



Janice K. Brewer  
Governor

## State Of Arizona Board of Podiatry Examiners

"Protecting the Public's Health"

1400 W. Washington, Ste. 230, Phoenix, AZ 85007; (602) 542-3095; Fax: 542-3093

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**

March 14, 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: Beth Campbell

(Please note that the items reviewed during this Board meeting were not reviewed in the order that they appear in the minutes.)

#### **I. Call to Order**

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

#### **II. Roll Call**

Dr. Kaplan noted for the record that all Board members were present as were Ms. Penttinen and Assistant Attorney General Elizabeth Campbell.

#### **III. Approval of Minutes**

a. February 8 Regular Session Minutes.

Dr. Kaplan offered several typographical and spelling corrections. The remaining Board members did not have any corrections.

MOTION: Dr. Kaplan moved to approve the minutes with the offered corrections. Mr. Rhodes 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. 10-11-C – Aprajita Nakra, DPM: Practice below the standard of care for refusing to provide a patient with a prescription for pain medication.

Dr. Nakra was not present. Ms. Penttinen was the investigator for this case and provided the following summary: a complaint was filed against Dr. Nakra by patient K.W. The patient stated that in the afternoon of March 2, 2010 he and his daughter called Dr. Nakra's office requesting that she call in a prescription for Percocet pain medication for foot pain. The patient was told that Dr. Nakra was seeing patients until 7 PM and would call him back after that time. The patient's daughter advised Dr. Nakra's staff that if a prescription was not called in prior to 5 PM, she and her father would file a malpractice suit against her. Dr. Nakra's medical assistant spoke with the patient who denied any acute distress or problems at that time. The patient also denied any recent injury or change in the status of his foot and refused to be evaluated to determine the need for pain medication. K.W. Had been a patient of Dr. Nakra for approximately 2 years and had never required pain medication in the past. The patient was advised that Dr. Nakra could not prescribe pain medication without evaluating him and that prescriptions for Percocet cannot be called into a pharmacy.

Ms. Penttinen had reviewed the patient's chart which was provided by Dr. Nakra. The correct date of the incident was March 3, 2010. There is proper documentation in the file regarding the discussions between Dr. Nakra's office staff and the patient and his daughter. Ms. Penttinen stated that in her opinion, because the patient had never required pain medication in the past, refused to be evaluated by Dr. Nakra, and was not demonstrating any acute problems at that time, Dr. Nakra handled this situation appropriately. The patient was not in any acute distress and did not suffer any causation of injury or exacerbation of an injury by Dr. Nakra's refusal to provide him with the requested pain medication. Ms. Penttinen stated that she does not believe there are any violations for practice below the standard of care in this case, but she defers any final opinion to the physician members of the Board.

Dr. Kaplan stated that he found it interesting that a patient who had never required pain medication in the past suddenly makes a very specific request for a specific pain medication. He added that such situations always seem questionable to him. Dr. Kaplan stated that he does not find any violations of state statutes in this case and he feels Dr. Nakra did the correct thing.

**MOTION:** Ms. Miles moved to dismiss this 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.

b. 10-21-C – Kris DiNucci, DPM: Practice below the standard of care for improper surgery. The physician investigator for this case was Dr. William Leonetti who was not present. Dr. William Leonetti's investigation report has been provided to the Board. Dr. DiNucci was present with attorney Bruce Crawford. Patient P.P. was present with his wife B.P. The patient and his wife addressed the Board as follows: The patient stated he was initially diagnosed by Dr. DiNucci as having a fracture and ruptured syndesmosis (of the left ankle). Dr. DiNucci spent a great deal of time showing the patient x-rays of a golfer who had a similar fracture and told the patient he could affix some type of device within the ankle joint so that the patient could play golf better than ever. The patient told Dr. DiNucci that he did not like golf and he just wanted his ankle fixed. The patient never heard the word "syndesmosis" from Dr. DiNucci; he only found later in the dictated notes. At a later date when the patient was consulting with Dr. Dillon, Dr. Dillon asked him where his MRI was. The patient told Dr. Dillon that he did not have an MRI and Dr. Dillon told him that a syndesmosis rupture could not be diagnosed without the MRI. The patient's insurance claim forms from Dr. DiNucci do not list a code for a syndesmosis rupture. Dr. DiNucci told the patient there was a 10 to 15% chance that he had a syndesmosis rupture. The patient is a mathematician and therefore concludes that there is an 85% chance that he did not have a syndesmosis rupture so he felt the doctor should have to prove to him that he actually had that condition before treating him for it. Dr. Leonetti interjected and advised the patient that there are a few clinical signs that can demonstrate that the patient has a syndesmosis rupture, one of which is the pre-operative x-ray. The patient advised that he did have his original pre-operative x-rays with him and provided a copy of those x-rays to the Board members. Dr. Leonetti looked at the film and advised the patient that within seconds he can see from them that the patient did have a syndesmosis rupture. Dr. Kaplan looked at the x-ray and agreed with Dr. Leonetti.

The patient continued as follows: Dr. Dillon also advised the patient that his superficial peroneal nerve was located in the lateral compartment, and had he not been treated for syndesmosis then the lateral compartment would not have been damaged. The damage caused to the nerves in that area necessitated additional surgeries which are very expensive and not covered by insurance. The patient repeated that Dr. Dillon told him that an MRI is required in order to positively diagnose syndesmosis. The patient is now being treated by Dr. Kerry Zang who told him that the original x-ray does not show a syndesmosis. Dr. Leonetti stated to the patient that he would disagree with the statements of Dr. Dillon and Dr. Zang. Dr. Leonetti added that a physician who repairs an ankle fracture and does not repair a syndesmosis rupture would be committing malpractice. Ms. Miles asked Dr. Leonetti to explain what he was seeing on the patient's x-ray. Dr. Leonetti showed Ms. Miles the film and explained that when there is a syndesmosis rupture, the ankle joint widens and the talar dome shifts laterally. Dr. Leonetti pointed out a gap between the bones in the patient's ankle and stated that gap was indicative of a syndesmosis rupture. He stated there should be a space of 1 to 2 mm between the medial malleolus bone and the medial aspect of the talar dome; when there is as much space in that area as is shown on the patient's x-

ray it means that the ligament has been torn and allowed the bones to separate. Ms. Miles asked the other physician members of the Board if they saw the same thing that Dr. Leonetti was seeing on the x-ray. Dr. Kaplan and Dr. Campbell both stated it was obvious to them on the x-ray that the patient did have a syndesmosis rupture. Dr. Leonetti added that an MRI would not be required to determine that this patient had a syndesmosis rupture.

The patient's wife, B.P., then spoke with the Board members and stated that she was a certified professional coder. She said she reviewed all of her husband's insurance claim forms and she saw that Dr. DiNucci had billed for code 27829 but did not use the proper ICD-9 code for syndesmosis. Dr. DiNucci's initial diagnosis code was 824.2 which is for a fracture of ankle, lateral malleolus, closed. Another diagnosis code used was 729.5 which is for other disorders of soft tissue with pain in the limb. And the last code used was 719.7 which is for other unspecified disorders of joint pain of the ankle and foot. Ms. Miles asked B.P. to confirm if the concern is that the patient did not have a syndesmosis and that part of the evidence of that was that there was no diagnosis code submitted for that condition. B.P. said that the CPT code was correct but the ICD-9 code was not. She also offered to the Board members a copy of a disability determination letter for her husband.

The patient stated he also wanted to address what he felt were inaccurate statements in the record-keeping. He stated that on Dr. DiNucci's initial assessment, Dr. DiNucci stated, "the patient relates he was home sitting on his computer." However the notes from the patient's primary care physician indicate that he was sitting in his lazy boy chair which was accurate. He had fallen asleep and then got up when he heard his dogs barking, but his left leg was asleep from the knee down. He read from Dr. DiNucci's notes from his chart, "I had a long discussion with the patient and his wife and fully informed them about the nature of the fracture and the concomitant syndesmosis rupture which occurs in 10 to 15% of distal fibula fractures." The patient then repeated his previous comments about being a mathematician and if there were an 85% chance that he did not have a specific condition he wanted the doctor to prove to him that he actually did have that condition. The patient continued his review of his chart from Dr. DiNucci's office and stated that on September 16 on the "pre-op study" the plan portion of that document states the patient would like to have surgery to correct the fracture. The patient stated again that he had never heard the term syndesmosis at that time and stated that an MRI would have shown the location of those nerves. Dr. Dillon had told him that if he had had an MRI he would have known exactly where to look for the nerves. Dr. Dillon also told him that his superficial peroneal nerve was located in the lateral compartment and there would have been no screws placed in that compartment if he had not been treated for syndesmosis.

The patient continued and stated that on his primary care physician's notes from September 14, 2009, which was his pre-operative examination, the doctor stated in large bold letters that the patient was allergic to codeine. At the age of eight he was bitten by a copperhead snake, he was given codeine, and subsequently he had an allergic reaction which caused him to have the hiccups for four days. However, Dr. DiNucci prescribed Percocet which has codeine in it which caused the patient to have hiccups for 8 1/2 days after surgery. Dr. Leonetti asked the patient about when he filled out his intake paperwork for Dr. DiNucci and whether he is listed an allergy to codeine on that paperwork. The patient's wife explained that on the day they saw Dr. DiNucci for the first time it was a very busy day. They were called back into the exam room while her husband was still filling out the paperwork so she completed it for him and assumed that he had already listed his allergy to codeine. The patient acknowledged that leaving that information out was his fault but also stated that Dr. DiNucci signed a piece of paper stating that he compared his history with the history that the patient gave to the surgical center. Apparently Dr. DiNucci stated that the histories were identical; however, the patient states he did list his allergy to codeine on the paperwork for the surgical center.

Dr. Leonetti asked the patient if he had ever taken hydrocodone. The patient stated that he had but asserted that the codeine and hydrocodone is a synthetic codeine and he has to take it very sparingly or it causes him to itch. Dr. Leonetti pointed out that Percocet has synthetic codeine as well. Dr. Leonetti added that when Dr. DiNucci conducted the patient's preoperative examination the day before the surgery he gave the patient the prescription for Percocet. The patient agreed. Dr. Leonetti then asked if, when the patient went to the pharmacy to fill the prescription, he was told that Percocet contains codeine. The patient's wife stated that she was the one who filled the prescription at the pharmacy. Dr.

Leonetti asked if the pharmacist reviewed the medication with her and she stated he did not. The patient's wife stated this was just a mix up but added that the primary care physician did indicate that the patient was allergic to codeine. The patient continued reading from Dr. DiNucci's records which states, "The patient has been seen by his primary care physician and has been cleared medically for surgery." The patient states that if Dr. DiNucci had read the primary care physicians report then he would have known that he is allergic to codeine.

Dr. Leonetti stated that if he had a patient who was allergic to codeine but could take hydrocodone, they may be able to tolerate Percocet. The patient stated that he has never been able to tolerate Percocet and Dr. Leonetti asked him if he had ever taken it before. The patient stated he taken it once. Dr. Leonetti asked the patient why he would accept a prescription for that medication if he had a problem with it. The patient stated that he did not know that Percocet was codeine. Dr. Leonetti pointed out that the patient had a problem specifically with Percocet previously and asked him why he would take it again. The patient's wife stated that as a layperson, when you go to the doctor, you depend on the physician to help you out. When she took the prescription to the pharmacy she had no reason to question Dr. DiNucci about anything. Dr. Kaplan asked the patient if, when the prescription bottle was brought home, he looked at the information that was contained on the label. The patient stated he was very groggy and never saw the prescription bottle; his wife gave him the medication to take. Dr. Kaplan asked the patient's wife if she had looked at the label at least to find out the dosage and the instructions for taking the medicine and, if so, did she see the wording on the label regarding what type of medication it was. Dr. Leonetti asked if it said Percocet or oxycodone or something that might indicate he would have a problem taking it. The patient's wife stated that it was her fault. Dr. Leonetti added that the prescription was given to the patient at the time of the pre-op consult and the prescription specifically stated Percocet. He added that if he were a patient who has a problem with Percocet, and the doctor gave him a prescription for Percocet, he would tell the doctor that he could not take it. The patient stated that Dr. DiNucci gave the prescription to his wife and that he never saw it. Dr. Kaplan stated that his wife did see the prescription and she was aware that he had a problem with Percocet. The patient stated that his wife knows he is allergic to codeine but did not know that there was codeine in Percocet. He added that he was not married to his wife at the time he had the problem with Percocet and the specific topic was never discussed between them regarding Percocet, only that he has an allergy to codeine. Dr. Kaplan asked the patient if he knew whether Dr. DiNucci wrote the prescription for generic Percocet. The Board members then reviewed the prescription and Dr. DiNucci's signature on the prescription form indicates that generic medication is permissible. Dr. Kaplan stated that the prescription bottle would have said oxycodone which has codeine in it. The patient advised the Board members that oxycodone is an opium derivative. Dr. Leonetti stated that hydrocodone is as well. The patient stated again that hydrocodone contains a synthetic form of codeine. Dr. Kaplan asked the patient if this particular point in his complaint against Dr. DiNucci is that he took a medication that he thought he was allergic to but didn't realize the reaction he would have to it. The patient stated it was a portion of his complaint but not the most important part. He added that he had only taken three tablets when he realized he had the hiccups and was having a reaction to the medication. Dr. Kaplan asked the patient if he had discussed the situation with Dr. DiNucci. The patient's wife stated that she contacted Dr. DiNucci's office and told them that her husband needed a different medication and that he was having hiccups. The patient required three additional medications to stop the hiccups.

Dr. Campbell asked the patient's wife to repeat the code that she had mentioned earlier. The patient's wife provided copies of her husband's billing records. Dr. Campbell reviewed the ICD-9 and CPT code books and compared them with the codes on the patient's records. Ms. Miles asked the patient to clarify what his concern was about the diagnosis of a syndesmosis; i.e. was he concerned that he was misdiagnosed, or that he did not give an MRI from Dr. DiNucci? She also asked if the patient felt the surgery was inappropriate. The patient's wife stated that her husband required additional surgery to correct the procedure that Dr. DiNucci performed. The patient stated again that Dr. Dillon told him the nerves would have been seen on MRI. The patient's wife stated that he was born with his nerve in an improper place within the foot. The patient stated that Dr. Zang told him he is one person in a million that has the superficial peroneal nerve in the lateral compartment and told him that an MRI would have shown the location of the nerve. Dr. Zang apparently also told the patient that the MRI would affect his treatment plan including any surgical correction of a syndesmosis if it were present. Ms. Miles stated that she was slightly confused because all of the consent forms that the patient signed indicated that the

procedure to be done was a repair of a left ankle syndesmosis. The patient stated again that he had never heard the word syndesmosis and he does not recall signing any piece of paper which had that word on it. Dr. Kaplan and Ms. Miles reviewed the surgical consent forms submitted from Dr. DiNucci's office all of which state syndesmosis. The patient's wife stated that they never saw that form. Dr. Kaplan pointed out that the patient did sign the form. The patient's wife stated that Dr. DiNucci has said the patient signed it but when they asked Dr. DiNucci for a copy of his chart it was not included. Ms. Miles provided a copy of the consent form to the patient and his wife and reviewed the document with them. Dr. Kaplan asked whose initials were on each of the items on the consent form and the patient stated he did not initial form. Upon further questioning from Ms. Miles, the patient stated that he did initial and sign the form, but then added that he would never have given Dr. DiNucci authorization regarding the disposal of any soft tissue parts. After additional brief discussion the patient stated that he does not believe he ever actually read the document. The patient's wife said the handwriting on the document did not appear to be her husband's handwriting and the patient agreed stating he does not believe he signed the form. The patient said he saw numerous discrepancies in the initials on the form and the signature. Dr. Kaplan asked the patient if he meant that he never signed any consent form whatsoever. The patient stated he does not recall ever seeing these forms and that the signature looks like he was drugged at the time. Ms. Miles pointed out that the date on this form from Dr. DiNucci was the day before his surgery so he would not have been drugged at the time that he signed it. The patient reiterated that he does not think the initials or signature on the form look like his handwriting. The patient's wife then said that she believes it is his handwriting. Patient stated he may have signed the document but he feels that it's possible all of the initial boxes were blank when he did so.

Ms. Campbell addressed the Board and stated that it seems as though the patient and his wife appear to have provided all of their information and were now reviewing statements already made. She suggested that the Board hear from Dr. DiNucci and then speak with the patient again if necessary. Dr. Kaplan stated that he had one additional question for the patient. Dr. Leonetti showed the patient a document from his chart from Dr. DiNucci which is a picture illustration of the foot anatomy which shows the intended location of the surgical incision and other details, and asked the patient if he had signed that form. The patient stated he had never seen that form and did not sign it; his wife stated she does not recall ever seeing that form. Both the patient and his wife said that if he did sign the form it would have been covered up so that they didn't see the substance of the language on the form; therefore, they did not know what he was signing.

Dr. DiNucci then addressed the Board with his attorney Mr. Crawford. Dr. Kaplan asked Dr. DiNucci if he had records from Desert Ridge Surgical Facility which is where this procedure was performed. Dr. DiNucci said he did not, but the patient would have signed a consent form at that facility. Dr. DiNucci added that the only document he would retrieve from the surgical center is the dictated operative report, and the surgical center did not ask him for a copy of the consent form signed in his office. Dr. Kaplan asked Dr. DiNucci if he would be able to obtain that consent form from the surgical center and provided to the board. Mr. Crawford stated that would not be possible because Dr. DiNucci does not have the right under HIPAA laws to obtain it. Ms. Penttinen stated that she could obtain the form by issuing a subpoena directly to the surgical facility. Mr. Crawford advised the Board members that the patient has filed a malpractice lawsuit against Dr. DiNucci regarding this incident, therefore neither he nor Dr. DiNucci want to come in front of the Board again if the patient filed a complaint for a HIPAA violation. He also stated that he has asked the patient for copies of all his medical records which he is required to provide under the law, however the patient has not done so yet. If the patient provides Mr. Crawford with a copy of that form he would be happy to forward it to the Board that he does not have it at this time.

Dr. DiNucci addressed the Board as follows: he heard the patient's statements before the Board and understands the complaint. He believes the pre-operative care and evaluation, the surgical procedure, and the post-operative care are all very well documented. As Dr. Leonetti had previously pointed out, the pre-operative x-rays show that the patient did have a syndesmosis rupture. With regard to the treatment, he informed the patient, as a matter of standard procedure, that 15 to 20% of this type of ankle fracture do have a tear of the syndesmosis. With regard to the consent form, he completes an in-office consent form with all of his patients and they initial every line of the form and sign the back. Completion of the form is witnessed by his nurse and he countersigns it. Additionally he utilizes diagrams with every surgical procedure, whether it is a soft tissue or bone procedure, and he shows the patient where

hardware is or will be placed. Regarding the outcome of this patient's surgery, he believes the patient feels that the aberrant nature of his nerve would have been visualized on MRI which is incorrect. It is a very small nerve and with the amount of trauma the patient had it would not be visualized on MRI. Dr. DiNucci stated he knows Dr. Dillon personally and knows that he is a hand surgeon, not a foot and ankle surgeon. Dr. Dillon performs peripheral nerve surgery and Dr. DiNucci has trained with him. However, to tell a patient that they must have an MRI to diagnose a syndesmosis rupture is incorrect. Additionally, the location of the incision on this patient and placement of hardware was not near the superficial peroneal nerve; it was posterior to the midline of the fibula, which does not violate the lateral compartment. Lastly, not fixing a syndesmosis rupture would have led to multiple other problems for the patient including post-traumatic arthrosis. Dr. DiNucci said he never knew of any complaint from the patient regarding his ankle function, his fracture, or arthritis of the ankle; it was solely a nerve issue. Dr. DiNucci stated that Dr. Dillon's report indicates the patient sustained a traction nerve injury. The patient chose to have surgery with Dr. Dillon and not another physician who was in his insurance network. Mr. Crawford offered a final comment and stated that he has appeared before the Board for cases which involved doctors who did not diagnose a syndesmosis injury and the Board disciplined those doctors.

Dr. Leonetti stated that based upon his review of the pre-operative x-rays there is no question in his mind that the patient had a syndesmosis rupture, and he commended Dr. DiNucci for repairing it. He added that even if Dr. DiNucci had not diagnosed the syndesmosis, he certainly would have seen it intra-operatively and would have corrected it at that time. Dr. Leonetti feels that Dr. DiNucci met the standard of care by correcting the syndesmosis rupture. Dr. Leonetti noted for the record that the physician investigator assigned to this case submitted his findings in the investigative report and indicated that he found no violations. Dr. Leonetti then stated that upon review of Dr. DiNucci's records, as well as Dr. Zang's records, he does not see any mention of any nerve pain or burning sensation until after the surgery performed by Dr. Galle. Dr. Leonetti asked Dr. DiNucci if he thought that the nerve injury was a traction injury at the time of the original injury which for some reason was not diagnosed because of other pain, or if there was a possibility of some other nerve damage sustained during the second procedure. Dr. DiNucci stated that he has not seen any of Dr. Zang's records for this patient so he cannot comment. He added that at the time the patient left his office he was immobilized in a posterior splint and had been non-weight-bearing. His exam was completely consistent with a post-traumatic ankle fracture repair; there was no nerve issue that he was aware of when the patient left his care which was approximately 6 weeks post-operative. Dr. DiNucci stated that the patient never complained to him about nerve problems and he was surprised to see this development in the patient's foot. Dr. DiNucci declined to make any assumptions regarding how the nerve issues developed or any problems the patient encountered as a after leaving his care.

Dr. Leonetti then asked Dr. DiNucci about the prescription given to the patient for Percocet. He stated that in Dr. DiNucci's records he does not see anything listed indicating that the patient disclosed that he had an allergy to codeine; therefore to him it would be safe to assume the patient does not have any problems with that type of medication. He believes that if a patient did have a problem with that medication they would tell him at the time they were given the prescription. He asked Dr. DiNucci if, at the time he wrote the prescription for Percocet, he had any knowledge that the patient had an allergy to codeine or its derivatives. Dr. DiNucci asked to clarify first that the patient had earlier stated that he, (Dr. DiNucci), had indicated in his notes that he had reviewed the patient's primary care physicians notes which indicated the patient had an allergy to codeine. Dr. DiNucci stated that the primary care physician's notes also indicated that the patient was on hydrocodone, so as a physician he recognizes that a patient may have an allergy to pure codeine but may have only an intolerance to the synthetic derivatives. He added that if a patient is taking hydrocodone they can likely take Percocet as well. There is a distinction between a true drug allergy versus a drug intolerance; the patient has an intolerance to Percocet which gives him an abnormal reaction but it is not a true allergy.

Dr. DiNucci continued and stated that when he goes over all of the pre-operative paperwork with the patient he gives them their prescription at that time and explains what the prescription is. He said he did so in this case and neither the patient nor his wife expressed any concerns about the prescription. The patient's intake form did not state that he had any problems with codeine. He added that there can be many barriers with regard to communication about patient's drug allergies and intolerances which include the information that the patient provides to the physician, the pharmacy that fills the prescription if the

patient has a known allergy, and the patient also recognizing what medication they are consuming once a prescription has been filled. Unfortunately in this case those barriers were not sufficient due in pertinent part to the information that he received from the patient. Dr. Kaplan stated that he felt Dr. DiNucci did a very good job with this patient, but he would like to pursue obtaining a copy of the consent form from the surgical facility. Dr. Leonetti stated that he performs surgery at Desert Ridge Surgical Center on a regular basis and can confirm that patients at that facility are never brought back into the operating room without having to consent form signed. Dr. Kaplan agreed but the patient is questioning whether or not he ever signed a form at that facility in this particular case. Dr. Leonetti stated that he could only speak from his own experience as a surgeon at that facility, but patients do not leave the pre-op area until they have signed the consent form and having it initialed by the physician and the admitting nurse. Dr. Leonetti stated that he questions the patient's memory because he clearly signed a consent form for Dr. DiNucci. Dr. Leonetti concluded that he feels the patient's fracture was properly diagnosed as well as the syndesmosis, the surgical repair performed by Dr. DiNucci was appropriate, and he does not find any violations in this case. With regard to the issue of Percocet, the patient had previously been on hydrocodone and did not list codeine as one of his allergies on his paperwork with Dr. DiNucci, therefore it was a reasonable mistake. He questions some of the things that Dr. Dillon is reported to have said regarding the need for an MRI.

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

**DISCUSSION:** Ms. Miles stated that she reviewed five different documents which contain the patient signature, and she does not find the writing style of the patient's last name to be consistent among any two of those signatures; each one is different. Therefore, she feels that it is more of an issue of the patient's memory regarding whether or not he signed the consent form rather than it being a fabrication. Dr. Campbell spoke briefly about the diagnosis and billing codes used by Dr. DiNucci. She reviewed the ICD-9 and CPT code books and there is no listing as a diagnosis specifically for a syndesmosis. That is likely why Dr. DiNucci chose a code of 718.87 showing an instability of the joint which occurred with the syndesmosis rupture. She also looked under the heading of "rupture" and there is no specific code for a syndesmosis rupture. She feels Dr. DiNucci use the appropriate codes. There was no further discussion.

**VOTE:** The motion passed unanimously by voice vote.

Following the Board's vote in this matter, Dr. Kaplan confirmed for Ms. Penttinen that the consent form from the surgical center was no longer needed. The Board then went into recess from 9:48 AM until 9:55 AM. During that recess the patient and his wife attempted to review and discuss the details of this case with the Board members. They were advised by Ms. Campbell that the matter had been concluded and there could be no further discussion about the case.

c. 11-02-C – Heather Couch, DPM: Any conduct or practice which is or might be harmful to patient health or safety due to staff's lack of familiarity with Dr. Couch's insurance contracts.

Dr. Couch was not present. Ms. Penttinen was the investigator on this case and summarized the complaint as follows: a complaint against Dr. Couch was received from patient J.W. The complainant stated that she made an appointment with Dr. Couch for an unspecified problem with her feet. At the time she made the appointment she asked Dr. Couch's staff if Dr. Couch accepted her insurance plan which was Banner Select. She was told that Dr. Couch was contracted with Banner Select; however, the patient did not have her insurance card with her at the time of the call so she was not able to provide Dr. Couch is staffed with her specific group or plan number or her ID number. (It is noted that the exact date of the patient's appointment could not be determined as the patient did not recall the specific details; the patient believes it was around the same date of her complaint submitted to the Board which is January 13, 2011.)

The day before the patient's appointment she received a reminder call from Dr. Couch's office staff. At that time she again asked the office staff if Dr. Couch were contracted with Banner Select and was told that she was. However, when the patient arrived at Dr. Couch's office for her appointment and presented her insurance card she was told that Dr. Couch is not contracted with that particular Banner Select

insurance plan. The essence of the patient's complaints is that she feels Dr. Couch should be required to ensure that her staff understands exactly which insurance plans she is and is not contracted with at all times in order to avoid patients being confused. The patient stated she has difficulty with transportation and that arriving for the appointment and then not being seen caused her great inconvenience. Ms. Penttinen stated that when she spoke with the patient by phone about her complaint the patient stated that the problem she was having with her foot was what she called a minor growth on one of her toes. The patient subsequently was seen by a different podiatrist and was able to completely resolve this problem simply by changing her shoe gear. The patient stated that she was not having any type of acute problem which required immediate attention on the date of her appointment with Dr. Couch.

In her written response to the complaint Dr. Couch did confirm that there was some confusion with regard to this patient's insurance coverage. Part of that confusion was due to the fact that the patient did not have her insurance card with her at the time she made the appointment therefore she was not able to provide Dr. Couch's office staff with her specific group or policy number or her ID number. Dr. Couch said she offered to treat the patient that day and bill the insurance, and if the insurance denied the claim then she would send the bill to the patient. However, the patient declined to be seen on that date.

Ms. Penttinen stated that this was an unfortunate situation for the patient which caused her some inconvenience. However, the patient was not in any acute distress at the time and did not suffer any injury by not being seen by Dr. Couch on the date in question. Ms. Penttinen states she does not find any violations in this matter. Dr. Leonetti agreed and stated that this was simply a misunderstanding about insurance coverage. He added that this type of situation occurs every day in almost every medical practice. Dr. Leonetti added that he sympathizes with the patient due to her difficulties with transportation, but it can be very difficult for most physicians to keep track of exactly which insurance plans they are contracted with any particular time. He feels it was appropriate for Dr. Couch to offer to see the patient at that time with the possibility that the patient would need to pay out-of-pocket; Dr. Couch did not refuse to treat the patient. Dr. Kaplan agreed with Dr. Leonetti's comments. Dr. Campbell added that she sees this type of situation in her office on a regular basis; however, she feels that it is ultimately the patient's responsibility to make sure that they have their insurance information available to provide to their doctor or the doctor's staff.

**MOTION:** Dr. Leonetti moved to dismiss this complaint finding no violations. Dr. Kaplan seconded the motion.

**DISCUSSION:** There was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote.

- 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. (Tabled from February 8, 2012 agenda – update only.)

Dr. Tallis was not present. Patient C.B. was present but did not address the Board during the time that this case was reviewed. Dr. Kaplan reviewed the allegations in this case. Ms. Penttinen reviewed that during the February 8, 2012 Board meeting the Board members had requested that she go to Dr. Tallis's office to obtain a copy of the lunch receipt in question, a copy of any documentation of the reimbursement of the patient's co-pays, all x-rays for the patient, to obtain the original version of the two paragraph document which was the subject of lengthy discussion during the last meeting, and to speak with the office manager Elizabeth. Ms. Penttinen explains that the office manager Elizabeth who was working with Dr. Tallis at the time that he submitted his response to the complaint is no longer working in that office. The current office manager told Ms. Penttinen that they do not have any contact information for Elizabeth whatsoever. In a subsequent telephone call with Ms. Penttinen, Dr. Tallis confirmed that he does not have any contact information for Elizabeth. Ms. Penttinen said she was able to obtain an address for Elizabeth using other investigative tools and has sent her a letter asking her to contact the Board's office to discuss this investigation case.

Ms. Penttinen advised that Dr. Tallis does not have any documentation or receipt for the lunch in question. Dr. Tallis also told her that he provided his original x-rays for the patient to Dr. Schulman. Ms.

Penttinen contacted Dr. Schulman's office and was advised that they do not have any x-rays at all from Dr. Tallis but they do have their own x-rays. Dr. Schulman's staff advised Ms. Penttinen yesterday that those x-rays have been copied and are ready to be picked up. Ms. Penttinen will obtain them and forward them to the physician investigator in this case. With regard to the two paragraph document in question, Ms. Penttinen advised that Dr. Tallis states there is no original for that document. In her direct review of the patient's chart at Dr. Tallis's office, Ms. Penttinen was only able to find copies of that document; the original document cannot be located. Dr. Leonetti asked Ms. Penttinen to confirm the information that Dr. Tallis had provided regarding sending his original x-rays to Dr. Schulman and whether there was any documentation in the patient's file to show an authorization to release records. Ms. Penttinen confirmed that Dr. Tallis did state he provided his original x-rays to Dr. Schulman, but she did not recall seeing an authorization to release records in the patient's chart. Ms. Penttinen said she had not specifically looked for that documentation in the patient's chart at the time she was a Dr. Tallis's office, but if there was such a form it should be it within the patient's chart submitted by Dr. Tallis to the Board. Ms. Penttinen added that she asked Dr. Tallis why he gave his original films to Dr. Schulman and that Dr. Tallis stated it was just easier that way.

Dr. Leonetti also asked about the original of the two-page document in question and Ms. Penttinen stated that Dr. Tallis does not have the original and did not have any explanation as to where the original might be located. Dr. Leonetti asked Ms. Penttinen to confirm whether the document was signed and submitted by the patient or if Dr. Tallis had produced the document. Ms. Penttinen explained that this was a document submitted by Dr. Tallis with his supplemental response to the third allegation, but it is unknown exactly where this document originated because the original cannot be located. Dr. Tallis told Ms. Penttinen that the document was provided by the patient to his former office manager Elizabeth. Dr. Kaplan stated that his confusion regarding this document arose during the last Board meeting when the patient initially stated that she did write the document and sign it, but then later in the meeting she stated that she did not write the document or sign it. He added that if the patient were to send a letter to a physician it is likely that they would keep a copy of that document; however, the patient states that she does not have a copy of this document. Dr. Kaplan stated he questions whether the document is correct based on the patient's previous testimony before the Board. He added that the patient changing her mind as to whether or not she had written the document places this matter into a "he said – she said" situation. For that reason he does not place much faith in the document at this point because it does not say very much about anything substantially related to the allegations in this case. Dr. Kaplan also spoke about the \$200.00 which Dr. Tallis claims he reimbursed to the patient. There is no record of any reimbursement and the patient denies ever receiving that money. The Board has no authority to require a physician to reimburse the patient's co-pays.

Dr. Leonetti agreed with Dr. Kaplan statements and added that the one person, (Elizabeth), who was supposedly involved with this interaction with the patient is no longer employed at that office and cannot be contacted to confirm or deny whether or not the lunch occurred or if the money was actually refunded to the patient. Without Elizabeth's testimony or statement from her, Dr. Leonetti believes that this issue is at an impasse as far as whether those events actually occurred.

Dr. Kaplan then reviewed the first allegation in this case which was practice below the standard of care due to multiple invasive procedures on the patient's toe which required additional surgery to correct. The physician investigator previously concluded in his investigative report that there was no deviation from the standard of care by Dr. Tallis and no violations. Dr. Leonetti agreed and stated that, although the outcome of the patient's foot condition was not optimal, he believes that is a known risk of performing the type of procedure that Dr. Tallis performed on this patient. He added that the patient was properly consented which means that she was aware of the potential complications of surgical procedures. Dr. Kaplan then addressed the second and third allegations in this case which were improper billing for in-office procedures and associated medical supplies, and alleged harassment of the patient. Dr. Kaplan stated that he does not see any evidence of harassment by Dr. Tallis or his staff against the patient. The fact that Dr. Tallis called the patient does not necessarily constitute harassment. With regard to the billing, it appears that Dr. Tallis made an error with inverting two numbers within the billing code which could be an honest mistake and Dr. Tallis has since corrected the billing with the patient's insurance company.

Ms. Miles asked the physician Board members to confirm that they did not find any issue or violations regarding the medical care provided by Dr. Tallis to the patient. Each of the physician members agreed that they found no violations in that regard. Dr. Leonetti stated that he was not happy with the outcome of the surgical procedures performed on the patient but he does not feel that it rises to the level of violation. Ms. Miles stated that she sees another issue in this case which is Dr. Tallis's management of his patient relationships. She feels that there was a breakdown in that relationship regarding this patient which is likely what caused the patient to believe that she was being harassed by Dr. Tallis. However, Ms. Miles does not believe that the events in this matter rise to the level of a violation regarding unprofessional conduct. She added that the patient was unhappy but it is unclear exactly what happened regarding the alleged lunch at the Mexican food restaurant and refund of the patient's co-pays; however, she does not find any evidence of a violation in this regard. Dr. Leonetti added that if there were someone else who could verify the information this case one way or the other, the Board would have better information to determine exactly what happened. However, with the information available to the Board at this time, he does not find that there have been any violations.

**MOTION:** Dr. Leonetti 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.

Following the conclusion of this case the Board members confirmed for Ms. Penttinen that the x-rays from Dr. Schulman are no longer needed.

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

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

Ms. Penttinen advised the Board members that the last progress report from Dr. Sucher was received in February. That report indicated that Dr. Shapiro was no longer participating in any monitoring activities. If Dr. Shapiro resumes monitoring with Dr. Sucher the next progress report would be received in the month of May 2012.

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

Dr. Kaplan reviewed the report submitted by Dr. Bui dated March 12, 2012 which indicates that he had no charts or records to submit for any durable medical equipment during the month of February 2012.

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

Ms. Penttinen advised that the most recent progress report from Dr. Sucher was received in February 2012. The next progress report is due in May 2012. Ms. Penttinen also advised that she followed up with Dr. Brown regarding the medication information that the Board members had requested during the February Board meeting. Dr. Brown has provided an e-mail containing a list of all of his current medications which was provided to the Board members this morning. Attached to that e-mail Ms. Penttinen formulated a list of the medications and what the medications are used for. The Board members did not have any questions regarding information provided by Dr. Brown.

**VI. Review, Discussion and Possible Action on Administrative Matters**

a. CME approval request from Alan Carlson, DPM for ACLES seminar.

The Board members reviewed the CME request submitted by Dr. Carlson which is for a seminar sponsored by the American College of Lower Extremity Surgeons. The seminar is a 40-hour program in lower extremity medicine and surgery. Dr. Leonetti and said he thought this was a very appropriate course for podiatry CME.

**MOTION:** Ms. Miles moved to approve the CME course for Dr. Carlson. Dr. Kaplan seconded the motion.

**DISCUSSION:** That there was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote.

b. CME approval request from Ronald Killian, DPM for hyperbaric medicine and wound management.

The Board members reviewed the CME request submitted by Dr. Killian which is for a seminar sponsored by Diversified Clinical Services for hyperbaric medicine and problem wound management which was completed in August of 2011. The total number of hours of CME for this seminar is 42.5 hours.

**MOTION:** Ms. Miles moved to approve the CME course for Dr. Killian 25 hours. Dr. Leonetti seconded the motion.

**DISCUSSION:** There was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote.

c. Review of new license applications:

- i. Peter Bregman, DPM
- ii. Tara Shirley, DPM.

The Board members reviewed the license application files for Dr. Bregman and Dr. Shirley. The Board members determined that the applications are administratively complete and did not have any questions for the substantive review.

**MOTION:** Dr. Kaplan moved to approve the license applications for Dr. Bregman and Dr. Shirley to allow them 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.

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

a. Open complaint status report.

Ms. Penttinen advised that she had forgotten to run the open complaint status report prior to the Board meeting. She advised that she has opened four new complaint investigations in the last month. One case was based on a malpractice report that the board reviewed at the February Board meeting. The remaining three cases are complaints which were filed by patients. Ms. Penttinen stated she believes the total number of open complaint at this time is approximately 61 to 62 cases.

b. Review of AZ State Bar seminar on February 10, 2012 entitled "Healthcare Professionals and Their Licensing Boards."

Ms. Penttinen reviewed with the Board members the information that was obtained in the Arizona State Bar seminar. The seminar was intended to give information to attorneys who represent healthcare professionals before their regulatory boards. There was a large booklet provided to each person who attended the seminar. Most of the booklet contained copies of disciplinary agreements between regulatory boards and their licensees involving substance abuse issues. Ms. Penttinen explained that a majority of the discussion during the seminar related to healthcare professionals who have substance abuse problems and how each different healthcare regulatory board addresses those problems. The seminar was geared directly towards attorneys and most of the information provided was information with which Ms. Penttinen was already familiar; however, Ms. Penttinen found this seminar to be very beneficial and informative.

c. Malpractice case report. (None at this time.)

Dr. Kaplan reviewed and Ms. Penttinen confirmed that there have been no malpractice case reports received within the last month.

## **VIII. Call To The Public**

C.B., who was the patient in case number 11-06-C, was present. She did not address the Board during the time that this case was reviewed today, but asked to do so during the Call to the Public. C.B. stated the following: she is amazed that certain things were stated during the Board's review. One of those things was that the Board could not assist the patient with getting her money back from Dr. Tallis because she never asked the Board to do so. She had only mentioned the issue about her co-pays in her complaint to try to demonstrate to the Board that Dr. Tallis was engaged in fraud. She is also surprised that her records were kept longer than necessary but that the Board is not going to punish Dr. Tallis for that. She is also surprised

that the Board was not able to obtain the original documents which Dr. Tallis stated he had. All of a sudden Dr. Tallis's staff is gone and this is apparently a management problem but she is "not buying it." She does not believe this case was handled properly and this has been going on for two years. Once Dr. Tallis found out that she filed a complaint with the Board his behavior towards her became worse. Dr. Tallis stated he had fired two members of his staff when he found that they were stealing money, and another employee (the previous office manager), has now vanished and there is no record of her. But yet there was so-called evidence to bring this up before the Board. She does not appreciate the way her complaint was handled. She never asked to get her money back. Her insurance company is aware of the billing problems she had with Dr. Tallis. She learned in the Board's discussion earlier that the Board did not receive her x-rays but made a judgment call about it based on the opinions of Dr. Tallis and the Board members that she would need additional surgery on her toe. That is not true; her issue was with the way it was handled at the time she had the procedure done with Dr. Tallis. She is surprised because Dr. Tallis has a history of "doing this." Now all of the evidence has vanished and she thinks that should raise a red flag. After all of Dr. Tallis's effort to get out of this complaint she was surprised about how this whole situation was handled. She asked her records to be redacted but they weren't. The board members did not respond to C.B.'s comments.

**IX. Next Board Meeting Date:**

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

**X. Adjournment**

**MOTION:** There being no other business before the Board, Dr. Kaplan moved to adjourn the meeting. Ms. Miles seconded the motion.

**DISCUSSION:** There was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote, and the Board meeting adjourned at 10:10 AM.