

[356] Exhibit 20 at p. 005473-77.

[357] *Id.* at p. 005473.

[358] *Id.* at p. 005474.

[359] *Id.* at p. 005614.

[360] *Id.*

[361] Tr. Vol. V at pp. 826-27.

[362] *Id.*; Exhibit 20 at p. 005473-77.

[363] Exhibit 1A at p. 100036.

[364] *See generally Id.* at pp.100036-39.

- [365] Tr. Vol. IV at pp. 732-33.
- [366] Exhibit 2A at p. 200000.
- [367] See generally *Id.* at pp.200000-04.
- [368] Tr. Vol. IV at pp. 747-48.
- [369] Tr. Vol. X at pp. 1633-37.
- [370] Exhibit 3A at p. 300004.
- [371] See generally *Id.* at pp.300004-07.
- [372] Tr. Vol. IV at p. 733
- [373] Tr. Vol. X at pp. 1640-42.
- [374] Exhibit 4A at p. 400073.
- [375] See generally *Id.* at pp.400073-77.
- [376] Tr. Vol. IV at pp. 770-71.
- [377] Tr. Vol. XII at pp. 1876-77.
- [378] Exhibit 6A at p. 600008.
- [379] See generally *Id.* at pp.600008-13.
- [380] Tr. Vol. V at pp. 798-99.
- [381] Tr. Vol. XII at pp. 1904-08..
- [382] Exhibit 20 at p. 005512.
- [383] See generally *Id.* at pp.005512-16.
- [384] Tr. Vol. V at pp. 827-828.
- [385] Most of the relevant underlying facts are set forth in Findings of Fact Nos. 110 through 113.
- [386] Tr. Vol. V at pp. 829-830.
- [387] Other relevant facts are set forth in Findings of Fact Nos. 130 through 135 (Client #8), Findings of Fact Nos. 78 through 83 (Client #9), and Findings of Fact Nos. 41, 159, 178 through 180 (Client #20).
- [388] Exhibit 7 at p. 001516.
- [389] Tr. Vol. XII at pp. 1924-25.
- [390] Tr. Vol. V at pp. 804-05.
- [391] Tr. Vol. XII at p. 1925.
- [392] Exhibit 8 at p. 002075.
- [393] Exhibit 8; Tr. Vol. V at pp. 811-13.
- [394] Tr. Vol. V at pp. 811-14.
- [395] Tr. Vol. XII at pp. 1937-38.
- [396] Exhibit 9 at p. 002132.
- [397] *Id.*
- [398] Exhibit 9 at p. 002249.
- [399] Exhibit 9; Tr. Vol. V at pp. 820-23.
- [400] Tr. Vol. V at pp. 820-23.
- [401] Tr. Vol. XII at pp. 1937-38.
- [402] Exhibit 20 at p. 005512.
- [403] Exhibit 20; Tr. Vol. V at pp. 827-28.
- [404] Tr. Vol. V at pp. 827-28.
- [405] Additional relevant facts can be found in Finding of Fact No. 172.
- [406] Exhibit 4A at p. 400073.
- [407] Exhibit 4A at pp. 400009-11.
- [408] See Exhibit 4A at pp. 400073-77.

[409] Tr. Vol. XII at p. 1876.

[410] Tr. Vol. IV at pp. 770-71.

[411] *Id.* at p. 771.

[412] Most of the relevant facts can be found in Findings of Fact Nos. 96 through 101.

[413] Exhibit 5A at p. 500004.

[414] *Id.* at p. 500006.

[415] Tr. Vol. V at pp. 788-89.

[416] *Id.* at pp. 789-90

[417] *Id.* at pp. 789-90

[418] *Id.* at p. 794.

[419] Tr. Vol. XII at pp. 1882-86.

[420] Respectively, Exhibit 1A at p. 10036; Exhibit 2A at p. 200000; Exhibit 3A at p. 300004; Exhibit 4A at p. 400073; Exhibit 5A at p. 500004; Exhibit 6A at p. 600008; Exhibit 8 at p. 002075; and Exhibit 20 at p. 005512. The ALJ concluded that the Notice of Hearing failed to provide fair notice of the same charge against Clinets #7 and #11. See discussion in Part III, "General Claims," of the Memorandum that follows.

[421] See also Tr. Vol. II at pp. 287-89.

[422] *Id.*

[423] Tr. Vol. IV at pp. 732-33.

[424] Tr. Vol. II at p. 289.

[425] In evaluating the Committee's motion for partial summary disposition, the ALJ characterized Claim 4-5 from the submissions on that motion as "Failing to provide a third-party payer with testing protocols when requested (alternatively, failure to provide adequate support for professional judgment that were made.) (Recommendation on motion for Summary Disposition (Administrative Record, Item 87) at p. 50.) But at this stage of these proceedings, the ALJ has concluded that the Notice of Hearing failed to give Mr. Appleman reasonable notice of any claim that he failed to give the insurer copies of test protocols, when requested. See Part III – "Client No. 4" of the Memorandum that follows. What remains of the claim is what the ALJ previously described in the alternative.

[426] Other relevant facts are set forth in Finding of Fact Nos. 172, 173, 191-193.

[427] Exhibit 4A at p. 400073. The tests that Mr. Appleman administered are identified in Finding of Fact No. 172.

[428] Exhibit 4A at p. 400076.

[429] *Id.* at p. 400074; Exhibit 32 at p. 10, ¶24.

[430] *Id.* at p. 400075.

[431] Finding of Fact No. 173.

[432] Exhibit 4A at pp. 400005-20.

[433] Exhibit 4A.

[434] Finding of Fact Nos. 191 and 192.

[435] Namely, Claim 4-5.

[436] Most of the relevant facts can be found in Findings of Fact Nos. 126 through 129.

[437] Exhibit 6A at p. 600003.

[438] *Id.* at p. 600004.

[439] *Id.* at p. 600004-05.

[440] *Id.*

[441] *Id.* at p. 600004.

[442] *Id.*

[443] Tr. Vol. IV at p. 645.

[444] *Id.* at pp. 713-14

[445] Tr. Vol. V at p. 881.

[446] Tr. Vol. XI at p. 1748.

[447] *Id.* at pp. 1750-51.

[448] *Id.* at p. 1760.

[449] Exhibit 44A at p. 70.

[450] Exhibit 44B at p. 106. See also Exhibit 28 at pp. 79 and 158.

[451] Exhibit 1A at pp. 100036-39. Tr. Vol. II at pp. 340-41.

[452] *Id.*

[453] Tr. Vol. IV at p. 738.

[454] Exhibit 2A at pp. 200000-04.

[455] *Id.*

[456] Tr. Vol. IV at pp. 759-60.

[457] Exhibit 3A at pp. 300004-07.

[458] *Id.*

[459] Tr. Vol. IV at p. 768.

[460] Exhibit 4A at pp. 400073-77.

[461] *Id.*

[462] Tr. Vol. IV at pp. 774-75.

[463] Exhibit 5A at pp. 500004-08.

[464] *Id.*

[465] Tr. Vol. V at pp. 792-93.

[466] Exhibit 6A at pp. 600008-13.

[467] *Id.*

[468] *Id.* at p. 600067. See Tr. Vol. XIII at pp. 2089-2090.

[469] Tr. Vol. V at pp. 801-02.

[470] Tr. Vol. VII at pp. 1196-97.

[471] *Id.* at pp. 1194-96.

[472] Exhibit 10 at pp. 002616-28.

[473] See *generally* Exhibit 10. Mr. Appleman's handwritten progress notes for Client #10 can be found in Exhibit 10 at pp. 002724-32.

[474] Exhibit 12 at pp. 002898-2900. Other relevant facts can be found in Finding of Fact No. 38.

[475] *Id.*

[476] See *generally* Exhibit 12. Mr. Appleman's handwritten progress notes for Client #11 can be found in Exhibit 12 at pp. 002906-16.

[477] Exhibit 14 at p. 003815.

[478] *Id.* at pp. 003772-75.

[479] See *generally* Exhibit 14. Mr. Appleman's periodic reports to Client #13's probation officer can be found in Exhibit 14 at pp. 003826-45.

[480] Exhibit 19 at pp. 004717-28.

[481] *Id.* at pp. 004926-28.

[482] See *generally* Exhibit 19.

[483] Exhibit 14 at p. 003595. The Committee obtained copies of this letter and the following five letters when it subpoenaed all records relating to Client #13 from the Olmstead County Corrections Office. See Exhibit 14 at p. 003589.

[484] *Id.* at p. 003607.

[485] *Id.* at p. 003671.

[486] *Id.* at pp. 003675-76.

[487] *Id.* at p. 003679.

[488] *Id.* at p. 003725.

[489] Tr. Vol. III at pp. 479-82 and Vol. IV at p. 605.

[490] Tr. Vol. IV at p. 611.

[491] Other relevant facts are set forth in Findings of Fact Nos. 41, 159, 160, 161, 178 and 179.

[492] Exhibit 20 at p. 005515.

[493] *Id.*

[494] Tr. Vol. IV at pp. 648-49.

[495] *Id.* at p. 714.

[496] Tr. Vol. VII at p. 1183.

[497] Tr. Vol. II at p. 307.

[498] Tr. Vol. IV at p. 612.

[499] Tr. Vol. II at pp. 306-07.

[500] Tr. Vol. XIII at pp. 2044-45.

[501] Exhibit 1 at p. 007025. Mr. Appleman frequently used a particular numeric billing code — i.e., “90853” — to indicate group therapy sessions. See Exhibit 36.

[502] *Id.* at pp. 007038-39

[503] *Id.* at p. 007041.

[504] *Id.* at p. 007043.

[505] *Id.* at p. 007046

[506] *Id.* at p. 000079

[507] *Id.* at p. 007048.

[508] *Id.* at p. 007050.

[509] Exhibit 25; Tr. Vol. I at pp. 156-57.

[510] Tr. Vol. II at p. 296.

[511] Tr. Vol. II at pp. 296-306; Exhibit 25 at pp. 007025, 007038-39, 007041, 007043, 007046, 000079, 007048, and 007050.

[512] Exhibit 1 at p. 007020.

[513] *Id.* at p. 007035.

[514] *Id.* at p. 007040.

[515] *Id.* at p. 000079.

[516] Exhibit 25; Tr. Vol. II at pp. 293-94.

[517] Exhibit 3 at p. 000768.

[518] *Id.* at p. 000771

[519] *Id.* at p. 000773

[520] *Id.* at p. 000777

[521] Exhibit 25; Tr. Vol. II at pp. 305-07.

[522] Tr. Vol. II at p. 307; Exhibit 25 at pp. 020073-74.

[523] Exhibit 12 at p. 3018.

[524] Exhibit A of Exhibit 41; see generally Exhibit 12.

[525] See Exhibit B to Exhibit 41 and pages noted there in Exhibit 14.

[526] Exhibit B to Exhibit 41; see generally Exhibit 14.

- [527] See Exhibit B to Exhibit 41 and pages noted there in Exhibit 14.
- [528] Exhibit B of Exhibit 41; *see generally* Exhibit 14.
- [529] See Exhibit C of Exhibit 41 and pages noted there in Exhibit 19.
- [530] Exhibit C of Exhibit 41; *see generally* Exhibit 19.
- [531] See Exhibit C of Exhibit 41 and pages noted there in Exhibit 19.
- [532] Exhibit C of Exhibit 41; *see generally* Exhibit 19.
- [533] Exhibit 1 at pp. 007057-58. Mr. Appleman frequently used a particular numeric billing code — i.e., “90841” — to indicate individual therapy sessions. See Exhibit 36.
- [534] Exhibit 1A at p. 10026.
- [535] *Id.*; *see generally* Exhibit 1A.
- [536] See Exhibit A of Exhibit 41 and pages noted there in Exhibit 12.
- [537] Exhibit A of Exhibit 41; *see generally* Exhibit 12.
- [538] See Exhibit A of Exhibit 41 and pages noted there in Exhibit 12.
- [539] Exhibit A of Exhibit 41; *see generally* Exhibit 12.
- [540] See Exhibit B of Exhibit 41 and pages noted there in Exhibit 14.
- [541] Exhibit B of Exhibit 41; *see generally* Exhibit 14.
- [542] See Exhibit B of Exhibit 41 and pages noted there in Exhibit 14.
- [543] Exhibit B of Exhibit 41; *see generally* Exhibit 14.
- [544] See Exhibit C of Exhibit 41 and pages noted there in Exhibit 19.
- [545] Exhibit C of Exhibit 41; *see generally* Exhibit 19.
- [546] Exhibit 20 at p. 008207.
- [547] *Id.* at pp. 005574 and 005608.
- [548] *Id.* at pp. 005517-23. The only entry for 8-8-94 is for a consultation with Client #20’s QRC.
- [549] Exhibit 21 at p. 005670 and 005673.
- [550] Exhibit 32 at p. 49, ¶ 171.
- [551] See Exhibit C of Exhibit 41 and pages noted there in Exhibit 19.
- [552] Exhibit C of Exhibit 41; *see generally* Exhibit 19.
- [553] Other relevant facts can be found in Findings of Fact Nos. 41 through 43, 108, and 109.
- [554] Exhibit 20 at p. 005608.
- [555] Tr. Vol. IV at p. 715.
- [556] Minn. Stat. §§ 14.50 and 148.941.
- [557] Minn. Stat. §§ 148.881 through 148.98.
- [558] Minn. R. ch. 7200. Unless otherwise specified, all references to Minnesota Rules are to the 1999 edition.
- [559] Minn. R. pt. 1400.7300, subp. 5. *See also In the Matter of Wang*, 441 N.W.2d 488, 492 (Minn. 1989).
- [560] Minn. Stat. § 148.941, subd. 2(b), (c), and (d).
- [561] Minn. Stat. § 148.941, subd. 2(a).
- [562] Minn. R. pts. 7200.4500 through 7200.5700.
- [563] Minn. R. pt. 7200.5700.
- [564] 78 N.W.2d 351 (Minn. 1956)
- [565] 78 N.W. 2d at 355.
- [566] Minn. R. pt. 1400.5600, subp. 5; *see In re Ruffalo*, 390 U.S. 544 (1968) *rehearing denied*, 391 U.S. 961, and *In re Graham*, 453 N.W.2d 313, 316 (Minn. 1990), *cert. denied*, 498 U.S. 820 (1990).
- [567] *Zotos Int’l v. Kennedy*, 460 F.Supp. 268, 274 (D.D.C. 1978)

[568] The Committee did not identify Claim 5-11 in Exhibit 86, which the Committee filed on December 7, 2000, at the ALJ's request. It first appeared in the Committee's Statement (Administrative Record, Item 124) at p. 36, which the Committee filed on February 5, 2001.

[569] Ultimately, the Board will have to interpret the legal effect that it intended its earlier ruling to have and to arrive at its interpretation of what standards apply to charges of substandard documentation. The ALJ has concluded and recommends that the Board conclude that "unprofessional conduct" by psychologists does embrace substandard documentation practices. See extended discussion in Parts V. and VI.

[570] For extended discussion, see Part II-A of the Memorandum that follows.

[571] Part II-B.

[572] Part II-B.

[573] As used hereafter in these Conclusions, the phrase "fail to meet (or conform to) usual and customary prevailing standards of practice (or behavior)," or words to the same effect, shall mean and refer to the definitions of "unprofessional conduct" in Minn. R. pt. 7200.5700.

[574] Minn. Stat. § 148.98(a) and in Minn. R. pt. 7200.5700.

[575] Minn. R. pt. 7200.5600.

[576] *Id.*

[577] Claim 1-1.

[578] Minn. R. pt. 7200.5700.

[579] Claims 8/9-1 and 8/9.1.1.

[580] Part VII-I-7.

[581] To the extent that Claim 20-1 embraces substandard documentation of client history, it is duplicative of Claims 20-9 and 20-11. See discussion in Part IX-F of the Memorandum that follows.

[582] In substance, the ALJ concluded that the evidence failed to establish the findings of fact that were necessary to the assertion of these two claims, so there are no findings of fact for this claim, *supra*. See discussion in Part IX-G-4 of the Memorandum that follows.

[583] Minn. Stat. § 14.62, subd. 1.

[584] Notice of and Order for Prehearing Conference and Hearing filed on July 8, 1998. (Administrative Record, Item 1)

[585] Specifically, that Mr. Appleman had given false testimony at a workers' compensation claim hearing. See Committee's Notice of Motion and Motion to Amend Notice of Hearing and for a Protective Order. (Administrative Record, Item 6)

[586] (Administrative Record, Item 13).

[587] (Administrative Record, Item 16).

[588] (Administrative Record, Item 63).

[589] Recommendation on Motion for Partial Summary Disposition filed on October 14, 1999. (Administrative Record, Item 87)

[590] *Id.* at Exhibit A.

[591] See Rulings on Motions and Order dated March 30, 2000 (Administrative Record, Item 112).

[592] Namely, Claims Nos. 7-5, 8/9-7, 8/9-8, OF-2, OF-3, OF-7, OF-8, OF-12, OF-13, OF-14, 20-7, 22-1, and 23-1. *Id.* at p. 3.

[593] See Exhibit 83; see also Tr. vol. XII at pp. 1853-1854.

[594] Tr. vol. XII at pp. 1853-1854; see also Tr. vol. XIII at pp. 2165-2166.

[595] *Id.*

[596] Exhibit 86.

[597] Claims Nos. 1-3, 1-8, 2-1, 2-4, 2-5, 3-1, 3-2, 3-7, 4-1, 4-4, 5-1, 5-2, 5-4, 5-7, 6-1, 6-4, 6-5, 6-7, 7-1, 7-2, 7-6, 8/9-5, 8/9-6, 8/9-9, 8/9-10, OF-4, 20-3. *Id.*

[598] Claims Nos. 1-9 and 1-12.

[599] Claims Nos. 1-6, 1-7, 1-10, 1-11, 1-13, 2-3, 2-6, 2-7, 3-3, 3-4, 5-6, 6-2, 6-6, 8/9-1, OF-6, and OF-9.

[600] Claims Nos. 1-1, 1-2, 1-4, 1-5, 2-2, 3-5, 3-6, 3-8, 4-2, 4-3, 4-5, 4-6, 5-3, 5-5, 6-3, 7-3, 7-4, 8/9-2, 8/9-3, 8/9-4, 8/9-11, OF-1, OF-5, OF-10, OF-11, 20-1, 20-2, 20-4, 20-5, 20-6, 20-8, 20-9, 20-10.

[601] 1-13.1, 1-14, 1-15, 1-16, 2-8, 2-9, 3-9, 3-10, 3-11, 4-7, 4-8, 4-9, 4-10, 5-8, 5-9, 5-10, 6-8, 6-9, 6-10, 7-7, 7-8, 7-9, 8/9-1.1, OF-15, OF-16, OF-17, OF-18, OF-19, OF-20, 20-11, 20-12, 20-13, 21-1, 21-2, 21-3, 21-4, 21-5, General Claim-1, General Claim-2, General Claim-3, and General Claim-4.

[602] As supporting authority, he cites *In re Ruffalo*, 390 U.S. 544 (1968), *Comm. On Prof'l Ethics v. Wenger*, 454 N.W.2d 367, 369 (Iowa 1990), and *Weiner v. Bd. of Regents*, 3 A.D.2d 113, 158N.Y.S2d 739 (N.Y.App.Div. 1956).

[603] *Humenansky v. Minn. Bd. of Medical Examiners*, 525 N.W.2d 559, 566 (Minn. App. 1994), citing *Greene v. McElroy*, 360 U.S. 474, 492, 79 S.Ct. 1400, 1411, 3 L.Ed.2d 1377 (1959).

[604] *Humenansky*, *supra*, 525 N.W.2d at 565.

[605] *Ruffalo*, *supra*, 390 U.S. at 552.

[606] *Zotos Int'l v. Kennedy*, 460 F.Supp. 268, 274 (D.D.C. 1978).

[607] *In re Graham*, 453 N.W.2d 313, 316 (Minn. 1990), *cert. denied*, 498 U.S. 820 (1990).

[608] Nothing precludes the Committee from asserting charges that it did not submit for summary adjudication but were still alleged in the Notice of Hearing

[609] Specifically, Minn. Stat. § 14.58.

[610] Minn. R. pt. 1400.5600, subp. 2D.

[611] Minn. R. pt. 1400.5600, subp. 5.

[612] Exhibit 84.

[613] Respondent's Post-Hearing Memorandum (Administrative Record, Item 126) at p. 4.

[614] *Hough Transit, Ltd. V. Harig*, 373 N.W.2d 327, 332 (Minn.App. 1985).

[615] Board's Rulings on Motions and Order (Administrative Record Item 112) at p. 4.

[616] See, e.g., Respondent's Memorandum in Opposition to Motion of the Complaint Resolution Committee for Summary Disposition (Admin. Record Item 77) at pp. 23-24.

[617] Minn. R. pt. 7200.5700.

[618] Minn. Stat. § 148.98(a).

[619] See Respondent's Reply Memorandum on the Doctrine of the Law of the Case (Admin. Record Item 134).

[620] As used in this Report, the term "substandard" means behavior and practices by psychologists that fail to meet "those standards of professional behavior that have been established by a consensus of the expert opinion of psychologists" (Minn. R. pt. 7200.5700) or that "fail to meet usual and customary professional standards." (Minn. Stat. § 148.98(a))

[621] Recommendation on Motion for Partial Summary Disposition (Administrative Record, Item 87) at p.50.

[622] *Id.* at p.15.

[623] As discussed below, such a failure also might amount to "unprofessional conduct" if it failed to conform to acceptable and prevailing practice standards. But in order to obtain summary disposition of that charge, it would have been necessary for the Committee to establish those standards with uncontroverted expert opinion testimony. See *Reyburn v. Board of Optometry*, 78 N.W.2d 351, 355 (Minn. 1956). Since the respective affidavits of experts that the parties submitted in connection with summary disposition were in conflict on this point, it would have been inappropriate for the ALJ to have recommended summary disposition of whether Mr. Appleman's documentation fell below prevailing standards.

[624] Board's Rulings on Motions and Order (Administrative Record, Item 112) at p. 4.

[625] Ultimately, the Board will have to interpret the legal effect that it intended its earlier ruling to have and to arrive at its interpretation of what standards apply to charges of substandard documentation. The

ALJ has concluded and recommends that the Board conclude that “unprofessional conduct” by psychologists does embrace substandard documentation practices. See extended discussion in Parts V. and VIII.

[626] Exhibit 32 at p. 44.

[627] Exhibit 20 at p.5549-50.

[628] *Id.* at pp. 5551-52

[629] *Id.* at pp. 5555-56.

[630] *Id.* at pp. 5560-65.

[631] Exhibit 20 at pp. 5561-62.

[632] *Id.* at p. 5563.

[633] Complaint Review Committee’s Post-Hearing Memorandum of Legal Points and Authorities (Administrative Record, Item 123) at p. 15.

[634] The Committee has withdrawn two of those charges — namely, Claim 20-3 and 20-7. See Exhibit 86 and discussion below.

[635] Exhibit 86 at pp. 8-9. At the hearing the Committee presented other evidence to establish the other charges relating to Client #20. See, e.g., Exhibit 20 and Tr. pp. 825-29.

[636] *Northwestern Nat’l Life Ins. Co. v. County of Hennepin*, 572 N.W.2d 51 (Minn. 1998).

[637] 472 N.W.2d 114 (Minn. 1991).

[638] *Id.* at 116.

[639] *AFSCME Council No. 14, Local Union No. 517 v. Washington County Bd. of Com’rs*, 527 N.W.2d 127 (Minn. App. 1995).

[640] *Johnson v. Consolidated Freightways, Inc.*, 420 N.W.2d 608, 613-14 (Minn. 1988).

[641] *AFSCME Council No. 96 v. Arrowhead Regional Corrections Bd.*, 356 N.W.2d 295, 299 (Minn. 1984).

[642] Minn. R. pt. 7200.5700.

[643] *Id.* See also discussion in Parts IV. And V., below.

[644] Minn. Stat. Ch. 176.

[645] Exhibit 20 at pp. 5560-65.

[646] But since the Committee did not present enough other evidence to revive this charge, the ALJ had recommended dismissal. See I-J-3, below.

[647] See Minn. Stat. § 176.135.

[648] Exhibit 86

[649] See Notice of Hearing at ¶¶ 1 and 2.

[650] See Notice of Hearing at ¶ 3.

[651] *Id.*

[652] See Notice of Hearing at ¶ 2.

[653] See Notice of Hearing at ¶ 6.

[654] *Id.* Although the Notice of Hearing does not specifically mention an MMPI performed on Client #1, a claim of substandard interpretation of that test is fairly embraced by references in ¶ 6 to “several psychological tests,” failure to link those tests “to his assessment and treatment for client #1,” and his failure to cite “any reservations or qualifications concerning the validity or reliability of the conclusions formulated and recommendations made.” Furthermore, the report of Dr. Cohen, which was provided to Mr. Appleman more than a year before the hearing, specifically addresses substandard interpretation of the MMPI. See Exhibit B to Affidavit of Norman J. Cohen dated June 10, 1999 (reintroduced into the hearing record as Exhibit 42B) at pp. 6-7. And, in fact, in arguing against summary disposition, Mr. Appleman specifically responded to Dr. Cohen’s opinion about the interpretation of the MMPI for Client #1 on August 20, 1999. See Exhibit 2 to Affidavit of Michael A. Appleman dated August 20, 1999 (reintroduced into the hearing record as Exhibit 44B) at pp. 25-26.

[655] See Notice of Hearing at ¶¶ 7 and 8.

[656] See Notice of Hearing at ¶ 8.

[657] See Notice of Hearing at ¶ 7.

[658] *Id.*

[659] See Notice of Hearing at ¶¶ 5, 9, and 10.

[660] Exhibit 86 at pp.1-2,

[661] “Failure to demonstrate an understanding of tests” may be evidence of substandard test interpretation but does not by itself appear to violate any rule or represent unprofessional conduct. It appears to be a dimensionless problem unless it results in a particular substandard test interpretation.

[662] In Exhibit 86, the committee identified Claim 1-16 as a “new claim #.” Even though Dr. Cohen covered the substance of the charges in that claim in his reports and the Committee subsequently presented relevant evidence at the hearing, nowhere in the Notice of Hearing did the Committee even touch on maintaining test protocols for Client #1 as an instance of a rule violation or of unprofessional conduct. The Notice of Hearing at ¶ 6 addresses “unnecessary and inappropriate” testing and inadequate interpretations of test results, both of which concern Mr. Appleman’s clinical judgment. On the other hand, failure to maintain test protocols is a an alleged instance of *improper record keeping*, which is not specifically discussed.

[663] See Notice of Hearing at ¶ 14.

[664] See Notice of Hearing at ¶ 15.

[665] *Id.*

[666] See Notice of Hearing at ¶ 16.

[667] Exhibit 86 at p.2,

[668] The ALJ previously identified Claim 2-3 in October 1999 as being a separate charge asserted by the Board based on the Affidavit of Dr. Cohen in support of the Committee’s motion for summary disposition (Exhibit 66). But since that time the Committee has never acted to amend the Notice of Hearing to formally assert that charge. And in Exhibit 86 the Committee identified Claim 2-8 as a “new claim #.” And as previously discussed in connection with Claim 1-16, failure to maintain test protocols is a charge of improper record keeping, which is not fairly described anywhere in the Notice of Hearing with reference to Client #2.

[669] See Notice of Hearing at ¶ 20.

[670] See Notice of Hearing at ¶ 22. But the issue is limited to whether Mr. Appleman’s failure to maintain group therapy notes represents substandard documentation practice and therefore unprofessional conduct in violation of Minn. R. pt. 7200.5700, since the Board has already ruled that it did not violate Minn. R. pt. 7200.4900, subp. 1a. See discussion in Part II-A, *supra*.

[671] See Notice of Hearing at ¶¶ 19 and 20.

[672] See Notice of Hearing at ¶ 20.

[673] *Id.*

[674] See Notice of Hearing at ¶ 21.

[675] Exhibit 86 at p. 3.

[676] The Notice of Hearing at ¶ 19 alleges that the evaluation report for Client #3 contained “only brief information” about test results” and that Mr. Appleman “fails to address other tests administered or the relevance of those test.” But neither of those allegations fairly suggest “making interpretive statements that were unsupported by test results,” which is the charge raised in Claim 3-8.

[677] Although inappropriately diagnosing Client #3 with somatoform pain disorder is addressed in Dr. Cohen’s original report (Exhibit 66) and both parties presented evidence on this issue at the hearing, this charge was specified nowhere in the Notice of Hearing, and the Committee never took steps to amend the Notice of Hearing to include it before the hearing ended.

[678] See Notice of Hearing at ¶ 27.

[679] See Notice of Hearing at ¶¶ 29 and 30. The allegations in those paragraphs support a charge that Mr. Appleman failed to provide adequate support for the professional judgments that he made about

Client #4, but nowhere in the Notice of Hearing are there allegations to support a charge that he failed to provide a third party payer with testing protocols when requested.

[\[680\]](#) See Notice of Hearing at ¶ 25.

[\[681\]](#) See Notice of Hearing at ¶ 26.

[\[682\]](#) See Notice of Hearing at ¶ 30.

[\[683\]](#) See Notice of Hearing at ¶ 26.

[\[684\]](#) Exhibit 86 at pp.3-4.

[\[685\]](#) In Exhibit 86, the committee identified Claim 4-10, which is directed at failing to maintain test protocols, as a “new claim #.” As previously noted, nowhere in the Notice of Hearing did the Committee allege failure to maintain test protocols for Client #4 as an instance of a rule violation or of unprofessional conduct.

[\[686\]](#) See Notice of Hearing at ¶¶ 33 and 34.

[\[687\]](#) See Notice of Hearing at ¶¶ 35 and 36.

[\[688\]](#) See Notice of Hearing at ¶¶ 35 and 36.

[\[689\]](#) See Notice of Hearing at ¶ 35.

[\[690\]](#) See Notice of Hearing at ¶ 37.

[\[691\]](#) Exhibit 86 at p.4.

[\[692\]](#) In the Committee's Statement (Administrative Record, Item 124) at p. 36, it identified Claim 5-11, relating to failure to maintain test protocols, as a new claim that had been “inadvertently omitted” from the list of charges it had previously tendered as Exhibit 86. But as was the case with Claim 1-16, failure to maintain test protocols is a charge of improper record keeping, which is not fairly stated anywhere in the Notice of Hearing with reference to Client #5.

[\[693\]](#) See Notice of Hearing at ¶ 40.

[\[694\]](#) *Id.*

[\[695\]](#) See Notice of Hearing at ¶ 42.

[\[696\]](#) *Id.*

[\[697\]](#) See Notice of Hearing at ¶ 43.

[\[698\]](#) See Notice of Hearing at ¶ 41.

[\[699\]](#) Exhibit 86 at p. 5.

[\[700\]](#) See Notice of Hearing at ¶ 49.

[\[701\]](#) The Board did grant summary disposition of Claim 7-5, so it is no longer at issue at this stage of these proceedings.

[\[702\]](#) Exhibit 86 at pp.5-6.

[\[703\]](#) The ALJ originally identified Claim 7-4 as being a charge that the Committee was asserting against Mr. Appleman based on the Committee's reference to expert testimony given by Dr. Cohen in his affidavit he tendered in connection with the motions for summary disposition. (See Exhibit 83.) Dr. Cohen did cover the substance of the charges in that claim in his reports and the Committee subsequently presented relevant evidence at the hearing, but the Notice of Hearing only speaks to improper record keeping. (Notice of Hearing at ¶ 49) Alleging that Mr. Appleman had made substandard interpretations of Client #7's test results essentially addresses his clinical judgment, which is not fairly brought into question in the Notice of Hearing. Again, the Committee did not subsequently amend its Notice of Hearing to include that charge before the hearing ended.

[\[704\]](#) As with Claim 7-4, this is essentially an alleged instance of substandard clinical judgment, which is not fairly embraced by the alleged violations of billing and record keeping standards alleged in ¶¶ 48 and 49 of the Notice of Hearing.

[\[705\]](#) Although the Committee presented testimony and documentary evidence at the hearing tending to prove that Mr. Appleman failed to elicit or document client history that bore on the reliability of his conclusions (Claim 7-7), that he failed to refer Client #7 for a neuropsychological evaluation (Claim 7-8), and that he prepared a substandard treatment plan for Client #7 (Claim 7-9), there were no allegations in

the Notice of Hearing, as amended, that fairly informed Mr. Appleman that he was being charged with those things.

[706] See Notice of Hearing at ¶ 67 and 68.

[707] See Notice of Hearing at ¶ 58. The Board did grant summary disposition of Claims 8/9-7 and 8/9-8, so they are no longer at issue at this stage of these proceedings.

[708] See Notice of Hearing at ¶ 55.

[709] Not indicated as withdrawn on Exhibit 86 but so indicated on Exhibit 83A, which the Committee prepared subsequently.

[710] Exhibit 86 at pp.6-7.

[711] Claim 8/9-4 originally appeared in Exhibit 83,. The ALJ characterized it as charging that Mr. Appleman made “interpretations of tests that were not based on valid or appropriate supporting information.” In ¶¶ 67 and 68 of the Notice of Hearing, the Committee simply alleged that Mr. Appleman’s client records lacked documentation that he administered certain tests. If the Committee’s charge in Claim 8/9-4 is simply that the absence of test protocols *per se* renders his test interpretations invalid or inappropriate, it is not really a new charge but essentially a restatement of the charge made in Claim 8/9-3

[712] On the other hand, if the charge in Claim 8/9-4 is that Mr. Appleman exercised substandard clinical judgment in interpreting tests, that charge was necessarily based expert testimony given by Dr. Cohen in the affidavit he tendered in connection with the motions for summary disposition. Even though Dr. Cohen covered the substance of the charges in that claim in his reports and the Committee subsequently presented relevant evidence at the hearing, nowhere in the Notice of Hearing did the Committee fairly make that charge. Nor did it subsequently amend its Notice of Hearing to include that charge before the hearing ended.

[713] See Notice of Hearing at ¶ b.

[714] See Notice of Hearing at ¶¶ b and 98.

[715] See Notice of Hearing at ¶¶ 117, 118, 129 and 146.

[716] See Notice of Hearing at ¶¶ 88 and 89. The Board did grant summary disposition of Claims OF-2, OF-3, OF-7, OF-8, OF-12, OF-13, and OF-14, so those seven charges are no longer at issue at this stage of these proceedings.

[717] See Notice of Hearing at ¶ 147.

[718] See Notice of Hearing at ¶¶ 81, 93, 102, 109, 125, and 142.

[719] See Notice of Hearing at ¶ 119.

[720] See Notice of Hearing at ¶¶ 133, 134, 135, and 138.

[721] See Notice of Hearing at ¶¶ b, 81, 93, 102, and 127.

[722] See Notice of Hearing at ¶¶ 81, 93, and 109.

[723] See Notice of Hearing at ¶ 96.

[724] Exhibit 86 at pp. 7.

[725] In Exhibit 86, the committee identified Claim OF-15 as a “new claim #.” Again, even though Dr. Cohen covered the substance of the charges in that claim in his reports and the Committee subsequently presented relevant evidence at the hearing, nowhere in the Notice of Hearing did the Committee allege failure to maintain test protocols for sex offender clients as an instance of a rule violation or of unprofessional conduct.

[726] See Notice of Hearing at ¶¶ 153, 156, 157, and 159 through 163.

[727] See Notice of Hearing at ¶¶ 154 through 157 and 159 through 161.

[728] See Notice of Hearing at ¶¶ c, 155, and 160.

[729] See Notice of Hearing at ¶ c, 155, and 163.

[730] See Notice of Hearing at ¶ c and 152.

[731] See Notice of Hearing at ¶ c and 163.

[732] The Board did grant summary disposition of Claim 20-7, so that charge is no longer at issue at this stage of these proceedings.

[733] The Committee's allegation in the Notice of Hearing at ¶ 163 that "[r]espondent's records for client #20 contain no data pertaining to the WRAT, the Strong-Campbell Interest Test or the Career Assessment Test" gives reasonable notice of failure to maintain test protocols.

[734] See Notice of Hearing at ¶ 158.

[735] See Notice of Hearing at ¶ 164.

[736] In the Committee's Statement (Admin. Record) at p. 27, the Committee stated that it was eliminating Claim 20-4 because it was duplicative of Claim 20-9.

[737] Exhibit 86 at p. 8.

[738] See Notice of Hearing at ¶¶ 173 and 182.

[739] See Notice of Hearing at ¶ 173.

[740] See Notice of Hearing at ¶¶ 177 through 181 and 186.

[741] Although Dr. Cohen gave opinions at the hearing about how Mr. Appleman may have failed to document cultural factors that could have affected Client #21's performance on certain test, there are no such allegations in the Notice of Hearing.

[742] As is the case with most other clients, the Notice of Hearing does not allege that Mr. Appleman failure to maintain test protocols for Client #21 was an instance of a rule violation or of unprofessional conduct.

[743] Claims Nos. 22-1 and 23-1 in Exhibit 83.

[744] Administrative Record, Items 62 and 63.

[745] See Notice of Hearing at ¶¶ 6, 15, 19, 26, 36 and 42. The allegations in the Notice of Hearing reasonably cover deficiencies in reporting the results of the Wide Range Achievement Test with reference to Clients #1 through #6, #8 and #20. But the allegations in the Notice of Hearing are insufficient to support the same charge with reference to Clients #7 and #11.

[746] See Notice of Hearing at ¶¶ 6, 15, 19, 42 and 163. The allegations in the Notice of Hearing reasonably cover improper billing for the Goldberg stress test with reference to Clients #1 through #3, #6 and #20. But the allegations in the Notice of Hearing are insufficient to support the same charge with reference to Clients #4, #5, and #21.

[747] See Notice of Hearing at ¶¶ 15, 49, 67, 68, 163, and 181. The allegations in the Notice of Hearing reasonably cover the charge of billing without documentation of test administration with reference to Clients #2, #7 through #9, #20, and #21. But the allegations in the Notice of Hearing are insufficient to support the same charge with reference to Clients #1, #5 and #11.

[748] Although Dr. Cohen gave opinions at the hearing about how Mr. Appleman may have failed to document cultural factors that could have affected Client #21's performance on certain test, there are no such allegations in the Notice of Hearing.

[749] In order to place the charge of providing false or misleading affidavit and hearing testimony at issue, the Committee clearly was obliged to amend its Notice of Hearing. (See Minn. R pt. 1400.5600, subp. 5.) Moreover, *In re Ruffalo*, 390 U.S. 544, 551 (1968) suggests that even with such an amendment, the ALJ would have been obliged to give Mr. Appleman "a reasonable time to prepare to meet the new issues or allegations if requested." (Minn. R pt. 1400.5600, subp. 5.) Since the Committee met none of the procedural or constitutional prerequisites with respect to this charge, it cannot be asserted against Mr. Appleman in this proceeding.

[750] Minn. R. pt. 1400.7300, subp. 5, provides that:

The party proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence, unless the substantive law provides a different burden or standard. A party asserting an affirmative defense shall have the burden of proving the existence of the defense by a preponderance of the evidence. In employee disciplinary actions, the agency or political subdivision initiating the disciplinary action shall have the burden of proof.

[751] Minn. R. pt. 1400.7300, subp. 5; *In the Matter of Friedenson*, 574 N.W.2d 463, 466 (Minn. App. 1998).

[752] Minn. Stat. § 147.091.

[753] *In the Matter of Friedenson*, *supra*.

[754] 441 N.W.2d 488 (Minn. 1989).

[755] 441 N.W.2d at 492.

[756] *Id.*

[757] Minn. Stat. § 148.907, subd. 1.

[758] Minn. Stat. § 148.941.

[759] A distinction can be made between professional practice standards and other types of conduct, such as criminal behavior, that may disqualify a practitioner from holding a license. For example, in Minn. Stat. § 148.941, subd. 1, the legislature lists several types of disqualifying behaviors that do not necessarily relate to a practitioner's professional competence or ability to provide psychology services.

[760] See Minn. Stat. § 147.091, subd. 1.

[761] But the legislature has given both of those boards to supplement statutory practice standards with rules. And, in fact, the Board of Dentistry has done so. See Minn. R. pts. 3100.6200 and 3100.6300.

[762] See Laws 1973, c. 685, § 11.

[763] *Id.*, as amended, codified as Minn. Stat. § 148.98..

[764] Minn. Stat. § 148.98 (1976).

[765] See Laws 1986, c. 444.

[766] See, *for example*, Chapter 7, Minnesota Code of Agency Rules (MCAR), § 10.008 (1982). When responsibility for publishing agency rules was transferred to the Revisor of Statutes on July 1, 1983, the Board's ethical code was incorporated into Minnesota Rules. See Minn. R. pt. 7200.4500 — 7200.5500 (1983) and subsequent editions of Minnesota Rules.

[767] Minn. R. pt. 7200.5700 (1990 Supp.), adopted on July 10, 1989. See 14 State Register 74.

[768] 78 N.W.2d 351 (Minn. 1956)

[769] *Id.* at 355.

[770] See Laws 1991, c. 255.

[771] Minn. Stat. §§ 148.90 through 148.98.

[772] Laws 1991, c. 255, §4, codified as Minn. Stat. § 148.881.

[773] Laws 1993, c. 206, §18, codified as Minn. Stat. § 148.941, subd. 2.

[774] *Id.* at paragraph (3). This amendment to the Psychology Practice Act became effective on May 15, 1993. (See Laws 1993, c. 206, §26.) Most of the other nine types of disqualifying behaviors that the legislature enumerated do not necessarily relate to a practitioner's professional competence or ability to provide psychology services.

[775] The ALJ notes, however, that there was nothing in the Board's pre-1993 rules or in *Reyburn* suggesting that actual injury was a precondition to discipline.

[776] The Committee framed most opinion questions to its expert witnesses in terms of "minimum standards of acceptable and prevailing practice in the State of Minnesota in the early to mid 1990s." Mr. Appleman framed many of his opinions in terms of "community standards." In this report, the ALJ refers most frequently to "usual and customary prevailing standards of professional behavior and practice." Moreover, none of these formulae reflect verbatim any of the three, somewhat different descriptions of standards found in *Reyburn*, in statute, or in rule. The ALJ considers the differences in phrasing to be immaterial. It is clear that the parties, the ALJ, the courts, the legislature, and the Board are all talking conceptually about the same set of standards from the same source — i.e., standards that a consensus of practitioners employ in their daily practices.

[777] In its post-hearing submission, the Committee also argues that the standards for determining whether unprofessional conduct has occurred are synonymous with the legal standards for determining whether a psychologist has committed professional negligence. (Complain Resolution Committee's Post-

Hearing Memorandum of Legal Points and Authorities (Administrative Record, Item #123) at pp. 6-11) But it is unnecessary to determine whether or not professional negligence also necessarily constitutes unprofessional conduct. All that is at issue here is whether Mr. Appleman engaged in conduct that fits the legal definition of unprofessional conduct. Moreover, none of the expert witnesses who testified in this matter were examined in terms of whether Mr. Appleman had been negligent in his evaluation and treatment of clients.

[778] Exhibit 35.

[779] See 7 MCAR § 10.08 A. 4. (Sep. 15, 1982), currently set forth in Minn. R. pt. 7200.4500, subp. 4 (1997).

[780] See, for example, Committee's Memorandum in Support of Motion for Partial Summary Disposition (Administrative Record, Item #63) at pp. 5-8. The Committee's expert witnesses did not specifically address this issue during the hearing, nor did the Committee discuss it in its post-hearing memorandum.

[781] Tr. vol. V at pp. 783-84 and vol. XI at 1693-95.

[782] Exhibit 35 at "Introduction."

[783] Minn. R. pts. 7200.4500 through 7200.5700.

[784] Minn. R. pt. 1400.7300, subp. 1.

[785] 78 N.W.2d at 355.

[786] *Id.*

[787] Respondent's Post-Hearing Memorandum (Admin. Record Item 126) at pp. 24-28.

[788] Exhibit 35 at "Introduction."

[789] *Id.*

[790] The ALJ notes that the same criticism could be raised against the opinions of Mr. Appleman's own expert witness, Dr. Wohl.

[791] See Findings of Fact Nos. 28 through 31.

[792] *Id.*

[793] Minn. R. 7200.4900, subp. 1a(A).

[794] Testimony of Dr. Cohen (Tr. Vol. IV at p. 745); Testimony of Dr. Wohl (Tr. Vol. XI at pp. 1785-89).

[795] Notice of Hearing at ¶¶ 130 through 138. In its post-hearing submissions, the Committee also relied on allegations that Mr. Appleman had made improper statements about other inappropriate sexual behavior to Client #15's probation officer and the Board. (Committee's Statement (Administrative Record, Item 124) at pp. 164-72. The ALJ believes that the Board should not allow the latter evidence to be included in Claim OF-17 because the Committee did not give Mr. Appleman fair notice of that aspect of Claim OF-17 in the Notice of Hearing. See discussion in Part I. of this Memorandum, *supra*.

[796] The ALJ is not necessarily subscribing to the view that hearsay evidence can never be used to support a licensure violation. The ALJ is only concluding that hearsay opinion on a matter about which reasonable psychologists could have differing opinions is insufficient to establish a charge where the only other supporting evidence is inferential.

[797] See Notice of Hearing at ¶ 96.

[798] Finding of Fact No. 38.

[799] See Finding of Fact No. 39.

[800] See Finding of Fact No. 40.

[801] Minn. R. pt. 7200.5600.

[802] The Committee also presented testimony from Thomas Thompson, who had been Client #11's probation officer, that after transferring to different sex offender and chemical dependency treatment programs, Client #11 was completely amenable to treatment, compliant with the terms of the programs, and successfully completed both. Tr. Vol. VII at pp. 1121-28. Apparently, that evidence was tendered to show that it was the statement to the Board that was misleading. But as discussed above, it was immaterial which of the two assessments was misleading.

[803] Exhibit 32 at p. 30, ¶ 96; see also Tr. Vol. III at pp. 473-475.

[804] See Finding of Fact No. 43.

[805] Minn. Stat. § 148.975, subd. 2.

[806] 496 N.W.2d 821 (Minn.App. 1993).

[807] *Id.* at 826.

[808] 496 N.W.2d at 824-25.

[809] Minn. R. pt. 7200.5000, subp. 1.

[810] Finding of Fact No. 52.

[811] Neither Mr. Appleman, Dr. Cohen, or Dr. Wohl was aware of the existence of any such manual or published information. See Exhibit 28 at pp. 107-08; Tr. Vol. II at pp. 252-54, Vol. IV at pp. 666-68; and Vol. XI at p. 1820.

[812] The Committee also alleged that Mr. Appleman violated Minn. R. 7200.5000, subp. 3, by “not disclosing in reports the limitations of the test.” But the ALJ concludes that in this context application of the two rules is mutually exclusive. In other words, if there is a duty to refrain from using the test, disclosing its limitations in testing reports is superfluous.

[813] Finding of Fact No. 54.

[814] Tr. Vol. II at pp. 252-53.

[815] Tr. Vol. XI at p. 1820.

[816] In the Committee’s Statement (Administrative Record, Item 124) at pp. 157-58, the Committee also proposed finding of fact relating to alleged improper efforts by Mr. Appleman to have Client #10’s probation revoked. But since no such allegations or charges are set forth in the Notice of Hearing or any amendment thereof, the ALJ considered those allegations and charges to be immaterial in this proceeding.

[817] Exhibit 35 at ¶ 4.09(c).

[818] Tr. Vol. IV at p. 648.

[819] Tr. Vol. III at p. 470.

[820] See Findings of Fact Nos. 57 through 61.

[821] Exhibit 29 at p. 256.

[822] Tr. Vol. VI at 1075-76.

[823] Exhibit 10 at p.002561.

[824] Minn. R. pt 7200.4700, subp. 1.

[825] Minn. R. pt. 7200.4900, subp. 1a.

[826] Minn. R. pt. 7200.4700 subp. 2.

[827] That is, diagnoses that failed to meet “those standards of professional behavior that have been established by a consensus of the expert opinion of psychologists” and therefore failed to meet “usual and customary professional standards.” (See Minn. Stat. § 148.98(a) and Minn. R. pt. 7200.5700.)

[828] Notice of Hearing ¶¶ 1 and 2.

[829] *Diagnostic and Statistical Manual of Mental Disorder (Third Edition –Revised)*, American Psychiatric Association (Washington, DC: 1987) admitted into the hearing record as Exhibit 79.

[830] Exhibit 79 at p. 251. DSM-III (R)’s full discussion of PTSD is contained in Exhibit 79 at pp. 247-51.

[831] Exhibit 1 at p. 000084-86; Exhibit 32 at p. 3-4.

[832] Complaint Resolution Committee’s Statement of Claims, Evidence, Standards, and Violations (hereinafter “Committee’s Statement”) (Administrative Record Item 124) at pp. 70-72.

[833] Respondent’s Post-Hearing Memorandum (Administrative Record, Item 126) at pp. 46-47.

[834] Tr. Vol. IV at p. 713.

[835] Tr. Vol. IV at pp. 712-13. It should be noted that Dr. Cohen stated that Mr. Appleman misdiagnosed Client #1 as having PTSD solely because the duration of symptoms criterion was not met. See Tr. Vol. IV at pp. 737-38.

[836] Tr. Vol. XI at pp. 1723-24.

[837] *Id.* at 1736.

[838] Exhibit 79 at p. xviii.

[839] *Id.* at p. xxiv.

[840] The Committee has collated most of the evidence adduced by both parties, together with references to germane portions of the hearing record, in Committee's Statement (Administrative Record, Item 124) at pp. 70-74.

[841] Given the qualifications expressed by both Drs. Cohen and Wohl in their opinions and the comments in DSM-III-R itself, the ALJ was also concerned about substantiating a charge of substandard diagnosis of PTSD without a supporting opinion by a clinician who had performed his or her own assessment of Client #1.

[842] Claim 1-2 charges Mr. Appleman with "inappropriately diagnosing Client #1 as having somatoform pain disorder," with Claim 1-4 charging him with "making an assessment of Client #1 that was insufficient to substantiate a finding of somatoform pain disorder." Exhibit 83 at p. 1.

[843] The Notice of Hearing at ¶ 3 alleges that "[I]n late November 1993, Respondent added the diagnosis of somatoform pain disorder for client #1. Respondent's diagnosis is not supported by his therapy records and does not comport with the DSM-III-R diagnostic criteria..

[844] Exhibit 79 at p. 266. DSM-III (R)'s full discussion of somatoform pain disorder is contained in Exhibit 79 at pp. 264-66.

[845] Findings of Fact No. 65.

[846] Tr. Vol. IV. at p. 712.

9<sup>[847]</sup> *Id.* at p. 711.

[848] Tr. Vol. XI at p. 1735.

[849] *Id.*

[850] Exhibit 9 at pp. 002132-35.

[851] *Id.*

[852] Exhibit 9 at p. 2121 (Lori J. Siegel, D.C.), p. 2152 (Joel D. Mack, M.D.), and p. 2157 (Spinal Care Center).

[853] Committee's Statement (Administrative Record, Item 124) at pp. 82-83; Tr. Vol. XIII at p. 2055.

[854] Tr. Vol. V at p. 824.

[855] *See generally* Tr. Vol. XI.

[856] Tr. Vol. XII at p. 1950; he was not cross-examined about that particular diagnosis.

[857] *Id.*

[858] Tr. Vol. V at p. 824.

[859] Exhibit 1A at p. 100044.

[860] *Id.* at p.100024.

[861] *See* Finding of Fact No. 86 and Tr. Vol. IV at pp. 731-32 and 735-36.

[862] *See* Finding of Fact No. 87.

[863] (Administrative Record, Item 71), filed on June 11, 1999, admitted into evidence at the hearing as Exhibits 44A and 44B.

[864] Exhibit 44A at p. 16.

[865] Exhibit 44B at p. 27, referring to Exhibit 1A at p. 100024.

[866] Exhibit 44B at p. 27.

[867] Tr. Vol. IV at p. 735.

[868] Minn. R. pt. 7200.5000, subp. 3C.

[869] Finding of Fact No. 88.

[870] Finding of Fact No. 89.

[871] *Id.*

[872] Exhibit 44B at p. 34.

[873] *Id.*

[874] There was no evidence to suggest that minimum practice standards for test interpretation are any different for neuropsychologists as compared to psychologists with a general clinical practice or for Ph.D. level psychologists as compared to M.A. level psychologists.

[875] Tr. Vol. IV at p. 749.

[876] Exhibit 44B at p. 36.

[877] Dr. Wohl offered nothing specific to this controversy.

[878] See extended discussions in Tr. Vol. IV at pp. 771-72, and Vol. XIII at pp. 2118-31.

[879] See extended discussion in Tr. Vol. X at pp. 1660-66 and Vol. XII at pp. 1860-1875.

[880] Minn. R. pt. 7200.5000, subp. 3B.

[881] Tr. Vol XIII at p. 2131.

[882] Tr. Vol. XII at pp. 1874-75.

[883] Tr. Vol. X at p. 1666.

[884] Notice of Hearing at ¶ 35.

[885] Tr. Vol. V. at p. 794.

[886] See Finding of Fact No. 102.

[887] See Findings of Fact Nos. 96-98.

[888] See Finding of Fact No. 106.

[889] See Finding of Fact No. 107.

[890] Exhibit 29 at p. 369.

[891] See Finding of Fact No. 108.

[892] Minn. R. pt. 7200.5000, subpart 3B.

[893] Exhibit 34.

[894] Findings of Fact Nos. 115, 117, and 120.

[895] Finding of Fact No. 116.

[896] Tr. Vol. VII at p. 1176.

[897] Exhibit 43A at pp. 3-4.

[898] Committee's Statement (Administrative Record, Item 124) at pp. 172-81.

[899] Finding of Fact No. 121.

[900] Minn. R. Evid. 404(a). The ALJ also disregarded statements by Mr. Thompson about what Client #11 told him about Mr. Appleman as hearsay that did not meet the *Wang* standard.

[901] The governing offense may well have warranted a stay of a presumptive 26-month sentence and probation under sentencing guidelines. But that does not mean that the court could not have or would not have revoked probation if Client #11 failed to complete treatment.

[902] Finding of Fact No. 123; Exhibit 20 at p. 005563.

[903] See Part II-B, above.

[904] Notice of Hearing at ¶ 20.

[905] Finding of Fact No. 125.

[906] Claim 3-5, which actually does charge Mr. Appleman with substandard documentation of Client #3's history, is considered below,

[907] In Exhibit 86, the Committee reworded Claim 6-2 to make it more specific, and it added Claim 6-10 as a “new claim #.”

[908] Finding of Fact No. 129.

[909] Relating to Claim 6-8. See Part VII-I-5, *supra*.

[910] Finding of Fact No. 133.

[911] Finding of Fact No. 132.

[912] Finding of Fact No. 133.

[913] Finding of Fact No. 134.

[914] Since ¶ 58 of the Notice of Hearing and Dr. Cohen’s opinion also support a charge of substandard *documentation* of history, the ALJ has considers in the succeeding section whether or not the Committee has proven that charge.

[915] Minn. Stat. § 148.98.

[916] Minn. Stat. § 148.98 (a).

[917] Minn. Stat. § 148.941, subd. 2 (3).

[918] Minn. Stat. § 148.98 (a).

[919] *Cf. Larson v. Yelle*, 246 N.W.2d 841, 845-46 (Minn. 1976).

[920] Minn. R. pt. 7200.4500, subp. 4.

[921] Rather than referring “unprofessional conduct,” the Board of Dentistry’s rules prohibit “[c]onduct unbecoming a person licensed to practice dentistry . . . or conduct,” which includes:

A. engaging in personal conduct which brings discredit to the profession of dentistry;

B. gross ignorance or incompetence in the practice of dentistry and/or repeated performance of dental treatment which fall below accepted standards;

Minn. R. 3100.6200. The essential thrust of these prohibitions is the same as the Board of Psychology’s prohibition of unprofessional conduct.

[922] *Matter of Proposed Disciplinary Action Against Dentist License of Schultz*, 375 N.W.2d 509, 514 (Minn.App. 1985).

[923] Minn. Stat. § 148.941, subd. 2(3).

[924] Like the Board of Dentistry’s rule, the Dental Practice Act refers to “[c]onduct unbecoming a person licensed to practice dentistry . . .” rather than to “unprofessional conduct.” But the import of the two terms is the same. See Minn. Stat. 150A.08, subd. 1(6) and *Dentist License of Schultz, supra*.

[925] See *generally* Findings of Fact Nos. 137 and 138.

[926] See *generally* Findings of Fact Nos. 139 through 140.

[927] Finding of Fact No. 140 b and c.

[928] Finding of Fact No. 140 c.

[929] See Exhibit 35, ¶ 1.23(a), quoted in Finding of Fact No.136.

[930] See Finding of Fact No.138 d.

[931] See Finding of Fact No. 140 a and d.

[932] See discussion in Part V-B, *supra*.

[933] See discussion in Part VIII-B, *supra*.

[934] Finding of Fact No. 138 d.

[935] Findings of Fact Nos. 142 and 143.

[936] *Id.*

[937] Finding of Fact No. 65.

[938] Mr. Appleman was asked to comment on that issue but never did. (Tr. Vol. X at pp. 1614-15)

[939] See Exhibit 35.

[940] Findings of Fact Nos. 146 and 147.

[941] *Id.*

[942] Finding of Fact No. 145. See also Tr. Vol. X at pp. 1636-37.

[943] Actually, the original charge was failure *to elicit* that history (see Exhibit 83), but the evidence tended to establish a failure *to document* rather than a failure to elicit. See discussion in Part VII-K-1, *supra*.

[944] Findings of Fact Nos. 148 and 149.

[945] Findings of Fact Nos. 151 and 153.

[946] Minn. R. 7200.5000, subp. 3C.

[947] Tr. Vol. IV at pp.775.

[948] *Id.* at 774.

[949] Findings of Fact Nos. 154 and 155.

[950] Tr. Vol. V at p. 787.

[951] Exhibit 5A at p. 500067.

[952] See discussion in Part VII-K-3.

[953] At ¶ 58.

[954] Tr. Vol. V at pp. 811-12.

[955] Finding of Fact No. 130.

[956] Finding of Fact No. 133.

[957] Actually, the original charge was failure *to elicit* that history (see Exhibit 83), but the evidence tended to establish a failure *to document* rather than a failure to elicit. See discussion in Part VII-K-1, *supra*.

[958] Findings of Fact Nos. 160 and 162.

[959] Finding of Fact No. 160.

[960] Findings of Fact Nos. 160 and 161.

[961] Findings of Fact Nos. 163, 166, 169, 172, 175, and 178, respectively.

[962] Findings of Fact Nos. 164, 167, 170, 173, 176, and 179.

[963] Findings of Fact Nos. 110 and 111.

[964] Tr. Vol. IV at p. 659.

[965] *Id.* at p. 733

[966] Findings of Fact Nos. 165, 168, 174, 177, and 180. Dr. Cohen did not give a specific opinion about the adequacy of test interpretation documentation for Client #3. But the ALJ concludes that it is embraced by Dr. Cohen's more general opinions on test documentation in Finding of Fact No. 138 h.

[967] Tr. Vol. XI at p. 1757.

[968] See Findings of Fact Nos.171 and 174.

[969] Minn. R. pt. 7200.5000, subp. 3.

[970] Exhibit 35.

[971] See Notice of Hearing at ¶ 49 (Client #7) and ¶¶ 67 and 68 (Clients #8 and #9). The Committee asserted claims of missing test protocols relating to several other clients, but the ALJ concluded that the Notice of Hearing failed to provide reasonable notice to Mr. Appleman of those charges. See Part III, *supra*.

[972] Findings of Fact Nos. 182, 184, 186, 187, and 189.

[973] Findings of Fact Nos. 183, 185, 188 and 190.

[974] Findings of Fact Nos. 191 and 192.

[975] Finding of Fact No. 193.

[976] Finding of Fact No. 96.

[977] Finding of Fact No. 195.

[978] Finding of Fact No. 196; Tr. Vol. XII at pp. 1882-86.

[979] Finding of Fact No. 195.

[980] Finding of Fact No. 197. The Committee also alleged that Mr. Appleman failed to report administering only one sub-test of the WRAT to Clients #7 and #11, but the ALJ concluded that the Notice of Hearing failed to give Mr. Appleman of the charge as it pertained to those two clients. See Part III, "General Claims," *supra*.

[981] Finding of Fact No. 198.

[982] Finding of Fact No. 199.

[983] Recommendation on motion for Partial Summary Disposition (Administrative Record, Item 87) at p. 50.

[984] See Part III – "Client No. 3," *supra*.

[985] Claim 4-7.

[986] Claim 4-9.

[987] See Parts IX-B-1 and 2, *supra*.

[988] Committee's Statement (Administrative Record, Item 124) ¶ 137 at p. 49.

[989] Finding of Fact No. 201.

[990] The Bender-Gestalt, the Trails A, and the Trails B. See Exhibit 4A at p. 400075.

[991] Exhibit 6A at p. 600008.

[992] Findings of Fact Nos. 128 and 203.

[993] Finding of Fact No. 129.

[994] The Committee also charged in Claim 7-9 that Mr. Appleman prepared a substandard treatment plan for Client # 7, but the ALJ concluded that the Notice of Hearing failed to give Mr. Appleman fair and reasonable notice of that charge. See Part III "Client #7," *supra*.

[995] Finding of Fact No. 204.

[996] Finding of Fact No. 205.

[997] Finding of Fact No. 206.

[998] Finding of Fact No. 219.

[999] See Finding of Fact No. 206.

[1000] Exhibit 35.

[1001] Finding of Fact No. 226.

[1002] Finding of Fact No. 227.

[1003] Minn. R. pt. 7200.4900, subpart 1aB.

[1004] Finding of Fact No. 228.

[1005] See discussion in Part II-B, *supra*.

[1006] Namely, Claims 1-10-, 1-11, 3-6, 4-2, OF-5, OF-6, 20-5, 20-6, 21-5, and General Claim-4.

[1007] Tr. Vol. VII at p. 1186. See Parts VII-C and IX-G-2, *supra*.

[1008] In the cases of Claims 20-8 and 21-5, the Committee did present additional affirmative evidence of charges of this kind.

[1009] Findings of Fact Nos. 230 through 233.

[1010] Finding of Fact No. 232.

[1011] Minn. R. pt. 7200.4900, subp. 1aA.

[1012] Perhaps, an argument could be made that by billing the charges, Mr. Appleman misrepresented that he had documentation in his files to substantiate that he provided him. But the ALJ concludes that is stretching the interpretation of Minn. R. pt. 7200.5200, subp. 3 too far.

[1013] Finding of Fact Nos. 234 through 246.

[1014] Finding of Fact No. 230.

[1015] Finding of Fact No. 233.

[1016] Finding of Fact No. 232.

[1017] Claim OF-5 embraced both billing for group therapy and for individual. So it is also addressed in Part IX-G-1, *supra*.

[1018] Findings of Fact Nos. 247 through 253.

[1019] Findings of Fact Nos. 230, 232, and 233.

[1020] Finding of Fact No. 253.

[1021] *Id.*

[1022] See Exhibit C of Exhibit 41 and pages noted there in Exhibit 19.

[1023] Exhibit C of Exhibit 41; see *generally* Exhibit 19.

[1024] Findings of Fact Nos. 231, 232, and 233.

[1025] See discussion in Part IX-B-2, *supra*.

[1026] See Part III, *supra*, e.g., discussion of Claims 2-8, 4-10, OF-15, and 21-4.

[1027] Other relevant facts can be found in Findings of Fact Nos. 41 through 43, 108, and 109.

[1028] Exhibit 20 at p 005608.

[1029] Committee's Statement (Administrative Record, Item 124) at p. 122.

[1030] Minn. R. pt. 7200.4900, subp. 1a-A.

[1031] Committee's Statement (Administrative Record, Item 124) at p. 122.

[1032] Findings of Fact Nos. 42-43 and 257.

[1033] Tr. Vol. IV at p. 715.