



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

February 8, 2012; 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: Bridget Harrington

I. Call to Order

Dr. Kaplan called the meeting to order at 8:30 a.m.

II. Roll Call

Dr. Kaplan noted for the record that Ms. Miles was absent. All other Board members were present as were Ms. Penttinen and Ms. Harrington.

III. Approval of Minutes

a. December 14, 2011 Regular Session Minutes.

MOTION: Dr. Campbell moved to approve the minutes as drafted. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

(It is noted that Ms. Miles arrived following this agenda item and was present for the remainder of the meeting. The following agenda items were not discussed in the exact order in which they appear on the agenda and minutes.)

b. January 11, 2012 Regular Session Minutes.

The Board members offered corrections of grammar and spelling errors. There were no corrections regarding content.

MOTION: Ms. Miles moved to approve the minutes with the offered corrections. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

c. January 11, 2012 Executive Session Minutes.

MOTION: Dr. Kaplan 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.

IV. Review, Discussion and Possible Action –Review of Complaints

a. 09-46-C – Aprajita Nakra, DPM: Refusing to provide care, possibly billing insurance for services not rendered.

Dr. Nakra was not present. Dr. Campbell recused herself as she was the physician investigator for this case. Dr. Campbell summarized the case as follows: A complaint against Dr. Nakra was received from

patient H.H. There was only one date of service which was 09/28/2009 where the patient presented to Dr. Nakra with nail problems and cracked skin on her heels. The patient told Dr. Nakra she was in a rush and only wanted her nails trimmed. The patient denied any pain or discomfort in her nails. Dr. Nakra noted that the patient complained she did not think it was fair to pay money to go to a nail salon to get her nails cut and felt she should be able to have a podiatrist cut them and bill her insurance. The patient stated she had seen other podiatrists in the past and was never billed. Dr. Nakra performed a history and physical on the patient. The patient denied any history of diabetes. Dr. Nakra noted that the pulses were palpable. The patient had incurvation and thickening of the left 4th and right 4th and 5th toenails. There was no tenderness to palpation of any of the nails and or evidence of any infection. Dr. Nakra's assessment was asymptomatic onychodystrophy bilateral, asymmetric heel fissure bilateral, and painful feet per the patient. Dr. Nakra noted that the patient was very abrasive, rude and uncooperative during the office visit. Dr. Nakra told the patient that her thickened toenails were caused by her shoe gear; however, the patient only wanted to have her nails trimmed and get medication for her heels which insurance should pay for. Dr. Nakra noted that the patient did not want to understand the cause of her dry, fissured heels and that such cause would need to be determined before treatment was rendered. The patient was unwilling to try any over-the-counter products. Dr. Nakra told the patient that her foot care was not medically necessary and would not be covered by Medicare. The patient told Dr. Nakra she would file a complaint with Medicare because she did not provide any services. Dr. Nakra told the patient it was unethical to bill for foot care which is not medically necessary.

Dr. Campbell stated she did not feel it was necessary to interview the patient or Dr. Nakra. She added that it appears the patient was uncooperative with Dr. Nakra and asked her to code the visit so the insurance would pay for it. Dr. Campbell also noted that the patient did not appear to be a good historian and may have benefited from having a friend or family member present who understands Medicare coverage and guidelines. Dr. Campbell concluded that the allegations are unsubstantiated and she finds no violations. A history was taken but the treatment was not provided because it was not medically necessary.

Dr. Kaplan stated that he feels allegation #2 is not substantiated. He asked Dr. Campbell what she would do if she were in the same situation with a patient and whether she would offer treatment to the patient with the understanding that it would not be covered by insurance and the patient would pay out of pocket. Dr. Campbell stated that would be one approach; also the insurance could be billed and the patient advised of what the cost would be when the claim is denied. Dr. Campbell noted that Dr. Nakra did not provide those options to the patient in this case. Dr. Leonetti stated he agreed and it is the doctor's prerogative to determine if they feel routine foot care is medically necessary. If they do not feel it will be covered they have the right not to provide the treatment or offer to have the patient pay out of pocket.

MOTION: Dr. Kaplan moved to dismiss this 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.

b. 10-09-C – David Corcoran, DPM: Failure to provide copies of patient records to another healthcare provider.

Dr. Corcoran was present with attorney Charles Hover, III. Ms. Penttinen was the investigator for this case and summarized the complaint as follows: A complaint was received from attorney Richard Bellah on behalf of patient G.I. The patient was under Dr. Corcoran's care for approximately one year before switching to Dr. Jerome Cohn. Mr. Bellah stated that multiple requests were sent to Dr. Corcoran for copies of the patient's records but they were not sent. The patient also received care from Dr. Ramon Alba who had requested the patients records from Dr. Corcoran but did not receive them.

In the written response submitted by Dr. Corcoran's attorney, Mr. Hover, it was stated that Dr. Corcoran's wife had worked in his office and was responsible for handling all records requests. However, she had become ill and was no longer able to work. Then the person who took over the records requests did not complete the requests for patient G.I. Dr. Corcoran was not aware of this problem until he received a letter from Mr. Bellah. He then immediately faxed the records to the requesting doctors, but their

provision was definitely outside the 21-day time requirement. Mr. Hover stated Dr. Corcoran has modified his office procedures to ensure that records requests are acted upon within 48 hours. Ms. Penttinen contacted the office of Dr. Cohn and was told that they did not have any records from Dr. Corcoran but the patient was only seen once in February of 2010 and has not returned. Ms. Penttinen also contacted the office of Dr. Alba and was told that they did receive records from Dr. Corcoran. Ms. Penttinen found that the allegation was substantiated and deferred to the Board to determine if the information provided by Dr. Corcoran about his wife's illness would be considered a mitigating factor.

Dr. Corcoran was asked if he wanted to make any statement. He said his response letter pretty much covered everything. Dr. Kaplan stated he understood that the circumstances surrounding this situation were very serious and could easily cause some confusion in the office with records requests and other administrative duties. Dr. Kaplan acknowledged the Board's statute regarding providing records within 21 days but feels that there were mitigating circumstances in this case. He further advised Dr. Corcoran to be particularly aware of this in the future. Dr. Kaplan stated that normally he might consider a Letter of Concern but in this case he does not feel it is necessary.

MOTION: Dr. Kaplan moved to dismiss this case due to the mitigating factors as discussed. Dr. Leonetti seconded the motion.

DISCUSSION: Dr. Leonetti echoed Dr. Kaplan's caution to Dr. Corcoran to be very careful in how he handles records requests in the future. There was no further discussion.

VOTE: The motion passed unanimously by voice vote.

c. 10-13-C – Kelvin Crezee, DPM: Refusal to provide copies of medical records to patient's guardian. Dr. Crezee was not present. Ms. Penttinen was the investigator for this case and summarized the complaint as follows: Complainant W.A. made a request to Dr. Crezee to obtain copies of medical records for her daughter V.F. The complainant was under the impression that Dr. Crezee was required to provide them to her within 48 hours. Ms. Penttinen attempted to contact the complainant to determine if she ever received the records; however, the complainant did not respond to her voice mails. In his written response Dr. Crezee stated he received a request for V.F.'s records on March 16, 2010. On March 22 the complainant was informed that the records were ready and she picked them up on March 23. Ms. Penttinen stated she finds the allegation to be unsubstantiated. The Board members reviewed the patient's records which Dr. Crezee provided and it was noted that there was no "authorization to release records" form in the chart.

MOTION: Dr. Leonetti moved to dismiss this case finding no violations. Included in the motion is a directive to Ms. Penttinen to include in the dismissal letter to Dr. Crezee a note regarding maintaining both the "authorization to release records" form and a signature from the patient / guardian verifying that they received the records." Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

d. 11-06-C – Arthur Tallis, DPM: Performing excessive invasive procedures to the patient's toe which were unsuccessful and required additional surgery by another physician; improper billing for in-office surgical procedures and supplies; alleged harassment or intimidation of the patient and revealing HIPAA-protected information.

(PLEASE NOTE: To avoid name confusion, all references in this case to "Dr. Leonetti" refer to Board member Dr. Joseph Leonetti. Investigator Dr. William Leonetti is referred to as "Dr. William Leonetti" or "the investigator.")

Dr. Tallis was not present. Patient C.B. was present and addressed the Board as follows: Dr. Tallis has been financially benefitting from this situation for two years. He has approached her in an effort to prevent her from going forward with her complaint against him with the Board. His office staff called her to offer her money. Dr. Tallis engaged in upcoding by putting a bandage on her foot then billing her insurance for a splint or a cast. He delayed procedures and "kept chipping away" at her toe which had

contractures. She was not able to wear shoes for an extended period of time. Dr. Tallis' office staff would collect her copays of \$30.00 (per visit) but only record \$20.00 so she was billed for the difference. Dr. Tallis said he would return her copays which she agreed to and told him he could mail the money to her P.O. Box which he did not want to do; he wanted her residential address. Dr. Tallis contacted her after the complaint was filed even though she had wanted her information redacted from the complaint. His staff also called her on her personal phone number.

Dr. Joseph Leonetti asked C.B. what she meant by saying Dr. Tallis offered her money. She stated he offered to refund her copays. Dr. Leonetti asked why and she said she did not know but possibly so she would not go forward with her complaint. She said Dr. Tallis wanted her to come to his office but her work schedule did not permit that so she told him to mail the money to her. Dr. Leonetti asked if she ever received any money from Dr. Tallis or anyone else in his office and she said she did not. Dr. Kaplan asked if she ever met with anyone from his office and she said she did not. C.B. said her concern was being billed for her copays even though she had paid them on each visit. She said his behavior was very questionable to her so she did not want to meet with him or his staff. Dr. Leonetti asked the patient if she ever signed a letter saying that she wanted to retract her complaint, and she said she did not. She added that when Dr. Tallis called her he was acting in a bizarre manner and told her in a voice mail message, "Believe me, I want you to call me, I knew nothing about this until you went to the Board." Ms. Miles asked the patient if she had changed her phone number and she stated she had and gave it to Board staff with the direction that it not be given to Dr. Tallis. Ms. Miles stated the investigator had been trying to reach her. C.B. alleged that she has never been contacted at any time in the two years since she filed her complaint until she received the notice of the Board meeting. Ms. Penttinen clarified that the complaint was not received until February 22, 2011. Dr. Kaplan asked the patient about the residential address listed in her complaint. She stated that was no longer a valid address but she changed it to a P.O. Box. The patient also confirmed that she had given Dr. Tallis her residential address when she was a patient. Dr. Kaplan asked the patient if she had signed an authorization for Dr. Tallis' office to contact her by phone. She said she had done so previously but not in relation to this complaint. Dr. Leonetti asked the patient if she had gone back to Dr. Tallis and asked him redact all of her contact information from her chart. She stated she indicated on her complaint form that she wanted her information redacted. Dr. Kaplan stated that Dr. Tallis already had her contact information in his chart. The patient confirmed that she had authorized Dr. Tallis to contact her on her home phone and address.

Dr. Kaplan then asked the patient about a document submitted by Dr. Tallis. Ms. Penttinen clarified for the record that it was a two-paragraph document starting with the phrase, "I spoke to Elizabeth at Dr. Tallis office." The patient was shown a copy of the document. Dr. Kaplan asked the patient to read the document and indicate if it is something that she signed. After reviewing the document the patient stated she did sign it but it was pertaining to the second complaint she filed because the Board claimed the first complaint was never received. Dr. Kaplan asked the patient why she wrote and signed the document and who typed it. The patient stated she typed it and signed it, meaning that "they would call me." Dr. Kaplan reviewed the specific language in the document stating, "Elizabeth was trying to make amends for the problems. I am also glad that they are willing to refund my copays to make up for my troubles. The patient stated, "Right, but they never did and I knew he wouldn't do it." The patient stated that Dr. Tallis was lying to her about her footcare needs, was "playing around" with her copays, and upcoding her insurance billing. Dr. Leonetti asked the patient to confirm if she ever received her copays back and she said she did not. The patient stated she always paid in cash so she asked for an audit of their petty cash at which time "the girl" said they would write off her balance due. Dr. Kaplan asked the patient if she requested to be reimbursed in cash because she had payed in cash. She stated said no and that "Elizabeth" (the office manager) told her she would be paid in cash and wanted the patient to go to the office to get it. The patient was unable to go to the office so Elizabeth said a check would be sent but it never was. Dr. Kaplan asked the patient if she ever met with Elizabeth at a Mexican food restaurant, if Elizabeth bought her lunch or gave her \$200.00 in cash. The patient stated none of those things occurred. Dr. Kaplan asked if she ever thanked Elizabeth for how she handled the issues and was happy because she needed the money to pay bills. The patient said she never made those statements.

Dr. Leonetti asked the patient about the surgical procedure on her second toe. She said it was to straighten the toe, release the contractures and scar tissue which were caused by repeated surgeries by Dr. Tallis. Dr. Leonetti asked what treatment was rendered by the doctor she saw after leaving Dr. Tallis.

(Dr. Daniel Schulman.) The patient said she had one surgery to have a pin inserted into the toe and at this time her toe is much shorter and disfigured and caused her problems wearing certain shoes and is very sensitive. Dr. Leonetti asked if there is any other treatment recommended or if it is stable. The patient stated no unless something else occurs. Dr. Leonetti asked if she knew whether Dr. Schulman had been in contact with Dr. Tallis about her records. The patient said the records were supposed to be delivered to Dr. Schulman but Elizabeth told her it would take many months to produce them. The patient said both she and Dr. Schulman made requests for her records. She believe Dr. Schulman eventually received some of the records but not all of them. Dr. Kaplan asked the patient if her toe is more flat now than it was prior to treatment with Dr. Tallis. She said it is flatter but not completely flat. Dr. Kaplan asked if Dr. Tallis discussed with her the type of procedure he was going to do. She said he did not. There was some discussion between Dr. Kaplan and the patient regarding the complications she had with scheduling her surgeries.

The investigator was Dr. William Leonetti. He was present and addressed the Board with the following information: In his review of the records the patient presented to Dr. Tallis in February 2009 for basically a hammertoe with pain and minor deviation of the toe. Dr. Tallis noted that the patient had previously had hammertoe surgery on the same toe four years prior and had developed some contractions. The patient was offered conservative and surgical treatment options and decided to have surgery. According to Dr. Tallis, (in a conversation with the investigator), he recommended that this type of procedure could develop scar tissue and would require pin fixation to hold the toe down, but the patient refused that type of procedure. On February 20, 2009 a consent form was signed for outpatient surgery which included arthroplasty hammertoe correction of the second digit and excision of a second innerspace neuroma. Post operatively the patient was advised to use taping and strapping to hold the toe down to prevent re-scarring and contraction. The notes indicate that the patient was non-compliant with that instruction. Dr. Tallis then tried steroid injections to break up the scar tissue. As a result of some continued slight contraction, Dr. Tallis did a second procedure four months later in his office which was a tenotomy and capsulotomy (T and C) to relax the scar tissue. According to Dr. Tallis there was no significant abnormality, only a slight lateral deviation of the toe. As a result of continued complaints, a "touch up" T and C was performed on July 30, 2009 in-office with local anesthetic. The records show that Dr. Tallis again recommended taping and strapping. At the end of his treatment of the patient in November 2009, Dr. Tallis recommended an additional inpatient procedure would be required to correct the contraction which would have to include pin fixation. The patient's notes reflect that the patient initially agreed to the surgery in early November 2009 but Dr. Tallis wanted to wait to see if the toe would reduce. The last evaluation was on November 5, 2009, shortly after which the patient switched to Dr. Schulman. On December 11, 2009, Dr. Schulman performed a revision arthrodesis with pin fixation, T and C, a flexor release of the mpj, and application of an external bone stimulator.

The investigator continued and stated he attempted to contact the patient several times but was not successful. The information provided by Dr. Tallis in a telephone interview was the same as what was submitted in his written response. Dr. Tallis noted that at the end of his treatment of the patient, the patient was very anxious to have additional surgery which he was not comfortable with. Dr. Tallis also stated that the patient was "too personal for his comfort zone" and therefore he decided not to move forward with additional surgery. Dr. Tallis stated that there was scar tissue present in the patient's toe due to the surgery she had four years prior to becoming his patient and he recommended the pin fixation which the patient refused; therefore he performed the arthroplasty and subsequent T and C's. Dr. Tallis did not feel there was a significant deformity to warrant such an invasive procedure. Dr. Tallis performed taping and strapping. With regard to the alleged improper billing, the records show that according to Dr. Tallis his staff improperly billed a taping and strapping code (29504) and listed it as (29405) on two separate occasions. Dr. Tallis said he contacted the patient's insurance company to correct the errors but ultimately he was never paid at all for the taping and strapping. With regard to the overbilling for copays, Dr. Tallis has stated that there was some discrepancy with a former employee of his who has been terminated in that the employee was billing the patient \$30.00 but only recording \$20.00. Dr. Tallis could not confirm it but suspected that the employee was pocketing the money. As a result of Dr. Tallis' inability to determine exactly how much money the patient owed for her copays he was willing to give the patient the benefit of the doubt and return all of her copays which was a total of \$200.00. Although the patient states she never received this money, Dr. Tallis insists that his staff member Elizabeth met with the patient at a restaurant (at the patient's request), bought the patient lunch, and gave her \$200.00 in cash. The investigator stated this would account for the letter signed by the patient which was discussed

earlier. With regard to the allegation of harassment, Dr. Tallis stated he had his staff contact the patient after the complaint was made about improper billing to inform her that the billing errors were corrected and the insurance company was informed of this. Dr. Tallis tried to contact the patient himself and left her a voice mail message but never heard back from her. Dr. Tallis denies ever harassing the patient.

The investigator concluded that he did not find any violations regarding the first allegation. With regard to the second allegation, there were some errors but they were properly corrected with the insurance company so he finds no violation there. With regard to the third allegation, he cannot confirm blatant harassment of the patient, although he was not able to speak with the patient during the investigation process. He added that he did see a possible violation in that there was a delay in forwarding the patient's records to Dr. Schulman. Dr. Tallis' response to that issue was that he ended up terminating the staff member who handled records requests and records were lost in the chart, but as soon as he learned of the request he sent the records, which was three and a half to four weeks after the request was received.

Dr. Kaplan asked reviewed the Board's statute regarding provision of records which states records must be provided within 21 days of receipt of a written request; in this case the time period only exceeded that by a few days. Dr. Kaplan reviewed the second allegation regarding the billing and confirmed with the investigator that Dr. Tallis was never paid for the tapings and strappings. He added that even though there were errors, they were corrected and there was no payment made by the insurance company. The investigator confirmed that Dr. Tallis did bring the errors to the attention of the insurance company but he never actually received payment even for the corrected codes. Dr. Campbell asked the investigator if he had reviewed any x-rays which he said he did not. Ms. Penttinen advised that no x-rays were submitted. Dr. Joseph Leonetti asked the investigator about the T and C's done in the office as to whether they were extensor or flexor in nature. The investigator said they were extensor with minimally invasive incisions from the top. Dr. Tallis felt it was appropriate to do those procedures in office with local anesthetic. Dr. Tallis told him the toe was slightly drifted but he did not see any significant deformity; he felt by releasing the capsular structures and taping the toe straight he could get the scar tissue to redirect itself and hold the toe straight without major invasive surgery. Dr. Joseph Leonetti asked why Dr. Tallis needed to perform a second T and C less than two months later. The investigator stated it was more because the patient was complaining that the toe was drifting again. Dr. Tallis said he suggested the more invasive procedure with pin fixation but that patient did not want to do that. It was unclear if the same incision was used for both T and C's. Dr. Joseph Leonetti asked, if the patient was so reluctant to have Dr. Tallis do that procedure, then why did she allow Dr. Schulman to do it. The investigator stated he was not able to ask the patient about that. He added that this was odd because Dr. Tallis had suggested the more invasive procedure which the patient refused as of November 5, but she then started treatment with Dr. Schulman on November 11 and had the surgery on December 11. Dr. Joseph Leonetti asked the investigator if he spoke with any of the staff at Dr. Tallis' office, and he said he did not. Dr. Leonetti reviewed Dr. Tallis' assertions that someone from his office met the patient at an off-site location and gave her cash. The investigator confirmed this and stated he had asked Dr. Tallis if it was standard for him to return copays. Dr. Tallis told him it was not but Dr. Tallis could not confirm the exact accounting as to whether his staff collected \$30.00 but only recorded \$20.00 on every visit or if that only happened on some visits. Dr. Tallis said that because he had no way to confirm exactly what the patient had paid or what his staff may have taken he just decided to refund all of the copays. The investigator added that Dr. Tallis denied paying patients in cash in the past and insisted that his staff met with the patient to give her the cash refund, even buying her lunch which he had the receipt to prove. Dr. Leonetti asked if the receipt was provided and the investigator said it was not.

Dr. Leonetti asked the investigator if he felt that was strange. The investigator stated he has never seen anybody's copays be returned before and found it strange to do so in cash because there is no legal documentation of it. The third thing the investigator found unusual was meeting at an off-site location; he felt an office matter should be conducted in the office or mailed by certified mail. Dr. Leonetti asked the investigator if he felt the payment from Dr. Tallis was in exchange for the patient rescinding her complaint. The investigator said he asked Dr. Tallis about that and Dr. Tallis said 'absolutely not,' that it was the patient's idea, and that the patient was insistent on meeting at an off-site location. Ms. Miles asked about the lunch which Dr. Tallis' said Elizabeth paid for. The investigator said that Dr. Tallis' told him he has a receipt for the meal but he did not know if it was paid with cash or credit card. Dr. Kaplan added that if he had made a payment to someone he would want something signed to verify that. The

investigator said that, according to Dr. Tallis, it was the patient who requested to meet Elizabeth at a restaurant near the State Capitol because she was a State employee and it was close to her work.

The Board then asked the patient if she would like to respond to the investigator's findings. The patient stated that, due to the way Dr. Tallis was acting at the time he called her and left a voice mail message, she knew he was either on drugs or drinking. She denied meeting Elizabeth for lunch and said Elizabeth and Dr. Tallis are "in cahoots on this." Dr. Kaplan asked the patient about whether she had actually spoken to Dr. Tallis by phone. She said she did not but even in the office when she saw him as a patient he acted "really weird." The last time she saw him she told him the surgery had failed. He would put a piece of tape on her toe and tell her to take it off in a week. The patient stated she followed all instructions from Dr. Tallis. Dr. Tallis never told her a pin was needed (to fix her toe). Dr. Kaplan asked the patient if she worked in the Capitol area. She stated she did at one time but not in May 2011 when the lunch in question is to have occurred. Dr. Kaplan asked the patient how she was "harassed" by Dr. Tallis. The patient said that last day she saw Dr. Tallis he said, "I'm sorry, I have to do something about it" and she told him things had been going on too long. Then when he called her and left the message he was "a blubbering idiot" and told her he never knew anything about "it" until she went to the Board. Dr. Tallis was angry and had Elizabeth call her asking her to return as a patient. Elizabeth said they would return her copays and immediately after that conversation Dr. Tallis called her back. The investigator asked the patient if she kept a recording of the voice mail from Dr. Tallis and she said she did not but her sister listened to it. Dr. Kaplan asked the patient to clarify that the "harassment" was the one voice mail message that Dr. Tallis left her. The patient said yes, because Dr. Tallis was behaving in a way that was unbecoming for a doctor because he seemed drunk. Dr. Campbell asked the patient about Dr. Tallis' statement that she had asked him out for a drink. The patient denied that ever happened. Mr. Rhodes asked the patient about her statements that when she was seeing Dr. Tallis as a patient he seemed like he was drinking or on drugs. The patient confirmed that is what she thought. Mr. Rhodes asked her why she would continue to go back and possibly put herself in jeopardy. The patient said she wasn't sure at the time until the last time she saw him in the office when he "wasn't acting right." She said Dr. Tallis is "conjuring up" things to get out of this situation which makes her believe there is something wrong with him. The patient also said that because of the delay copying her records that Dr. Tallis had time to alter them and she knows that because he was told by his staff that it would take several months to get her records sent to Dr. Schulman. Ms. Penttinen clarified for the Board members that there were no allegations in the patient's complaint about falsifying records, refusal to provide copies of the records, or any impairment. Dr. Kaplan noted that Dr. Schulman did not indicate in his chart the length of time it took to receive the records from Dr. Tallis.

Dr. Leonetti discussed the surgery performed by Dr. Schulman which included putting a pin in her toe. He asked the patient about Dr. Tallis advising her that a pin would be needed but according to Dr. Tallis she refused to have that done. The patient denied this and said Dr. Tallis never discussed with her putting a pin in the toe. Dr. Leonetti then asked the patient about the two-paragraph document signed by the patient which was discussed previously. He specifically reviewed the statements, "I'm satisfied that my concerns were addressed," and "I'm glad that they are willing to refund my copays to make up for my troubles." Dr. Leonetti asked the patient when she signed this document. The patient asked if it was in the packet of information she sent to the Board. It was clarified that the document was submitted by Dr. Tallis but when the patient reviewed it earlier in the meeting she stated she did write it. The patient said she did that because she was led to believe that her copays were going to be returned to her but they never were. The patient said Dr. Tallis "may have altered a few things." Dr. Leonetti asked if she meant that Dr. Tallis altered this specific document and she said yes. The patient confirmed for Dr. Leonetti that at the time she signed this document she had not received any refund from Dr. Tallis. The patient confirmed to Dr. Kaplan that she did type this document but believes Dr. Tallis may have changed it. Ms. Miles gave a copy of the document back to the patient and asked her to point out what she thought was different. The patient reviewed the document and said Dr. Tallis may have taken some of the information from her complaint addendum and added it to the document.

Ms. Miles reviewed with the patient that earlier she told the Board that she wrote the document and did not indicate that anything appeared to have been changed. The patient said she signed it and it was basically a summary of different things she wrote in her complaint. The investigator asked the patient if it was her signature on the document. She said it was her signature but the composition may have been altered. Ms. Miles asked the patient why she thought that. The patient said that one thing is that the

content of the language contains things she wrote in her complaint, which Dr. Tallis received a copy of, but she would not have composed (the language) the way it is written in this document. Ms. Miles reviewed that the first time the patient looked at and read the document she said that she wrote it. The patient said the top of the document is not how she "does it." Ms. Miles asked the patient why, when she first looked at the document, she did not tell the Board these things. The patient said it was because her signature is on the document. Ms. Miles asked the patient why her response is now changing (regarding whether or not she wrote the document). The patient said she is finding the document odd coupled with Dr. Tallis' insinuation that she wanted to have a drink with him. Ms. Miles told the patient she would understand if she was upset after hearing the things that Dr. Tallis said in his response and asked the patient if those things may be causing her the change her mind with regard to writing the letter. The patient said no because she believes Dr. Tallis is capable of "doing things." She added that she always uses a document format with her address on the top, and that the document looks like a "cut and paste." Ms. Miles asked the patient if she saved a copy of the document. The patient said she did not, but added that she would not have sent this type of letter without keeping a copy. Ms. Miles asked the patient if she was now saying that she did not write the document. The patient said she thinks that maybe some of the information in the document was taken from her complaint letter and she is apprehensive about how it is composed. After further questions from Ms. Miles, the patient said she may have written a document similar to this but it was altered. The patient said she was beginning to think she did not write the document because of what Dr. Tallis "conjured up" about her wanting to have a drink with him and her meeting with his staff. The patient said she would like to see the original of this document. Dr. Leonetti said he would also. The patient added that Dr. Tallis has done things like this before, that he has been sued before, and this seems like "one of his tricks."

Dr. Leonetti stated he has some concerns about the document in question. He would like to see the original document. Dr. Leonetti stated he also was concerned about the vast difference between Dr. Tallis's account of his staff meeting the patient at a restaurant and giving her cash versus the patient adamantly denying that ever happened. Dr. Leonetti would also like an interview conducted with Dr. Tallis' staff member who he says met with the patient and gave her the refund. He also would like to see a copy of the lunch receipt and any documentation of the copay refund. Ms. Penttinen will go to Dr. Tallis' office to inspect the patient's original records, specifically the document in question, and will follow up on each of the other items as requested. The Board members agreed to table this matter until that information is obtained. Ms. Penttinen will also obtain copies of all x-rays for the patient as none were submitted by either Dr. Tallis or Dr. Schulman.

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

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

The Board reviewed the progress report from Dr. Sucher dated February 7, 2012. That report indicates that he had some concerns in December 2011 about Dr. Shapiro's medication usage and a possible relapse. Dr. Shapiro had entered a substance abuse treatment facility. However, Dr. Shapiro left that facility immediately after the Board summarily suspended her license in a separate matter. (The summary suspension occurred on December 30, 2011.) Since that time Dr. Shapiro has not been participating in an monitoring activities with Dr. Sucher which constitutes additional allegations in the separate case. Ms. Miles asked when the formal hearing in that separate case will be scheduled and if there was enough time to properly notify Dr. Shapiro of any additional allegations. Ms. Penttinen advised that the hearing is scheduled for February 22 and the Attorney General representative who is handling that case will determine how to proceed with this information.

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

Dr. Kaplan reviewed the letter submitted by Dr. Bui indicating that he has no charts to submit for DME charges for the month of January 2012.

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

Ms. Penttinen reviewed the progress report submitted by Dr. Sucher dated February 7, 2012. She also had asked Dr. Sucher to state whether he felt Dr. Brown was using his medication(s) within acceptable therapeutic doses. Ms. Penttinen also obtained copies of all Dr. Brown's drug test results which show he has only tested positive for substances for which he had valid prescriptions. The drug tests now include an automatic verification of the quantitative values. Dr. Sucher stated in his progress report that he feels Dr. Brown's medication use is within therapeutic or sub-therapeutic ranges. Ms. Miles asked what Dr.

Brown's drug of choice had been. Ms. Penttinen stated it had been vicodin and alcohol. All drug tests include testing for ethylglucaronide and any positives for opiates are confirmed for the quantity present. The Board members reviewed the prescription report from the AZ Pharmacy Board which was submitted by Dr. Sucher. Ms. Miles was concerned about why Dr. Brown needs to be prescribed the same medication which was the substance that he overused in the past. Dr. Kaplan stated he would like to confirm if Dr. Brown is still affected by diabetes and if he is taking any medication for that. Ms. Penttinen will follow up with Dr. Brown and ask him for a complete list of all medications he is currently taking.

VI. Review, Discussion and Possible Action on Administrative Matters

a. Status of current physician investigators contracted with the Board.

Dr. Kaplan advised that he has been seeking additional help from podiatrists to serve as physician investigators for the Board. Dr. Jerome Cohn has agreed to do so and he believes Dr. Kris DiNucci may be available as well. Dr. Kaplan asked Dr. Leonetti to contact Dr. DiNucci in this regard. Dr. William Leonetti also will be staying on contract on an as-needed basis, and Dr. Dedrie Polakof remains on contract on a regular basis. Dr. Kaplan stated he does not feel this is enough investigators but he has not had much luck in finding podiatrists in the Phoenix area who are able to work with the Board. He feels out of town investigators would have too many logistical problems. Dr. Kaplan asked if it is possible for the Board members, if they were to serve as an investigator for a complaint case, to be compensated at the same rate as the outside consultants are rather than the compensation rate of a Board member. Ms. Penttinen reviewed the Board member compensation rate with Ms. Harrington. Ms. Harrington stated she is uncertain but will check and follow up with Ms. Penttinen. Dr. Campbell asked how this Board compares with other boards regarding the time frame from when a complaint is first received and when it comes before the Board. Ms. Penttinen stated it is a lengthy time period due to the backlog of cases. Ms. Penttinen stated she believes all of the healthcare regulatory boards aim for a period of 180 days to complete an investigation once a complaint is received, which is also this Board's goal. However, when an emergency case comes up such as the recent investigation regarding Dr. Shapiro, all other cases are put on hold until the emergency case can be completed.

b. Review of current legislation.

i. HB 2236 – Regarding changes to AHCCCS coverage for podiatry services.

The Board members reviewed the bill which would allow podiatry services to be covered by AHCCCS when provided by a podiatrist. Ms. Penttinen advised that this bill was heard in the House Health Committee on February 1, 2012 and received a "do pass" recommendation. However, an amendment was made to the bill requiring that the care must be ordered by a primary care physician. Ms. Penttinen stated that the legislative liaison for AHCCCS had addressed the committee and stated that the expected cost savings (from removing podiatry care previously) had not been achieved and there had been a recognition of potential complications of foot issues which would cost additional money down the road.

Dr. Leonetti noted that this version of the bill still excluded podiatry services provided by a podiatrist. The Board members decided that they do not wish to take an official position on this bill.

(It was later learned that there was a second amendment which had not been posted to the bill information on the House website. That second amendment removed the podiatrist exclusion.)

ii. HB 2244 – Regarding composition of members for healthcare regulatory boards.

Ms. Penttinen reviewed the bill which states, for all boards, that no more than 25 percent of the board members may be regulated in the profession or occupation overseen by that board. The bill was scheduled to be heard in the House Commerce Committee on January 25, 2012 but has been held and is not expected to be rescheduled. If it were to pass, in order for the Podiatry Board to maintain three physician members, there would have to be 12 members total. Dr. Leonetti stated that this is not feasible for a Board of our size.

MOTION: Dr. Leonetti moved not to support this bill as written. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

- iii. SB 1189 – Regarding provision of services at free medical clinics and associated licensing requirements.

Ms. Penttinen advised that this bill has been pulled from committee and it is unknown if or when it will be rescheduled. Staff for the sponsor, Senator Nancy Barto advised Ms. Penttinen that Sen. Barto is looking at some possible amendments. Ms. Penttinen had been contacted by Senate research staff and asked for feedback. She advised that she had three concerns she would discuss with the Board as follows: 1) there is no definition of “free medical clinic,” 2) if the provider is not licensed in Arizona there is no jurisdiction to investigate any malpractice or negligence, and 3) there is no credentialing process to require these clinic to verify valid licensure of the providers. Senate staff had stated that those same concerns were voiced by other boards as well.

MOTION: Ms. Miles moved to oppose this bill as written based on the following: there needs to be a definition of “free medical clinic;” there needs to be patient protection if something goes wrong, i.e.: the ability to investigate; and there needs to be some form of license verification or assurance that the “clinic” would verify the license with the issuing agency. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

- c. Review of new license application: Scott Bleazy, DPM.

MOTION: Dr. Kaplan moved to approve the application for Dr. Bleazy and allow him to sit for the oral exam in June 2012. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

- d. Discussion regarding substance abuse and probation monitoring requirements.

Ms. Penttinen advised that she has received copies of the consent agreements used by the Arizona Medical Board related to licensees with substance abuse issues. She also received a copy of Dr. Sucher’s monitoring agreement but has not received anything yet from the Nursing Board. Ms. Penttinen reviewed the document which she crafted which is a combination of all of the separate documents with proposed terms that she has been working on to make this type of consent agreement more comprehensive. She advised it is a rough draft and seeks the Board’s opinion on whether certain terms should be added, deleted or modified. Ms. Penttinen spoke specifically about requiring the licensee(s) to complete drug testing even if they are out of town or out of state, so the only exception to drug testing would be illness verified by a medical provider. In her previous work experience at the Az MRTBE Board, licensees were allowed to use Concentra Labs in the case of domestic travel; they were required to test if their random color came up because some licensees had tried to use being on vacation as a way to abuse substances without being tested. Ms. Penttinen advised that she will update the Board once she receives the information from the Nursing Board. The Board members did not have any feedback or suggestions at this time.

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

- a. Open complaint status report.

Ms. Penttinen advised that there are currently 65 open complaints including those on today’s agenda. She received two new complaints in the last month. There are five cases ready to assign to an investigator. These cases will be given to Dr. Polakof while she works on getting Dr. Cohn’s paperwork done.

- b. Malpractice case report.

- i. Edward Kelly, DPM: Claim from patient R.W. filed on 05/23/11. (Board case not yet opened.)

The Board members reviewed the report which indicates the "Nature of Claim" is that the patient was treated in-office for a fractured foot after which he felt dizzy. The patient then drove himself home and was involved in an auto accident. The patient feels Dr. Kelly should not have allowed him to drive. The claim was closed via a negotiated withdrawal and no payment to the patient. The Board members decided not to take any action on this matter at this time.

- ii. Aprajita Nakra, DPM: Claim from patient N.H. filed on 11/17/11. (Board case already opened upon complaint filed directly from the patient.)
The Board reviewed the PICA report. Ms. Penttinen will file the PICA report in the file for the complaint already received from the patient.
- iii. Chad Thompson, DPM: Claim settled for patient A.E. (Previously disclosed and reviewed by the Board on Dr. Thompson's 2010 license renewal application. Investigation case was not opened at that time.)
Ms. Penttinen explained that Dr. Thompson disclosed this matter on his 2010 license renewal application with a letter from his attorney. The Board elected not to take any action at that time. Now there has been a settlement against Dr. Thompson.
MOTION: Dr. Kaplan moved to open a complaint investigation case for this matter. Dr. Leonetti 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 at the Call to the Public.

IX. Next Board Meeting Date:

- a. March 14, 2012 at 8:30 a.m.

X. Adjournment

MOTION: Dr. Campbell moved to adjourn the meeting. Dr. Leonetti 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 10:56 a.m.