



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

December 14, 2011; 8:00 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: Beth Campbell

I. Call to Order

Dr. Kaplan called the meeting to order at 8:00 a.m.

II. Roll Call

Mr. Rhodes was not present. All other Board members were present. Ms. Campbell was not present.

III. Review, Discussion and Possible Action on Administrative Matters:

- a. Administration of oral examinations for the following new license applicants:
- i. Michael Costantino, DPM
 - ii. Timothy Fisher, DPM
 - iii. Scott Gordon, DPM
 - iv. Whitney Hunchak, DPM
 - v. Kirk Larkin, DPM
 - vi. Ryan Mackey, DPM
 - vii. Erin Martin, DPM
 - viii. Carmen Partridge, DPM
 - ix. Shaun Simmons, DPM
 - x. Alex Stewart, DPM
 - xi. Judianne Walker, DPM
 - xii. Michelle Zhubrak, DPM

MOTION: Dr. Campbell moved to go into Executive Session for the purpose of administering confidential oral examinations for new license applicants. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the Board went into Executive Session at 8:03 a.m.

The Board returned to Regular Session at 8:25 a.m. and immediately recessed until 8:40 a.m. Upon reconvening, Mr. Rhodes and Ms. Campbell were present.

IV. Approval of Minutes

- a. November 9, 2011 Regular Session Minutes.
Drs. Kaplan and Leonetti offered spelling and grammatical corrections to the minutes.

MOTION: Ms. Miles moved to approve the minutes with the spelling and grammatical corrections.
Dr. Campbell seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

b. November 21, 2011 teleconference Regular Session Minutes.

MOTION: Dr. Campbell moved to approve the minutes as drafted. Ms. Miles 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 –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. 09-21-C - J. David Brown, DPM: Practice below the standard of care for improper surgery and failure to timely diagnose and treat a post-operative infection.

Dr. Brown was present with attorney Bruce Crawford. Dr. William Leonetti was the investigator and summarized the case as follows: Patient M.P. was referred to Dr. Brown by her family physician for a bunion deformity and an overlapping second toe. Dr. Brown identified a hallux abductovalgus deformity and a hammertoe of the second toe. Dr. Brown recommended a hallux valgus correction surgery and second metatarsal joint repair & capsulotomy with hammertoe correction. On the 2nd visit on 08/28/2007 a pre-op evaluation took place. The consent form specifically stated hallux abductovalgus correction & left 2nd MPJ capsulotomy with second toe k-wire. It is noted that it was never listed on the consent form to 1st metatarsal osteotomy or screwed fixation. On 09/07/2007, the patient was brought to surgery at Warner Surgical Park where the following procedures took place: hallux valgus correction left, correction of hammertoe acquired 2nd left, 2nd left metatarsal joint capsulotomy and insertion of pain pump. A review of the operative report shows that in fact that an Austin bunionectomy was performed, an osteotomy of the 1st metatarsal with screw on the left. A hammertoe surgery was performed with complete capsulotomy and k wire was placed in the 2nd toe. On the same day as the surgery, Dr. Brown contacted the patient by phone where the patient admitted to stepping down on the left foot several times to maintain balance.

Dr. William Leonetti continued: The first post-op visit occurred four days post-op, which took place on 09/11/2007. The first post-op x-rays were taken. Dr. Brown noted that on several occasions, the patient lost her balance and put her foot down to steady herself. Dr. Brown's notes from the first visit state that the vascularity appeared to be intact, but the second tow appeared to be darker in color. There was no mention of the pin being jammed into the second digit; there was no mention of the pin being bent on the first post-op evaluation. It was noted that Dr. Brown originally scheduled the second visit 10 days later but the patient contacted him two days later, (six days post-op), noting that there were some changes. The patient was seen that day and Dr. Brown's notes state that the patient admitted to putting weight on her foot. There was increased darkness of the toe and the pin seemed to be very tightly attached to the end of the second toe, more so that during surgery. The second toe was now also mildly cyanotic. Records note that the capillary filling time was 10 seconds, which is three times normal. Dr. Brown stated that he first adjusted the pin and then chose to pull the pin from the toe. He noted that the pin appeared to be bent. Patient was advised that she may be at risk due to lack of circulation due to the bent pin. Dr. Joseph Leonetti asked what date the pin was pulled and Dr. William Leonetti stated there was confusion on that: Dr. Brown's records indicate that it was pulled on 09/13/2007, but the patient's recollection was that it occurred on 09/18/2007. The patient believes that on the second visit, the pin was turned by Dr. Brown. Her recollection is that it didn't really change the color of the toe. Dr. Brown's records and recollection is that the pin was turned, pulled, and removed on the second visit.

Dr. William Leonetti continued: The third post-op visit takes place 11 days post-op. Dr. Brown uses the term to describe the toe "worsened, blackened in color, vascular embarrassment, and may not be viable" regarding the discoloration of the second toe. The treatment recommended was for warm compresses and Nitro-Bid ointment, which is a topical ointment used to open blood vessels. Dr. Brown records also state that consideration should be given to radical debridement of the toe, i.e. amputation. At this time, still no referral has taken place. On 09/20/2007, 13 days post-op, the patient is seen for a fourth time by Dr. Brown. His records state that the toe appeared to have taken on dried gangrene and there was no

frank infection, but the patient was placed on antibiotics. Dr. Brown again documented consideration of radical debridement or amputation of the second toe might need to take place. Again, no referral was made, but there was consideration of referral to Dr. Brown's associate Dr. (Mary) Peters at the Chandler Regional Wound Clinic, and the patient was advised to continue using the Nitro-Bid ointment. On 09/20/2007 the referral occurs, but the patient is not seen for another 5 days on 09/25/2007, which was 18 days post-op. Patient eventually ends up having 58 hyperbaric treatments at the Chandler Wound Clinic, and 5 months post-op ended up having amputation of the second toe. During interviews with the patient she was adamant that at no time did she place weight on the foot; she does not remember injuring the foot and that she was compliant. She states that the pin was not removed until the third visit, and that she was sure that she was aware that the procedure involving fracturing or performing an osteotomy of the first metatarsal was going to be performed or listed on the consent form. The patient was also upset that it took so long to receive a referral after the issues with her toe were discovered. The patient's recollection was that the toe was discolored right after surgery.

Dr. William Leonetti continued: In a conversation with Dr. Brown and Mr. Crawford, Dr. Brown stated he diagnosed a bunion and a second toe overlapping deformity. The patient was 70 yrs. old and she refused conservative care and she wanted surgical intervention. Dr. Brown stated that his process of placing the pin is to retrograde the pin from the center of proximal ipj out distally out to the end of the toe and then driving it back to the proximal placement. He does not remember any abnormal pin placement in the first redressing. It is noted that Dr. Brown did not take any inter-operative x-rays to check the pin placement. On the x-ray from the first post-op visit Dr. Brown did not remember any jamming of the pin or pin abnormality. On the second visit he noted that the pin pressed up against the skin and he believes jammed the toe causing most of the problems. When Dr. Brown was asked to describe his practice by he stated that he shares his office with a vascular surgeon. Dr. Brown was asked why he did not immediately refer his patient to physician he shares an office with and Dr. Brown said that he felt the patient would be better served by referring her to his associate Dr. Peters. Review of the x-ray taken 09/11/2007 shows it was a dorsal plantar view. There is no mention of jamming of the pin. The end of the pin does not appear to be jammed when looking at it from the dorsal plantar view into the toe, but when the x-ray is looked at further all the joints are extremely compressed indicating that there is compression of the second toe. Additionally, on all three x-ray views it is visible that the pin is bent. From a lateral view the pin is placed in an unusual plantar-grade position. It appears to be below the second toe but the proximal end of the pin is sticking up out of the top of the cortex in the second metatarsal which means it was put in in a most unusual position.

Dr. William Leonetti continued: He addressed the second allegation first, which was the failure to diagnose and treat in a timely manner post-operative infection of the patient's second toe. The patient never had an infection, therefore no violation has occurred. As for the first allegation for practice below the standard of care by incorrectly placing a pin into the patient's second toe which caused lack of blood flow, Dr. Leonetti believes that allegation to be true. When the first post-op x-ray is looked at, it can clearly be seen that the pin has compressed the toe and as a result of the compression it caused vascular compromise. There is also some concern as to why it took so long for a referral to take place, especially given that toe was severely darkened post-op, in addition to Dr. Brown's observations of the toe "worsened, darkened, gangrene" it took 13 days to get a referral. Another question that was not brought up in the report, but appeared after the fact, when Dr. Leonetti looked at the billing records, was why instead of sending the patient to the specialist that he shares office space with, Dr. Brown chose instead to refer the patient to his colleague. Additionally, when billing is done, Dr. Brown's office does the billing for Dr. Peters. So, the question that was raised was if Dr. Brown was benefiting financially from Dr. Mary Peters treating the patient while the patient was associated with Dr. Brown.

Dr. Joseph Leonetti asked if the pin placement is plantar to where it should be. Dr. William Leonetti stated the pin is incorrectly placed and it is important to look at all three views of the x-rays, there is no question that the pin is bent. This was at the first post-operative visit when the surgical site was redressed but there is no mention of the pin being jammed, there is no mention of the pin being bent when Dr. Brown reviews his radiographs, but it is clear that the pin is bent. Dr. William Leonetti believes the pin is bent because of the angle that it was put in was so extreme that it actually exits the top of the second metatarsal, and in doing so it compressed all three joints which is easily viewed on the dorsal plantar view. When you compress these joints it is easy to compress the vascular structures on both

sides of the toe. One of the first rules of pin placement is that if there is any type of vascular immediately, the pin is pulled.

Dr. Kaplan reviewed where the records indicate on where the pin was driven from distal to proximal originally, and then the report from the investigator states that Dr. Brown indicated that he retrogrades the placement of the pin. Dr. Kaplan asked if the placement of the pin could happen from trying to drive the pin from distal to proximal in the metatarsal, therefore causing it to bend because it is being driven through three small bones of the toe into the metatarsal. Dr. William Leonetti stated that is correct and that the operative report states Dr. Brown drove the pin down through the toe into the second metatarsal. He asked Dr. Brown about that in their phone conversation and Dr. Brown responded that it was standard practice to do the opposite which is to retrograde it out distally which is usually done for more accuracy, that way you can aim the pin and set the base of the proximal phalanx and be able to drive it out straight. By placing the pin as was done in this case it allows for less control and it is more likely when the pin crossed the joint to torque the pin or bend it, which Dr. Leonetti believes is what happened., it can be seen from the x-rays that the proximal end of the pin is sticking out of the second metatarsal shaft. It is reiterated that it takes a tremendous amount of strength to drive the pin through the dorsal cortex, which would make the pin torque. Dr. Kaplan then asked that if the end of the pin could be felt on the top of the foot if it was in this position Dr. William Leonetti stated that was unlikely as it is only a millimeter or two that would be sticking out.

Dr. Brown provided his original x-rays to the Board for review and addressed the Board as follows: He disagreed with the investigator's observation that the pin was driven in the way it was into the second metatarsal because he does not see this on the films. He states that visually that may not look as well as if it was in the center but it doesn't have a clinical significance. If the pin had hit the dorsal cortex in the second metatarsal, then the pin would be bent in the apex in a dorsal attitude not a plantar attitude. He states that if the pin had been hit with as much force as Dr. Leonetti claims that it was hit, that it would be bent in the apex, therefore it is clear that the patient stepped down on the pin. The pin was properly placed center of the toe. Dr. William interjected that they must be looking at different x-rays, as it is clear that the pin went below the distal phalanx coming out the bottom of the toe, and the pin is going up through the proximal phalanx through the top of the second metatarsal. Dr. Brown disagreed stating that in the x-ray, you can't even see the second metatarsal, that there is too much overlapping. Dr. Joseph Leonetti stated that it is very clear on the x-rays. Dr. Brown stated that the foot was slight inverted in the x-ray image. Dr. Joseph Leonetti stated: he hoped that Dr. Brown does not feel that this is proper placement of a second toe, because it is not; the toe is compressed and there is a gap between the second toe and the pin; and, Dr. Brown had claimed that the pin was up against the skin of the toe, which it is not.

Dr. Kaplan then asked if the x-rays provided were the only ones that were taken post-op, and Dr. Brown said yes. Dr. Kaplan asked if maybe another x-ray should have been done, considering the amount of hardware and the problems that the patient was having. Dr. Brown said he would have to take a look at that. Dr. Kaplan asked for what factors contributed to the gangrenous of the toe. Dr. Brown said he believed the patient stepped down on the pin. Dr. Brown said he had done a complete pre-op evaluation on the patient, she thought about the surgery for a couple of months before she had it, he went through in fine detail on what the surgery was, possible complications, what was expected of the patient post-op, and so on. He called the patient in the evening to confirm that the toe was viable. The patient was extremely groggy on the phone and was confused about stepping down on the foot. Dr. Brown believes that in the patient's confusion she stepped down on the foot and bent the pin. Dr. Kaplan asked if Dr. Brown usually keeps these patients non-weight bearing. Dr. Brown stated that no matter what, he advises his patients to be non-weight bearing for two weeks. Dr. Kaplan asked if the patient was kept non-weight-bearing because of the pin in the second or the procedure done on the first metatarsal, to which Dr. Brown stated it was both. Dr. Kaplan asked if Dr. Brown ever allows patients to be ambulatory with a cam walker, which Dr. Brown stated that he does not. Dr. Kaplan then asked why Dr. Brown dispenses the cam walker if he does not allow for the patients to be ambulatory. Dr. Brown replied that they will be walking again after the two weeks. Dr. Kaplan asked why he doesn't wait the two weeks to dispense the cam walker as those costs the patient a lot of money and sometimes may not be used. Dr. Brown said it was to protect the pin. Dr. Joseph Leonetti asked if the patient could have stepped on the foot while using the cam walker, which Dr. Brown stated that he did not know. Dr. Kaplan again asked why the cam walker was dispensed and stated there is nothing about the cam walker that indicates non-

weight bearing told to the patient. Dr. Brown stated that it is listed in the post-op instructions. Dr. Kaplan reviewed the pre-op instructions, which states that the patient was having problems ambulating. The question that is brought up is that how is how the patient was having problems ambulating when the surgery has not even been done at that point and the cam walker has already been dispensed. Dr. Kaplan asked if the patient was in pain the entire time leading up to the surgery to where she could not walk. Dr. Brown stated that the patient was having problems walking and Dr. Kaplan stated that was not mentioned anywhere in the notes. Dr. Brown's notes also state that the patient was dispensed crutches and a roll about walker, and that a cam walker is prescribed. Dr. Kaplan questioned if the patient could not walk how she is supposed to go about getting these things. Dr. Brown stated that in the pre-op consultation, the instructions state to not put weight on the foot and to use crutches at all times. Dr. Kaplan questioned why a patient would be given a cam walker if they are supposed to stay off their foot. Dr. Brown said that it was prescribed on the side of caution. Dr. Kaplan asked if she slept with the cam walker and Dr. Brown stated that she did. Dr. Kaplan asked if she was given crutches, Dr. Brown said that she was given a roll about.

Dr. Kaplan reviewed the consent form. He asked Dr. Brown if the patient was well aware of everything that would be done, which Dr. Brown said she was. Dr. Kaplan stated he does not see any of the specific information listed on the consent form in regards to pins or compression. Dr. Brown stated that there is one form that has all information listed, but the form that was used is left open to be able to fill in as needed. Dr. Kaplan stated that on Dr. Brown's form it does not state that he discussed possible complications with the patient; in fact, the form does not even state the route that Dr. Brown was going to take at all with the patient. Dr. Kaplan asked if the patient was aware that she was going to have a pin in her second metatarsal, or a screw in her first metatarsal. Dr. Brown said that she was aware of this.

Dr. Kaplan again asked Dr. Brown when he would allow a patient to bear weight. Dr. Brown stated that it is evaluated at two weeks; with a pin that is plantar-flexed as he was taught to perform this procedure, he may modify the boot for accommodate the pin and allow them 30 percent weight-bearing. Dr. Kaplan asked when the surgery occurred, and Dr. Brown said September 7th. Dr. Kaplan reviewed the notes from September 11 which state the patient was placed back in the cam walker asked if that meant it was taken off to change the dressing which Dr. Brown confirmed. Dr. Kaplan then asked if she was allowed to walk on the foot at that time. Dr. Brown stated that the cam walker is placed on at surgery and is only taken off to change the dressing. Dr. Kaplan asked for confirmation of if the patient was on crutches, or if she had the roll about. Dr. Brown responded that on 09/11, she had to place her foot down several times to move from the chair to the wheelchair. Dr. Kaplan said that on that day, which was four days post-op, the changes in the second toe were noticed and asked Dr. Brown if he thought about referral at that time for a vascular specialist or other consult. Dr. Brown stated that in looking back on this case he would have conferred with the vascular surgeon about how to proceed. Dr. Brown added that he was asked by the investigator if he consulted with a vascular specialist prior to the surgery but he did not note any vascular problem prior to the surgery.

Dr. Kaplan confirmed the date of the first post-op x-rays. Dr. Kaplan asked why he would wait so long to see the patient again if there were so many concerns. Dr. Brown said that he was not concerned at that time as this was normal response to this type of surgery. Dr. Brown added that on 09/11, the vascular status was intact with pulse present. Dr. Brown also stated that the post-op notes are not as detailed as the pre-op notes, to which Dr. Kaplan replied that there were plenty of notes about the coloration of the toe. Dr. Brown said the changes noted at that time were not excessive. Dr. Kaplan then reviewed the pathology report, and asked why a pathology report was done. Dr. Brown stated that in the capsule of the mpj there was tissue removed so he sent the tissue to pathology. Dr. Kaplan stated that on 09/13, two days after the color changes were noticed, the pin was twisted and removed which Dr. Brown confirmed. Dr. Kaplan asked if there was any concern about referral to a vascular surgeon at that point because it seemed to be getting worse. Dr. Brown said that several minutes after he twisted the pin, the toe reacted and color was restored. Dr. Kaplan then asked if Dr. Brown reappointed the patient for five days later, or if she came in on her own. Dr. Brown could not remember but that the patient had problems making it to any other office other than his Ahwahtukee office. Dr. Kaplan stated after twisting and moving the pin it appeared to be bent, and wanted to know how Dr. Brown knew this as he hadn't removed it. Dr. Brown stated that he did remove it at that visit. Dr. Kaplan asked if this was the first time that Dr. Brown knew that the pin was bent and Dr. Brown said it was more bent than on 09/11. Dr. Brown said he noticed a slight bending of the pin on 09/11 at the time of the first x-ray. Dr. Kaplan then asked

Dr. Brown why he did not consider taking the pin out at the time he first saw that it was bent on 09/11. Dr. Brown confirmed that on that date the pin was bent. He added that on the 13th the patient had called, claiming she stepped down on the foot causing the pin to bend down more than it was on the 11th and he decided to remove it at that time. Dr. Kaplan stated his concern was that had this patient not called, but rather stayed with her initial appointment which was 10-12 days after the procedure, she could have had a major problem. Dr. Kaplan added then stated that by seeing the bent pin, Dr. Brown might have considered removing the pin sooner. Dr. Brown stated that on the 11th, he was not overly concerned as it did not appear to be excessive and that if the patient was told that if she had any concerns about changing color or temperature to immediately call the office. The patient did so and was seen the same day.

Dr. Kaplan asked when Dr. Brown looks at the post-op x-rays. Dr. Brown stated that he looked at them that day. Dr. Kaplan asked if any notes were written about the bent pin and Dr. Brown said there weren't any notes about the films. Dr. Kaplan asked if at any point he went over the x-rays with the patient and explained how the pin was bent and should be removed. Dr. Brown stated that he did not recall.

Dr. Kaplan then reviewed the notes from 09/18 which indicated that the pin had been removed on the previous office visit. Dr. Kaplan asked if at that point if Dr. Brown had mentioned that the bent wire could have been causing any of the other problems with the toe. Dr. Brown stated that it was possible. Dr. Kaplan asked Dr. Brown if he saw the need for a referral to another podiatrist or vascular specialist at that point. Dr. Brown stated that the first step was to refer to a vascular consult and he did consider referring her at that point. When the patient came in two days later, when things were very bad on the toe, that was when a referral was made. Dr. Kaplan reviewed that after all treatments listed above, five months later, the toe had to be amputated. Dr. Kaplan asked if the patient ever used the cam walker. Dr. Brown stated that she did, two weeks later. Dr. Kaplan asked if the cam walker was returned, if Dr. Brown was paid for it, and which billing code was used. Dr. Brown said the cam walker was not returned but he did not know if he got paid for it. Dr. Brown said the code that was used was under review in another case which, at the time, he believed to be the right code. He has since changed which code he uses. Dr. Kaplan stated that Dr. Brown billed \$795 for the cam walker, and he must have been paid as the rest of the billings were taken care of, but the paperwork is not there for the rest of the billings. Dr. Kaplan stated it was not the correct code. Mr. Crawford stated that this code issue with Dr. Brown had already been addressed by the Board. Dr. Kaplan agreed but stated this was a separate case. Ms. Campbell stated that if an improper code was used and it is being addressed in a different case which his still pending, her assumption is that the cases could be combined for disposition at an informal or formal hearing. Ms. Campbell said that officially noting the billing issue is sufficient. Mr. Crawford stated that in the other case they are still awaiting documentation from the insurance company to demonstrate that the billing was corrected. Dr. Kaplan asked to consider executive session to further discuss how the Board should handle this type of billing issue if it comes up again in cases that date back to the time period involved in this case. Ms. Campbell advised that at this point of an investigational interview it seems that the billing issue has been address and can be noted here now.

Dr. Joseph Leonetti asked if the x-rays are reviewed with the patient the day that they are taken, and Dr. B said yes. Dr. Leonetti added the following: on 09/11 there is no mention of reviewing the x-rays with the patient - it should have been mentioned in the notes but it was not; if a reasonable physician noticed an issue such as a bent pin and noticed the other changes such as color change at four days post-op then it should have been removed that day; and, he believes that there was a vascular problem from the start and should have been corrected immediately with referral and/or emergency room, instead of waiting. Dr. Leonetti continued that he believes that the issues arose from poor pin placement, and should have been addressed much sooner. Mr. Rhodes mentioned that the patient mentioned the day of the surgery that she was going to have pins put in, and asked if the patient had had poor circulation prior to the surgery. Dr. Brown stated that he did not believe so. Dr. Joseph Leonetti said he believes the patient did not have vascular problems prior to the surgery and that the surgery caused the vascular problems. He added that he does not have any issue with the post-operative infection but agrees with the investigator's conclusion that there was a problem with the care of the patient. Dr. Kaplan asked if one of the allegations could be dismissed. Ms. Penttinen stated that it would be noted that the second allegation was not substantiated so everything going forward would only deal with the first allegation.

Ms. Penttinen asked the Board if they wanted to consider offering a consent agreement rather than going to an informal or formal hearing. Ms. Campbell suggested combining the current case along with the other existing case which the Board did not want to pursue. Dr. Kaplan stated that a consent agreement could be considered but the Board members were uncertain of what terms they would like to offer. There was discussion among the Board members, Mr. Crawford and Ms. Campbell regarding the options of a consent agreement or any type of hearing, and what type of additional information could be obtained in a hearing process which has not been brought forward yet.

MOTION: Dr. Joseph Leonetti moved to refer this case to an informal hearing regarding allegation one. Dr. Campbell seconded the motion.

DISCUSSION: Dr. Kaplan stated he would like to recess for a few moments to see if the Board could come up with possible consent agreement terms. Ms. Campbell suggested that the Board complete action with this motion and then the Board could work on proposed consent agreement terms.

VOTE: The motion passed by voice vote with Mr. Rhodes dissenting.

The Board recessed for approximately eight minutes the members to individually contemplate consent agreement terms. Ms. Campbell advised the Board members not to discuss anything with one another.

Upon reconvening, Dr. Kaplan wanted to discuss again the issue with the billing for the cam walker. He asked if Dr. Brown would be or could be required to correct that. Ms. Campbell advised that such a term could be included in a consent agreement. Dr. Kaplan offered the following terms for a consent agreement: probation for six months during which time Dr. Brown would be required to submit his charts for Board review for all surgeries involving Kirschner wires or pins, refund the patient's insurance company for improper billing for the cam walker (code L2116), and civil penalty of \$2000.00. Dr. Leonetti agreed with the chart review and insurance reimbursement, does not see the need for CME, but does not care either way regarding a civil penalty. Ms. Miles agreed. Mr. Rhodes stated he feels the fine is a little high. Dr. Leonetti stated he would like to eliminate the fine. Ms. Penttinen asked for clarification of the exact violation(s). Dr. Kaplan stated it would be practice below the standard of care for improper pin placement which caused vascular compromise on the patients toe, and misuse of billing code L2116. The citations would be A.R.S. §32-852(6) via 32-854.01(20). Ms. Miles clarified that the motion would be to offer a consent agreement with the terms just discussed except for the fine, and asked to add a term that if the consent agreement is accepted within 30 days from the date it is mailed then the informal hearing could be vacated. Ms. Campbell advised that the informal hearing would be continued until the agreement is accepted and signed by the Board. Dr. Kaplan asked about proof of refund to the insurance company. Mr. Crawford explained that Dr. Brown may not be able to get proof from the insurance company because they have not been cooperative in these regards but he could demonstrate his efforts to correct the billing. Mr. Crawford stated that it would be re-billed but then Dr. Brown would have to wait for the insurance company to tell him how much money he owes them; if the insurance company does not cooperate then all he can do is demonstrate good faith efforts. Ms. Miles stated he is satisfied if he can demonstrate such efforts. The other Board members agreed. It was also discussed that Dr. Brown must officially request termination of the probation.

MOTION: Dr. Campbell moved to offer a consent agreement to Dr. Brown with the terms as discussed above. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. 09-39-M - Carl Beecroft, DPM: Practice below the standard of care for improper surgery. Dr. Beecroft was present with attorney Bruce Crawford. Dr. William Leonetti, DPM was the investigator and summarized the case as follows: Patient HL presented to Dr. Beecroft on 07/11/2007 for a painful right foot, specifically bunion pain and pain in the 5th metatarsal base and head. Dr. Beecroft assessed the following conditions: HAV dislocated joint, right; tailor's bunion, right; calcaneovalgus bilaterally; and posterior tibial tendonitis. Dr. Beecroft had noted that since conservative methods had not worked, and the patient has continued to have pain, that he was recommending surgery. Surgery recommended was HAV reduction of tightrope & Tailor's bunionectomy. On 07/20/2007, the patient was seen for pre-operative evaluation and discussed a hallux valgus correction and tailor's bunion. The consent form stated that repositional osteotomy of first metatarsal and tailor's bunion right foot. The consent form did

not mention any tightrope procedure used in the bunion or drilling of the second metatarsal or any type of tarsal/metatarsal reduction. On 07/27/2007 the following surgery was performed on an outpatient basis: repositional osteotomy of the first metatarsal and tailor's bunionectionomy right foot. When reviewing the billing for the procedure, the bunionectionomy was billed as a 28290, which is a simple bunionectionomy. The tailor's bunionectionomy was billed as 28110. And there was a third entry was billed as 28615 which is open treatment of tarsal/metatarsal joint dislocation, which was not on the consent form. Lastly there was a code 11981 which was implantation of a pain pump.

Dr. William Leonetti continued: Post-operatively, the patient was seen on a regular basis by Dr. Beecroft. When Beecroft was treating the patient post-op bunion, the patient developed plantar fasciitis on the same foot which was treated with strapping and ultrasound treatments. At three weeks post surgery, Dr. Beecroft allowed the patient to discontinue the boot and begin walking in tennis shoes. By five and a half weeks post-surgery, the patient notes some pain in second metatarsal and was placed back in a cam boot and referred for physical therapy. By six weeks post-surgery, it was discovered radiographically that the patient now had a stress fracture in second metatarsal. Patient was once again placed back in the boot, and there is no mention of complete none-weight bearing. By eight weeks post-op, Dr. Beecroft diagnosed of a complete fracture of the second metatarsal with abduction of the metatarsal. Treatment included use of the cam boot and he recommended a bone stimulator. By ten weeks post-op, there was a complete transverse fracture of the second metatarsal. Treatment remained the same with weight-bearing. By 12 weeks, Dr. Beecroft mentioned the possibility of needing a second surgery, but continued the same treatment with the bone stimulator and the boot. By five months post-op, it was determined that the patient would indeed require additional surgery with Dr. Beecroft recommending an HAV deformity by Aiken bunionectionomy to straighten the toe, ORIF of the second metatarsal & an injection of cortisone into the arch. On 07/27/2007, the consent form was signed to fractured second right metatarsal, hallux abductovagus and plantar fasciitis. The surgery was to include repair of a fractured second metatarsal, Aiken osteotomy repair of the great toe, and injection of the right foot. The procedures were performed on 01/04/2008, which was five and half months after the initial procedure was performed. When reviewing the billing codes, the Aiken osteotomy was billed correctly. The open reduction internal fixation of the metatarsal was not; it was billed for fixation of a fracture of a phalanx not a metatarsal.

Dr. William Leonetti continued: Post-op from the second surgery, the patient was allowed to increase weight at the six week mark. Dr. Beecroft noted gapping of the second metatarsal which was fixated. By five months post-op, the pain was worse, and by six months post-op, Dr. Beecroft noted that x-rays showed a non-union of the second metatarsal & a return of the hallux valgus deformity. The patient was referred to Dr. Beecroft's associate, Dr. Crezee, DPM. After two meetings, Dr. Crezee confirmed a non-union of the second metatarsal and re-development of the bunion, and additional surgical procedures were recommended. Multiple attempts were made to contact the patient for an investigational interview, even going as far as to contact the patient's attorney Jim Claypool. Mr. Claypool informed him that there was a gag order between Mr. Claypool & attorney Bruce Crawford. Mr. Crawford informed Dr. William Leonetti that this was incorrect but the patient never returned the investigator's phone calls. Dr. Beecroft told Dr. William Leonetti that the patient was given proper information regarding the surgeries and was instructed with handouts and information about the surgeries that would be taking place including the tightrope education. Eventually the patient left his care to go to another physician for additional procedures to fix the non-union and the bunion.

Mr. Crawford then addressed the Board and stated that there was never a gag order and that he never made any such statements. If a case is settled, there is confidentiality, but not a gag order and that the client cannot speak to the Board or file a complaint with the Board. Dr. Kaplan asked if Dr. Beecroft brought any of the handouts that were provided to the patient; Dr. Beecroft said he did not. Dr. Kaplan asked for elaboration on the type of handouts that are given for the tightrope procedure. Dr. Beecroft stated the handouts were from Arthrex but he no longer performs these procedures, so he does not have any of the handouts that would have been given to the patient. Dr. Kaplan asked if in the handout, it mentions the possibility of a stress fracture from this type of procedure, to which Dr. Beecroft stated that it does not. Dr. Kaplan then asked if Dr. Beecroft had explained this possible side effect to the patient, to which Dr. Beecroft said that he did pre-op, but did not have it written down. Dr. Campbell then asked if it was normal procedure for patients to go back into normal shoes after three weeks, to which Dr. Beecroft responded with that this was a newer procedure at the time, and his reason for doing this procedure was

faster healing, less invasive and less pain. Dr. Beecroft had conversed with another physician who had performed this procedure and had scrubbed in on cases with that doctor. He also said he also talked to Arthrex representatives and had decided that this was a good procedure. Dr. Beecroft stated that the investigator's summary was accurate; unfortunately there was a bad outcome which he tried to fix. He added that two weeks after this first procedure, he performed the procedure on another patient, with similar fracture results, but not as severe. He then decided to stop performing this procedure. Dr. Beecroft then stated that the reason why he advised going back into regular shoes was due to what he believed was a faster healing process with this type of procedure. Dr. Campbell asked about the patient using a treadmill. Dr. Beecroft explained that the patient was anxious to start walking again and he believed it was OK.

Dr. Kaplan then asked if Dr. Beecroft if the doctor that he had scrubbed in on these procedures had discussed with him the possible complications. Dr. Beecroft said he spoke with that doctor extensively about the possibility of a second metatarsal stress fracture. The other doctor indicated had done a number of these procedures had advised Dr. Beecroft where to place the tightrope for the best results to eliminate complications and achieve better outcomes. That doctor also told Dr. Beecroft that he had removed a number of them because he was "still on the learning curve of where to place the tightrope." Dr. Campbell then asked about the cortisone injection that was administered in the second surgery. Dr. Beecroft said the patient initially did not want the injection due to pain so he did it during the surgery. Dr. Campbell asked if he thought that maybe this would cause any healing issues with the bone, to which Dr. Beecroft said no because the injection was on the heel at the fascia insertion. Dr. Kaplan asked if the patient was aware that she could develop a stress fracture, to which Dr. Beecroft said yes. Dr. Kaplan then asked who informed Dr. Beecroft of the quicker healing from this type of surgery. Dr. Beecroft said based on information he received from Arthrex, online information, and conversing with the other physician he studied the procedure with, he felt it was correct information. Dr. Kaplan asked who the other doctor was, and Dr. Beecroft said it Dr. (Lewis) Freed. Dr. Beecroft added stated that Dr. Freed had informed him that the chance of a fracture was not great. Dr. Joseph Leonetti asked Dr. Beecroft what a repositional osteotomy is, to which Dr. Beecroft explained that he asked Arthrex what codes to use because he had not billed for a tightrope procedure before. He said that was their terminology and code they used. There was brief discussion offered by Dr. Joseph Leonetti regarding billing codes and he added that he felt the post-operative care was good. Dr. Kaplan stated that the new developments in this procedure (since this patient's procedure was done) may increase the success rate. Dr. Campbell added that in an affidavit from Dr. (Luke) Cicchinelli, it was noted that the patient was disregarding medical advice by taking off the cam boot and wearing "crocs" and sandals before she was supposed to. Dr. Kaplan asked if the handouts given to the patient at the time of surgery included any information that she could get back to activities sooner. Dr. Beecroft said it did and Dr. Kaplan replied that the patient then could not be faulted if she followed what the handout said.

MOTION: Dr. Kaplan moved to dismiss the case finding no violations. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion

VOTE: The motion passed unanimously by voice vote.

c. 10-03-C – William Leonetti, DPM: Inaccurate report following an independent medical exam for the patient's worker's compensation matter.

Dr. William Leonetti was present. Dr. Joseph Leonetti recused himself from this matter. (All references to "Dr. Leonetti" stated in this case refer to Dr. William Leonetti.) Dr. Dedrie Polakof, DPM was the investigator and summarized the case as follows: A complaint was received from patient J.H. who was sent to Dr. Leonetti for an industrial injury medical review. Dr. Leonetti saw the patient once and completed his review. At that time he suggested an MRI be done on the patient. The patient had the MRI and Dr. Leonetti's report was amended after he received and reviewed the results of the MRI. There were two additional amendments made to Dr. Leonetti's report after each time the patient was treated by other physicians and the records were submitted to him for review. Dr. Leonetti had concluded at the end of all his reviews that he did not recommend additional surgery because he did not feel there was adequate documentation from the patient's treating physician to justify it. Dr. Leonetti did not see in the MRI results any reason for hardware removal at that time, but if pain persisted then the hardware could be removed. Dr. Leonetti concluded his evaluation stating that the patient had a

disability of 14 percent. He recommended orthotics, physical therapy and an AFO. In Dr. Polakof's review of the records she feels Dr. Leonetti's reviews of the patient's records and reports were appropriate and were not influenced by any positive or negative economic factors for the patient. She does not find any violations in this matter.

Dr. Leonetti addressed the Board and advised that he was an "independent medical evaluator" for the patient. He was hired by the patient's insurance company to review a worker's compensation injury for this patient. He only saw the patient one time. He stated that the quality and completeness of his report is influenced by the insurance carrier because he can only answer the questions that are specifically asked of him. In this case the insurance company came back three separate times asking additional questions, and each time he answered those questions with an amendment to his original report. He believes this may have caused confusion with the patient. Dr. Kaplan asked Dr. Leonetti to clarify the method of questioning from the insurance company. Dr. Leonetti explained that the insurance company will give him a list of questions after his evaluation of a patient, usually in regard to work status, impairment rating, if the case is opened or closed, or whether the patient requires additional care. The more efficient the questions are, the better the report is.

Dr. Leonetti continued as follows: In this case, the patient had an initial MRI which showed a high ligament strain to the anterior syndesmosis, but that the ATF and CF ligaments were normal. However, the treating physician chose to perform a lateral ankle stabilization procedure where he used a graft to reconstruct those ligaments. As a result of that, the patient was affected in his biomechanics and the way he walked. When he (Dr. Leonetti) first saw the patient, the patient complained of feeling a painful mass on the outside of his ankle. He felt an MRI was necessary to determine if there were problems such as a foreign body that could be removed. The MRI indicated that the patient had stable lateral ligaments but there an inflamed peroneus tersious tendon. Dr. Leonetti then filed an amendment to his report which agreed with the MRI findings in that the grafting of the lateral ligaments caused undue stress on the remaining anatomical structures including the peroneus tersious tendon. He also included in that report his recommendation that if mass was painful or did not respond to conservative care then to remove it. Approximately four to six months later he was advised that the patient's treating physician wanted to perform surgery to repair the peroneus tersious tendon. At that point he was concerned because he did not know of any procedure which is directed at repairing that tendon; it was a biomechanical issue due to the immobile lateral ligaments and should respond to conservative care, particularly when the MRI showed that this tendon was intact. In the last request from the insurance company he was only asked if the patient was stable. He feels he was very generous with the patient as far as the impairment rating and extensive supportive care award. The patient has permanent work restrictions as a result of the surgery to ligament which were never torn in the first place. He feels the patient was upset because he only saw Dr. Leonetti once and did not understand the report addendum process (as dictated by the insurance company).

Dr. Kaplan asked to clarify when the patient's injury occurred and Dr. Leonetti confirmed it was on July 4, 2008. The first MRI was done on August 21, 2008 shows no abnormalities other than a slight strain to the anterior syndesmotoc ligament. Dr. Kaplan wanted to clarify for the record that he felt Dr. Leonetti carried out his responsibilities to this patient appropriately and feels there may be an economic reason for the complaint. Dr. Kaplan added that he feels the surgeries performed by Dr. O'Brien are what caused an aggravation of the patient's condition.

MOTION: Dr. Kaplan moved to dismiss this case finding no violations. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

d. 10-23-C – Steven Abrams, DPM: Practice below the standard of care for improper surgery.

Dr. Abrams was present with attorney Bruce Crawford. Dr. Dedrie Polakof, DPM was the investigator for this case and summarized the case as follows: Patient K.W. had surgery by Dr. Abrams to correct a union of his left 1st toe and hammertoe of the left 2nd toe. Following the surgery the patient developed an infection/. During the second post-op visit it was noted that the first toe was in a plantar-flexed, or dropped, position as well as the second toe. The patient was referred to Dr. Jerome Steck, DPM, for

treatment and follow-up. The patient was surprised that he was referred to another physician so soon in the post-op phase and that there was no splint or taping of the toes to hold them in the right position. The patient saw Dr. Steck who suggested that it was too soon for another surgical procedure but that another surgery would be needed at some point. The patient's post-operative infection did resolve. The patient also splinted his own 2nd toe with tape and it eventually achieved a more straightened position. However, the first toe was still in a dropped position and the patient stated he had tripped on it approximately four times since the surgery. Dr. Polakof concluded that there were many factors in this case. The infection could have affected the extensor tendon which caused the first toe to drop. Also, lengthening the extensor tendon is also a hazard because it can rupture which it did in this case. Dr. Polakof stated that these issues are a complication of surgery and that Dr. Abrams appropriately noted the post-op problems and made an appropriate referral to another physician with expertise in resolving those problems. Dr. Polakof finds the allegation to be unsubstantiated and that there is no violation in this case.

The Board members reviewed all available diagnostic films. Dr. Abrams addressed the Board and stated the patient was referred to him for a Keller bunionectomy and second toe hammertoe condition. The patient was non-weight-bearing for the first week and he put the patient in antibiotics because it appeared the patient may have an infection around the first metatarsal. On the first post-op visit he noted that the hammertoe which was corrected with arthroplasty was in a contracted position and there was no dorsiflexion in the hallux. The foot was splinted and the patient was told to remain non-weight-bearing. As soon as the infection resolved he referred the patient to another podiatrist who he thought could address the complication the patient was having. The patient did not want to do any of the surgical corrections recommended by Dr. Steck. Dr. Abrams believes the patient was fine for about eight months until he stubbed his toe and that was when the complaint was filed.

Dr. Kaplan asked Dr. Abrams to explain more about the hallux being in a plantar-flexed position and why that was. Dr. Abrams stated the following: He had lengthened the extensor tendon and initially he thought he may have lengthened it too much but did not think it was ruptured at that time. For the hammertoe, he usually does an arthroplasty and if that does not work then he will use other techniques to achieve a straightened position of the toe. In this patient's case he only utilized arthroplasty and inter-operatively it looked good. Subsequently the toe did come down with the patient splinting it himself.

Dr. Kaplan asked again about the condition of the hallux and Dr. Abrams stated that either he over-lengthened the tendon or it eventually ruptured. Dr. Kaplan asked if Dr. Abrams had the patient try to lift his toe against resistance and Dr. Abrams said the patient could not do that but at the time his primary concern was addressing the patient's infection; he then referred the patient to another doctor. Dr. Kaplan asked Dr. Abrams, if he suspected a rupture of the tendon if he could have gone back to surgery sooner to correct it. Dr. Abrams said he was not sure it was a rupture at that time and also, since the patient was non-weight-bearing and the foot was splinted, he did not want to do surgery while the patient had an infection in the foot. Dr. Kaplan asked if he considered an MRI and Dr. Abrams stated he did not; he took an x-ray to see if there was any bone infection and then referred the patient to another physician who he felt would be better able to address the patient's complications. Dr. Kaplan asked to clarify when Dr. Abrams had the patient non-weight-bearing. Dr. Abrams stated that what he usually does, even for a Keller bunionectomy, the patient is non-weight-bearing for a week post-operatively and then they are put into a cast boot. However, this patient was told to continue non-weight-bearing until he could see the other doctor. Dr. Kaplan asked why Dr. Abrams has his patients be non-weight-bearing for that procedure. Dr. Abrams stated that he wants to decrease swelling and if the patient is not having pain they may be over-active. Dr. Abrams also clarified for Dr. Kaplan that the patient stubbing his toe did not happen while he was under his care.

Dr. Leonetti asked Dr. Abrams if he did surgery the patient's right foot previously to which Dr. Abrams said no, this was the first surgery he did on this patient. Dr. Kaplan asked why he chose the Keller bunionectomy procedure for this patient. Dr. Abrams stated the patient had a moderate bunion so an osteotomy was ruled out because he did not think the metatarsal angle was increased enough to do an osteotomy. Dr. Abrams added that with the patient's age and type of the bunion he thought the Keller procedure would work well. Dr. Kaplan said that in review of the pre-operative x-rays he feels it would have been appropriate to do a first metatarsal osteotomy and there does not appear to be any significant arthritis or degeneration in the joint. Dr. Abrams agreed and added that he did not think an implant

would be appropriate for this patient and he thought the Keller procedure would be best. Dr. Leonetti asked when the post-operative x-rays were taken and Dr. Abrams said it was two to three weeks after the surgery. Dr. Leonetti asked why an x-ray was not taken at the first post-op visit if it was noted that there were problems with the positioning of both the first and second toes. Dr. Abrams stated at that time he was concerned with the infection in the foot. Dr. Leonetti asked if the hallux was dislocated and Dr. Abrams said it was not. Dr. Leonetti asked Dr. Abrams to review the hallux on the post-op x-rays and explain what is there. Dr. Abrams said again that he was looking to address any infection that may have been present but it looks like the toe is plantar-flexed. Dr. Leonetti stated the toe is significantly plantar-flexed especially for a Keller procedure; Dr. Abrams agreed. Dr. Leonetti reviewed the complaint filed with the Board where the patient stated Dr. Abrams told him he "made a mistake" in the surgery. Dr. Abrams said he told the patient there were complications and that he felt another doctor would be best to address those; he does not remember telling the patient that he made a mistake. Dr. Leonetti asked Dr. Abrams why he thought the second toe was out of position. Dr. Abrams said that during the procedure it looked good but it probably contracted again at the mpj; he thought that perhaps he should have used pin fixation. Dr. Abrams clarified for Dr. Leonetti that the infection was clearing up just as the patient was getting in to see the new doctor. Dr. Leonetti asked Dr. Abrams why he did not want to do the corrective surgery. Dr. Abrams said he felt the patient would be more comfortable with another doctor at that time and that the other doctor was better suited to address the problems with the tendons.

Dr. Kaplan reviewed Dr. Abrams' notes from 07/01/09 with the history and physical. Under the "plan" it states there would be a bunionectomy with possible osteotomy and second toe correction using arthroplasty and possible pin fixation. Dr. Kaplan asked why that was stated because Dr. Abrams stated earlier that he did not plan to perform an osteotomy and added that the plan does not really describe what was going to be done. Dr. Abrams said what he meant by "bunionectomy" was correction of the prominence and possible osteotomy of the distal metatarsal. Dr. Abrams added that the plan included things that might have needed to be done but when he was in surgery he ended up doing a lesser procedure. Upon questioning, Dr. Abrams explained that when he speaks with patients prior to surgery he explains what he is going to attempt and what could happen during the procedure; he asserted that this patient was aware of what was going to be done in surgery. Dr. Kaplan asked if the patient signed a consent form. Dr. Abrams said the surgery center does the consent form and in this case it said bunionectomy and second digit hammertoe correction. There was additional discussion about the consent form, the information that was provided to the patient regarding what was planned in the surgery and what additional measures may be needed. Dr. Abrams again stated that the patient was aware of what was going to be done and what the possible complications could be. Mr. Crawford stated that the history and physical dictated on 06/30/09 documented the discussion with the patient about the procedure and possible complications.

Dr. Leonetti asked Dr. Abrams at what point it was that he decided to do the Keller procedure rather than the osteotomy. Dr. Abrams said it was when he released the soft tissue inter-operatively, but that observation was not documented in the operative report. Dr. Leonetti stated that the Keller procedure is a joint-destructive procedure and is very different from a simple bunionectomy and osteotomy; it may be simpler to perform and decreased some of the post-operative complication such as non-union, but the patient should be informed that it is a possibility and he does not see that documented anywhere. Dr. Kaplan asked how the tendon-lengthening was done. Dr. Abrams said at the distal medial part of the HL tendon he made a cut through just under half of the tendon width, and then another cut on the proximal medial aspect. He then pulled or slid the tendon and achieved the length he wanted. Dr. Abrams stated he did not do a "z-plasty" and that he made two cuts.

Dr. Leonetti stated the outcome was not what was hoped or planned, but it was a possible complication of this type of surgery. He feels Dr. Abrams addressed the infection well. He is uncertain why Dr. Abrams did not want to do the repair himself but if he felt it was in the patient's best interest to be treated by another physician that is his decision to make. Dr. Leonetti added that he is not comfortable with the consent form and that there should have been better documentation about what type of procedure was going to be done and what information was given to the patient. Dr. Kaplan agreed with these concerns and added that Dr. Abrams should develop his own consent form which is more informative. Dr. Campbell added that the operative report should have documented the condition of the joint to explain why the Keller procedure was done.

MOTION: Dr. Leonetti moved to dismiss the case finding no violations. Dr. Campbell seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

e. 10-36-C – Todd Haddon, DPM: Ordering a CT scan which was not necessary; refusal to perform surgery.

Dr. Haddon was not present. Dr. William Leonetti, DPM was the investigator and summarized the case as follows: A complaint was received from patient L.D. alleging that Dr. Haddon ordered a CT scan which was not necessary and that Dr. Haddon refused to perform surgery to correct loose hardware in his right foot. The patient saw Dr. Haddon for a hammertoe condition of the right 2nd and 3rd toes and possible hardware removal from a heel fracture three years prior which was causing pain. Dr. Haddon assessed a severe heel valgus position, arthritis, painful internal fixation, and a questionable mid-foot condition. Dr. Haddon ordered a 3D reconstructive CT scan which showed subcortical sclerosis and osteophyte formation, arthritis in the subtalar joint and calcaneal cuboid joint, and positive calcaneal navicular fibrous bar which limited the range of motion. Dr. Haddon told the patient he would eventually need surgery to realign the ankle but was willing to perform surgery for only the hardware removal.

The patient wanted to schedule surgery and Dr. Haddon advised him that his staff would call him the schedule it. The patient had a \$40.00 copay for each of two office visits with Dr. Haddon as well as a \$200.00 copay for the CT scan. When Dr. William Leonetti spoke with the patient, the patient stated he was only concerned about having the hardware in his foot removed and did not know why the CT scan was done and thinks it was inappropriate. The patient stated he wanted all of his copays reimbursed.

Dr. William Leonetti stated he felt Dr. Haddon's treatment of the patient was appropriate and that the CT was needed to properly assess the total pathology and determine an appropriate course of treatment. Dr. Haddon had no control over the patient's copay amounts. The patient never returned to Dr. Haddon and did not have surgery with him. Dr. William Leonetti stated he found no violations. He feels the assessment was correct as confirmed by the CT scan. Dr. Joseph Leonetti stated that he agreed with the investigator's findings.

MOTION: Dr. Kaplan moved to dismiss the case finding no violations. Mr. Rhodes seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

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

a. 07-28-C – Kent Peterson, DPM: Monthly update and comprehensive probation review.
Dr. Peterson was present with attorney Bruce Crawford. Dr. Leonetti recapped that Dr. Peterson was on probation due to his misuse of billing code 10060 and has been submitting copies of his records and billing documents. The reason the Board requested him to spear for a probation status interview is that there has been some concern that he is now misusing the billing code 11730. Specifically, the problem with 10060 was that the Board felt he was not properly documenting an incision and drainage procedure ("I & D"). However, his use of 11730 is concerning because in the patient's charts, Dr. Peterson is debriding nails under code 11721 for onychomycosis and then billing 11730 as a partial nail avulsion. Dr. Leonetti stated he feels Dr. Peterson's description of what is being done to the patient(s) is better than it used to be; however, he is not using an injectable anesthesia for the 11730 procedures which is a requirement to use that particular code. In addition, if that code is used, meaning it is a surgical procedure, then it requires a consent form. Dr. Leonetti noted that the patient(s) charts indicate that topical Lidocaine is being used, which is acceptable, but according to proper billing standards the use of code 11730 requires injectable anesthesia unless there is documentation of neuropathy or other condition which would negate the need for such. Dr. Leonetti stated topical anesthetic is not acceptable for those procedures.

Dr. Peterson stated that when his understanding of the use of code 11730 was that injectable anesthetic was acceptable but that topical was also appropriate. Dr. Leonetti stated that the code 10060 for I & D can be done under topical or injectable anesthetic; however, codes 11730 and 11750 require injectable

anesthesia unless the physician can document why it was not used. Dr. Leonetti stated that in all of Dr. Peterson's cases he has reviewed, there were none where the patient received injectable anesthesia. Dr. Leonetti added that Dr. Peterson's notes have improved and better illustrate the procedures being done on the patients, but his concern is whether the billing is proper because a nail avulsion almost always requires anesthesia due to the pain involved. Dr. Peterson stated he understood Dr. Leonetti's concerns and sometimes the patient's do experience pain even with the topical anesthetic. Dr. Leonetti stated he should start using injectable anesthetic and documenting the procedure with a consent form. Dr. Kaplan agreed and asked if Dr. Peterson was performing a matrixectomy under this code. Dr. Peterson said he was only avulsing a portion of the nail.

Dr. Kaplan stated that some doctors do have consent forms for that type of procedure but he does not do that himself because he does not consider nail avulsion to be an invasive procedure. Dr. Peterson stated he does use a consent form for procedure 11750 and it would not be difficult to do the same for 11370. Dr. Leonetti stated if Dr. Peterson was going to inject the toe enough to do a total or partial nail avulsion then he feels a surgical consent form is appropriate because it is different from a simple nail trimming. Mr. Crawford questioned the Board as to the opinion of the Board's billing expert who advised the Board that if Dr. Peterson was using code 11730 then injectable anesthetic must be used. Drs. Kaplan and Leonetti confirmed this. Dr. Kaplan also offered to forward to Dr. Peterson a copy of the Medicare guidelines which confirm this. Dr. Leonetti stated that Medicare will reimburse for it but a red flag may be raised if the doctor is audited and it is discovered that the wrong code was used. Dr. Leonetti stated his reason with wanting to speak with Dr. Peterson was to make sure he is using the proper billing code and, if not, to provide him with the correct information.

Dr. Peterson stated the code 10060, which he almost never uses anymore, had previously been used when there was not necessarily an abscess; but now he only uses it if there definitely is an abscess. Dr. Leonetti stated that latter of Dr. Peterson's statement was the correct interpretation of the proper use of that particular billing code. However; different billing services and seminar advisors have decided to promote the use of code 10060 to get around the appropriate debridement codes. The problem now that this code is overused so much that it raises red flags especially with Medicare. Dr. Leonetti stated he is concerned that all the providers who were previously using code 10060 are now moving toward using 11730 and the same thing will happen. Dr. Leonetti advised Dr. Peterson that he should consult the CPT code books when in doubt about any billing code, but he feels Dr. Peterson's billing and documentation are very much improved. He added that adding a consent form will help educate the patient of what he is going to do and what he will bill for so when they receive an EOB they are aware of what is being billed to their insurance.

Dr. Leonetti asked how much time was left on Dr. Peterson's probation. Ms. Penttinen advised that the only requirement left was for Dr. Peterson to submit a letter requesting his probation to be terminated. Dr. Leonetti stated he would like to see one more month of documentation. Dr. Kaplan stated there was a delay due to the time period involved in gathering and reviewing the patient chart information. Dr. Peterson stated he thought a request for termination was submitted because the probation has ended in June 2011, although it was determined that the request was not sent. Dr. Leonetti stated the Board would like to see one more month of records to show the changes in documentation with regard to the use of 11730. If Dr. Peterson does that and it appears satisfactory then termination of probation would be appropriate. Ms. Penttinen asked Ms. Campbell if there would need to be an amendment made to the consent agreement. Ms. Campbell stated that due to the lack of a written request to terminate the probation, the Board could receive and review the requested records at the next Board meeting and make a determination at that time. Mr. Crawford stated that he does not feel an amendment is necessary; Dr. Peterson is willing to provide another month of records. Mr. Crawford will submit the records along with a letter requesting termination of the probation. It was decided that the one month of records to be submitted would be from December 14, 2011 through January 6, 2011. Dr. Peterson will submit his patient notes and superbills, but EOB's will not be necessary.

(The Board recessed from 11:55 a.m. to 12:03 p.m.)

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

Ms. Penttinen advised that the most recently quarterly report from Dr. Sucher was received in November 2011. The next report is due in February 2012.

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

Ms. Penttinen reviewed the CME certificate submitted by Dr. Bui for a billing seminar sponsored by ACFAS which the Board had previously approved. However, Dr. Bui had only requested 10 hours of CME when the seminar was actually 14 hours. Ms. Penttinen has verified with ACFAS that Dr. Bui did attend all 14 hours of this billing seminar. The Board and Ms. Penttinen reviewed the other courses which the Board already approved which are through E/M University which was a total of 12 hours CME and Dr. Bui was required to complete 25 hours total. Ms. Penttinen stated she will verify the E/M University course completion once Dr. Bui sends his completion certificates. Dr. Kaplan also reviewed the correspondence from Dr. Bui which indicates that he had no charts or records for DME in the previous month.

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

Ms. Penttinen advised that the most recently quarterly report from Dr. Sucher was received in November 2011. The next report is due in February 2012.

VII. Review, Discussion and Possible Action on Administrative Matters

a. Request from the Arizona Podiatric Medical Association for approval of four hours of continuing medical education for seminar in January 2012.

MOTION: Dr. Kaplan moved to approve the AzPMA Association meeting in January 2012 for four (4) hours of CME. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. Request from David Savage, DPM to reinstate expired license.

Ms. Penttinen advised the Board that Dr. Savage previously held an Arizona license which was issued in 2003 and expired in 2011. Dr. Savage had moved and not updated the board with his new address. He did not receive his renewal application and did not contact the Board to have one sent to him. Ms. Penttinen recently received a call from Dr. Savage asking about reinstating his license and she advised him that the Board does not have a reinstatement clause so he would have to reapply as other doctors have done. Dr. Savage feels it is unfair for him to have to reapply since it has been such a short amount of time and he would like to reinstate without having to go through the application process again. Dr. Kaplan stated that there is a requirement in the Board's statutes that a doctor notify the board within 30 days of a change in address and he feels this is not the Board's responsibility. Dr. Kaplan stated he feels that if Dr. Savage wants to have a license in Arizona he will have to re-apply. Drs. Leonetti and Campbell agreed. Ms. Miles agreed that this issue is defined in the Board's statutes and is not discretionary. Upon discussion with Ms. Campbell, the Board agreed that Dr. Savage is not eligible for reinstatement because there is no such provision under the Board's statutes.

c. New license applications: The Board will review, discuss and take possible action for the following new license applicants. (Possible actions may include approval to sit for the license oral examination, denial of the application, or asking for additional information under the Administrative Review or Substantive Review.)

i. Peter Bregman, DPM

ii. Matthew Hinderland, DPM

iii. Ryan Wood, DPM

Ms. Penttinen and the Board members reviewed the correspondence between Dr. Bregman and Ms. Penttinen regarding the current status of his application. The application was received on May 16, 2011 but was deficient, and a deficiency notice was sent the next day. The Dr. Bregman's application was dormant until September and he eventually missed the 30-day deadline for his application to be complete in order to sit for the oral licensing examination administered today. Dr. Bregman sent a letter to the attention of Dr. Kaplan alleging that his application process is not being handled in a fair or timely manner. Ms. Penttinen responded to Dr. Bregman's correspondence with regard to his concerns about the application process. Dr. Kaplan stated he agreed with the information provided to Dr. Bregman in Ms. Penttinen's correspondence to him and agreed that the Board has no control over other agencies with regard to the time periods in which they submit the necessary information to the Board for the new license application process. Ms. Penttinen advised that upon her receipt of Dr. Bregman's license

verification from the state of Nevada she contacted the director of the Nevada podiatry board and requested the date that Dr. Bregman's license verification request was received. Per that agency, they did not receive the verification request until November 22, 2011. Ms. Penttinen advised that a member of Dr. Bregman's staff has apparently been handling the application paperwork on his behalf. Ms. Penttinen confirmed that at this time Dr. Bregman's application remains administratively incomplete due to outstanding license verifications from three other states. The Board members were in agreement with the information that Ms. Penttinen provided to Dr. Bregman and do not feel that any additional response is necessary. Dr. Bregman's application remains incomplete at this time. The next oral exam for which he would be eligible is in June 2012.

The Board members then reviewed the license applications for Drs. Hinderland and Wood.

MOTION: Dr. Kaplan moved to approve Drs. Hinderland and Wood to sit for the oral licensing examination in June 2012. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

d. License renewal applications: The Board will review, discuss and take action to approve, deny, or issue a deficiency notice for the following physicians' license renewal applications and/or dispensing registrations:

Todd Zang, DPM

Parker Gennett, DPM

MOTION: Dr. Kaplan moved to approve the license renewal applications for Drs. Zang and Gennett. Dr. Leonetti seconded the motion. Ms. Miles was not present during review of this agenda item.

DISCUSSION: There was no discussion on the motion.

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

VIII. 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 pending. That total includes three new complaints received in the last month, the cases reviewed today, cases that have previously been reviewed and tabled for various reasons, and cases that are currently with investigators and completing the investigation process. Dr. Kaplan stated that Dr. Campbell would be presenting information regarding the Board's complaint investigations at the AzPMA meeting in January. Ms. Penttinen stated the Board has received 42 complaints in the present calendar year. Dr. Leonetti asked how many investigations which are currently opened are the result of a malpractice complaint as it appears there has been a high number of malpractice investigations. The current Open Complaint report indicates that 24 of the current 74 open complaint investigations are related to malpractice claims. Dr. Leonetti asked about complaint number 11-38-C in which the complainant is listed as Patricia Kirk, DPM and the complaint against Alex Bui, DPM. Ms. Campbell advised that the specifics of that complaint case could not be discussed because it was not specifically stated on the agenda for today's meeting. Dr. Leonetti stated he only wanted to confirm that the report did not contain a typo and that the complaint was filed by another doctor.

b. Review of A.R.S. §12-2295 and discussion regarding proposing legislation to amend the statute.

Ms. Penttinen explained that this issue arose due to her receipt of an invoice for fees associated with a records request. Under the cited statute, the only boards which are exempt from being charged a fee for records are the Arizona Medical Board and the Arizona Osteopathic Board. It is unknown why that is. Ms. Penttinen asked what the Board members would think about pursuing legislation to amend this law to exempt all healthcare regulatory boards from being charged fees for obtaining records from healthcare providers. Ms. Penttinen advised that she does not receive very many invoices for records so it may not be worth the legislative exposure; however, she received an invoice for \$69.00 for one CD of diagnostic reports totaling nine pages not including the associated reports. If someone wanted to charge the board for providing records, even pursuant to a subpoena, it could cost upwards of \$100-\$200 per investigation case. Dr. Leonetti stated that he feels the only way to undertake such legislation would be if there were a large number of healthcare boards who were in agreement and would support the legislation. Ms. Penttinen stated that due to the close proximity of the impending spring legislative session it may be

better to hold off and conduct research prior to the 2013 legislative session in order to determine if it is feasible to attempt a legislative change. Dr. Kaplan asked if this would open up the Board's statutes to legislative changes. Ms. Penttinen advised that this is a law which applies to all healthcare regulatory boards and would not affect the Podiatry Board's laws individually. Dr. Campbell stated she could discuss this issue with the lobbyist for the AzPMA when that association meets in January 2012 and gather information as to the potential success of this proposed legislation pending further information.

c. **Malpractice case report.**

- i. Kevin O'Brien, DPM: Claim filed by patient C.P. Board investigation case already opened.

Dr. Kaplan reviewed the report and because there is already a case opened in this matter, no further action is required at this time.

IX. Call To The Public

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

X. Next Board Meeting Date:

- a. January 11, 2012 at 8:30 a.m.

XI. Adjournment

MOTION: Dr. Campbell moved to adjourn the meeting. Mr. Rhodes 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 12:30 p.m.