



Janice K. Brewer
Governor

State Of Arizona Board of Podiatry Examiners
"Protecting the Public's Health"

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Barry Kaplan, DPM; Joseph Leonetti, DPM; Barbara Campbell, DPM;
M. Elizabeth Miles, Public Member; John Rhodes, Public Member; Sarah Penttinen, Executive Director

BOARD MEETING MINUTES

November 9, 2011; 8:30 a.m.
1400 West Washington St., B1
Phoenix, AZ 85007

Board Members: Barry Kaplan, D.P.M, President
Joseph Leonetti, D.P.M., Member
Barbara Campbell, D.P.M., Member
M. Elizabeth Miles, Secretary-Treasurer
John Rhodes, Public Member

Staff: Sarah Penttinen, Executive Director

Assistant Attorney General: Marc Harris

I. Call to Order

II. Roll Call

III. Approval of Minutes

a. October 12, 2011 Regular Session Minutes.

Dr. Kaplan offered corrections regarding the discussion of complaint case numbers 09-14-C and 10-16-C, and the malpractice case report [Agenda Item VII(b)]. Ms. Miles abstained from discussion due to her absence at the October 12, 2011 meeting. The remaining Board members agreed with the proposed corrections.

MOTION: Dr. Kaplan moved to approve the minutes as corrected. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles abstaining.

b. October 12, 2011 Executive Session Minutes.

MOTION: Dr. Leonetti moved to approve the minutes as written. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles abstaining.

IV. Review, Discussion and Possible Action –Review of Complaints (NOTE: The subject matter listed for each agenda item represents the allegation(s) being investigated. The presence of allegations does not automatically indicate violation of Statute or Rule in connection with the practice of podiatry.)

a. 10-06-C – M.A. Rosales, DPM: Practice below the standard of care for failure to diagnose and treat a soft tissue condition.

Dr. Rosales was not present. The patient was present but did not wish to address the Board. Dr. Dedrie Polakof, DPM was the investigator and was present. Dr. Polakof summarized that the patient initially saw Dr. Rosales and was diagnosed with a vesicular tinea pedis condition and probably onychomycosis. She feels Dr. Rosales' initial treatment was effective but then the patient returned for follow-up and it was at that time Dr. Polakof has questions regarding why a culture was not done or a biopsy not taken. Dr. Polakof stated Dr. Rosales did recommend the patient be seen by a dermatologist for a biopsy which is appropriate, or Dr. Rosales could have done it in his office. Dr. Polakof stated she had concern that Dr. Rosales ordered oral anti-fungal medication as well as oral steroid because of possible contraindications. Dr. Polakof stated that, because the patient did not have any biopsies or diagnostic lab studies done by Dr. Rosales prior to prescribing the medications that were given, she feels the allegation is substantiated that Dr. Rosales fell below the standard of care.

Dr. Kaplan stated that in his review of the chart he feels a second allegation may need to be added relating to a matrixectomy the patient had on 06/1/09 (unrelated to the current complaint). He stated there is no informed consent form in the patient's chart for that procedure. Dr. Polakof confirmed that a matrixectomy had been performed but there was no informed consent form in the chart. Dr. Kaplan stated he was uncertain if the consent form was just not submitted or did not exist. Ms. Penttinen confirmed that the subpoena she sent to Dr. Rosales was for "all patient records." Dr. Kaplan stated that if that is the case then a second allegation needs to be added for lack of informed consent. Dr. Polakof stated she agreed with the addition of the second allegation and Dr. Kaplan inquired as to how to proceed at this point. Ms. Penttinen stated the Board can table the case for further investigation while she sends Dr. Rosales a re-notice with the second allegation. When his response to that allegation is received she will forward to Dr. Polakof for a supplemental report. Mr. Harris suggested that the Board may wish to document the new concern with a motion and vote to add the new allegation. Dr. Kaplan agreed.

MOTION: Dr. Kaplan moved to table this case for further investigation and add a second allegation for lack of informed consent for the matrixectomy performed on the patient on 06/11/09. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Following the vote Dr. Leonetti asked Dr. Polakof if Dr. Rosales had prescribed that patient oral Lamisil in June 2009, which Dr. Polakof confirmed. Dr. Leonetti stated it appeared that a liver function test had been done then but not a KOH test, both of which Dr. Polakof confirmed. Dr. Polakof explained that the patient had initially improved but re-presented with the same dermatologic conditions and Dr. Rosales prescribed another topical cream and oral steroid medication. Dr. Leonetti noted that the noted from the dermatologist indicated an initial diagnosis of possible onychomycosis and asked Dr. Polakof whether the oral medication given to the patient was for nail care or skin care. Dr. Polakof stated she believed it was both. Dr. Leonetti also asked Dr. Polakof about Dr. Rosales performing any cultures or biopsies. Dr. Polakof confirmed none were done. However, she noted that the dermatologist's notes indicate a KOH test was done at every visit, although none were positive and the dermatologist's diagnosis was vasicular bolus excema. Dr. Leonetti asked if the patient's medication could affect the KOH results and provide a false negative. Dr. Polakof affirmed that could happen and stated that most podiatrists have a microscope in their office to conduct this type of testing. Dr. Polakof stated she felt some type of diagnostic testing should have been done for this patient. She added that if Dr. Rosales could not do a KOH test in his office there are many labs available in the area where he practices where the patient could have been sent for testing; if Dr. Rosales was unsure if the patient's infections was fungal or bacterial, a wound culture could have been utilized. Dr. Leonetti stated he agreed particularly in light of the fact that Dr. Rosales had been treating the patient for so long for the same condition.

There was no further discussion.

b. 10-29-C – Kathleen Richards, DPM: Charging or collecting an excessive fee / charging for services not rendered.

Dr. Richards was not present, nor was the patient. Dr. Polakof was the investigator and summarized the complaint information as follows: Patient N.R. called Dr. Richards' office to find out the cost for trimming her toenails, but the doctor's staff would not tell her. When she went to see Dr. Richards, the doctor spent less than five minutes in the room with her. Dr. Richards did cut the nails but they were jagged and no other services were provided. The patient feels she was overcharged.

Dr. Polakof reviewed the patient's chart which states Dr. Richards did a complete review with the patient and discussed the pros and cons of various nail procedures to treat painful ingrown toenails on both great toes. The patient decided on the least invasive procedure to release the pressure of the nails which included removing a small portion of the nail borders on both side of both great toes. No anesthetic was used, and the remaining toe nails were trimmed in a normal fashion. Dr. Polakof stated she was undecided regarding whether the allegation is substantiated because she is uncertain if a proper incision and drainage (I & D) procedure was actually done, which would support the billing code

of 10060 used by Dr. Richards. The records do not indicate there was any infection or drainage in the nails so it is unclear what was incised and drained.

Dr. Kaplan stated he agreed with Dr. Polakof's concerns regarding the use of billing code 10060. He stated there has been an ongoing issue with doctors misusing that code. Dr. Campbell agreed and added that there was no consent form for an I & D. Dr. Kaplan also questioned whether there would need to be anesthetic used for a true I & D procedure.

Dr. Leonetti provided the following discussion: the billing code for an I & D procedure implies that an infection is present, but if there is no redness or drainage then what was incised and drained. He feels doctors may be using the 10060 code to gain higher reimbursement for only trimming painful toenails which is what may have happened in this case but the proper billing code should be used. If there was no anesthetic used and no consent form, then it appears this was not a true I & D. He feels the "new patient" charge was appropriate, and that it can be difficult to give patients prices for services ahead of time without actually seeing the patient's condition. He would defer to Dr. Polakof's opinion as to what level billing code should have been used based on the patient's chart, but he understands the patient's concerns. He feels the main concern is whether or not an I & D was actually done based on what was documented in the patient's chart.

Dr. Kaplan stated he agreed with Dr. Leonetti's comments. Ms. Miles asked Dr. Leonetti to clarify if he had concerns with both the potential improper billing and inaccurate records, which Dr. Leonetti confirmed. Dr. Kaplan suggested that an informal hearing may be needed.

MOTION: Dr. Leonetti stated that based on the investigator's report and his review of the patient's records, he feels there is a potential violation for improper billing or charging an excessive fee and he moved to conduct an informal hearing. Ms. Miles asked Dr. Leonetti if he would be willing to amend the motion to include inaccurate record-keeping, to which Dr. Leonetti agreed. Ms. Penttinen asked Mr. Harris if the second allegation could be included in the invitation to attend the informal hearing or if a separate re-notice letter would need to be sent as well. Mr. Harris first confirmed with the Board members that there are two potential issues: either the records are accurate and the billing was excessive, or the billing was appropriate but the records were not accurate to justify the billing code used. Dr. Kaplan stated that Dr. Richards indicated an I & D was done, but the patient's records do not support that so using the 10060 code would be up-coding. Dr. Polakof agreed and added that, based on what is documented in the patient's chart, the proper code would be 11721 for bilateral debridement of toenails. Mr. Harris clarified that there was a motion on the table to conduct an informal hearing and add a second allegation for inaccurate record-keeping. Mr. Rhodes seconded the motion.

DISCUSSION: There was no further discussion.

VOTE: The motion passed unanimously by voice vote.

Following the vote Mr. Harris suggested that Dr. Richards be notified of the new allegation and asked to respond in writing prior to the informal hearing. The Board members agreed and moved to have staff make such notification.

MOTION: Dr. Kaplan moved to notify Dr. Richards of the second allegation and request a written response to be submitted prior to the informal hearing. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

c. 10-33-C – Andrew Lowy, DPM: Charging or collecting an excessive fee.

Dr. Lowy was not present, nor was the patient. Dr. Polakof was the investigator on this case and was present. Dr. Polakof provided the following summary of the complaint: The patient S.S. alleged charging or collecting an excessive fee. She saw Dr. Lowy for a lesion on her heel which Dr. Lowy removed. Dr. Lowy submitted a bill to the patient's insurance which was rejected as being a cosmetic procedure. Dr. Lowy consulted his coding staff who worked with the patient's insurance company and decided on a different code which was more appropriate for the type of lesion the patient had. The patient also stated

she had requested her records from Dr. Lowy on three occasions. Dr. Lowy had explained that the patient submitted two requests within a one-week period. Upon the second request, Dr. Lowy asked the patient where she would like the records faxed to and the fax was sent within one hour; however, a third record request was received the next day. The patient was upset because she wanted to know the billing codes used and wanted the codes changed. Dr. Lowy's staff had explained to the patient that they had to follow a process which can be lengthy and they could not change it based only upon the patient's request.

Dr. Polakof stated there were no questions or concerns regarding the quality of care provided to the patient. The insurance company who worked with Dr. Lowy's staff to find the appropriate code and the bill was then re-submitted. Dr. Polakof finds that the allegation of charging or collecting an excessive fee is not substantiated.

Dr. Kaplan stated he feels the initial code that was billed would be appropriate and Dr. Campbell agreed. Dr. Kaplan stated he does not understand what the issue was with the insurance company but the billing matter did get resolved. The patient is not unhappy with the final outcome. Dr. Leonetti reviewed a letter submitted by the patient which states her complaint was not about money, but rather Dr. Lowy and his staff sharing information (about the billing code). He asked why there was an allegation about charging an excessive fee. Ms. Penttinen explained that the letter Dr. Leonetti was referring to was sent by the patient after she was notified of this case being on today's meeting agenda; the initial complaint information submitted by the patient only included the billing issue. Dr. Polakof stated that when she spoke with the patient, the patient indicated she is happy with Dr. Lowy as a doctor and she wanted him to be paid, but she was disappointed that she had a copay. The patient told Dr. Polakof that since she worked in the healthcare industry she thought the services would be "professional to professional."

Dr. Leonetti asked what type of treatment was given to the patient. Dr. Polakof explained that Dr. Lowy injected the area of the lesion and "scooped" it out. Dr. Lowy was uncertain if it was a granuloma but he did not think it was a wart. He then applied phenol and dressed the wound and the lesion has not returned. Dr. Campbell noted that she did not see a pathology report in the patient's chart. Dr. Polakof stated pathology would not be needed; Drs. Leonetti and Kaplan agreed. Dr. Polakof added that Dr. Lowy thought perhaps the patient had a plugged sweat gland but he was able to clear the entire lesion area and it appeared to be fine. Dr. Leonetti asked if Dr. Polakof felt there was any violation regarding Dr. Lowy's office sharing information with the patient. Dr. Polakof stated no and added that Dr. Lowy's office had to try several times to fax the patient her records because she was at different office locations (at work) on different days. Dr. Polakof confirmed that there was no significant delay in getting the patient her records.

MOTION: Dr. Leonetti stated that based on the investigation report and his review of the records he moved to dismiss the complaint finding no violations. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

V. Review, Discussion and Possible Action – Probation / Disciplinary Matters

a. 07-28-C – Kent Peterson, DPM: Monthly update.

Dr. Leonetti confirmed that he has received all necessary billing records. The comprehensive probation review will be conducted at the December 14, 2011 Board meeting. There was brief discussion regarding which attorney is representing Dr. Peterson. Ms. Penttinen explained that she has been directed to contact him through Bruce Crawford. Ed Gaines had been representing Dr. Peterson during the investigation process but once the consent agreement was offered Mr. Crawford essentially took over.

Dr. Kaplan asked Dr. Leonetti if there was anything he wanted to discuss at this time. Dr. Leonetti stated that his review of the records submitted during probation shows similar billing problems as there were before as far as improper use of billing codes. The matter will be reviewed in depth at the December meeting.

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b. 08-03-C – Elaine Shapiro, DPM: Monthly update.

Dr. Kaplan reviewed the progress report submitted by Dr. Sucher which indicates that Dr. Shapiro is in compliance with all monitoring requirements.

c. 08-44-C – Alex Bui, DPM: Monthly update.

The Board reviewed correspondence submitted by Dr. Bui indicating he had no charges for durable medical equipment during the month of October. The Board also reviewed the information Dr. Bui submitted by Dr. Bui regarding the “E/M University” and Dr. Peter Jenson for his CME requirements. Ms. Penttinen advised that she went to each of the websites provided in Dr. Bui’s documents and verified that they are all accurate. Dr. Kaplan asked to clarify how many hours of CME are now being requested for approval which Dr. Bui states are not related to hospital-based billing. The Board reviewed the information previously submitted by Dr. Bui to determine the total number of hours for the E/M University courses would be twelve. The Board previously approved a billing seminar put on by the ACFAS for ten hours, so Dr. Bui would then only need three more hours of CME. There was discussion regarding the number of CME hours that could be completed via the Internet (as with the E/M University courses.) Dr. Bui’s consent agreement was reviewed and it states he must complete 25 hours of CME in billing in addition to his annual CME requirements, but it does not specify if the courses have to be in-person or could be completed via the Internet.

MOTION: Dr. Kaplan moved to approve the twelve hours of CME through E/M University. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Following the vote Dr. Kaplan inquired as to what form of proof Dr. Bui would submit to verify he completed these courses. Ms. Penttinen reviewed the information submitted by Dr. Bui which does not indicate when proof would be given because Dr. Bui can take the courses at any time. Ms. Penttinen will advise Dr. Bui to send completion certificates which she will verify independently.

d. 09-17-B – J. David Brown, DPM: Monthly update.

Dr. Kaplan reviewed the progress report submitted by Dr. Sucher which indicates that Dr. Brown is in compliance with all monitoring requirements.

VI. Review, Discussion and Possible Action on Administrative Matters

a. Discussion regarding “fish pedicures” and any possible official Board opinion thereof.

Dr. Kaplan stated that a number of podiatrists have been contacted and requested to prove expert witness testimony regarding fish pedicures. He recommends that the Board should not render any opinion regarding this matter and he feels it should be addressed by the AZ Cosmetology Board. Dr. Kaplan asked Mr. Harris if a motion would need to be made. Mr. Harris advised that if there is no action being taken then a motion is not necessary.

b. Review of new license applications and possible approval to sit for oral exam on December 14, 2011:

- i. Michael Costantino, DPM.
- ii. Timothy Fisher, DPM.
- iii. Scott Gordon, DPM.
- iv. Whitney Hunchak, DPM.
- v. Kirk Larkin, DPM.
- vi. Erin Martin, DPM.
- vii. Alex Stewart, DPM

Drs. Erin Martin and Scott Gordon were present. The Board members did not have any questions for the applicants.

MOTION: Dr. Campbell moved to approve the license applications for all doctors listed. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Ms. Penttinen advised the Board members that there may be a need to hold a teleconference to review new license applications which are still incomplete. The deadline to submit documentation for applications is November 14. There are currently five application files which are incomplete but may be completed by the deadline and would need to be reviewed and approved to sit for the December oral exam. Ms. Penttinen stated she will notify the Board if a teleconference for this matter is needed.

VII. Executive Director's Report – Review, Discussion and Possible Action

a. Open complaint status report.

Ms. Penttinen reviewed the report which indicates there are currently 74 open complaints. This includes cases which have been tabled or postponed by the licensee's request and those that were on today's agenda. Approximately 20 cases are with investigators right now. In speaking with investigation consultants Ms. Penttinen believes there should be a large number of cases on the December agenda. As the consultants submit their reports on cases already assigned she then sends out the new cases to them.

Dr. Leonetti had a question about case number 10-30 filed by Paul Sacco. He is aware that Mr. Sacco is a malpractice attorney and asked if this was a malpractice case. Ms. Penttinen explained that Mr. Sacco submitted the complaint letter on behalf of a patient and advised to contact the patient directly.

b. Malpractice case report.

- i. Aprajita Nakra, DPM: Claim filed by patient D.A. Board investigation case already opened.
- ii. Kris DiNucci, DPM: Claim filed by patient P.P. Board investigation case already opened.
- iii. Kelvin Crezee, DPM: Claim filed by patient R.R. Board investigation case already opened.
- iv. Stanton Cohen, DPM: Claim filed by patient P.M., date of occurrence 08/18/10. (Board case not opened yet – this is the first report.)
- v. Kevin O'Brien, DPM: Claim filed by patient C.D. Board investigation case already opened.

MOTION: Dr. Leonetti moved to open a complaint investigation case for the matter involving Dr. Cohen. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

VIII. Call To The Public

There were no requests to speak during the Call to the Public.

IX. Next Board Meeting Date:

- a. December 14, 2011 at 8:00 a.m.

X. Adjournment

MOTION: Dr. Kaplan moved to adjourn the meeting. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the meeting was adjourned at 9:49 a.m.