



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

September 12, 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: Anne Froedge

I. Call to Order

Dr. Kaplan called the meeting to order at 8:38 a.m.

II. Roll Call

Dr. Kaplan noted for the record that all Board members were present as were Ms. Penttinen and Ms. Froedge.

III. Approval of Minutes

a. July 11, 2012 Regular Session Minutes.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. August 8, 2012 Executive Session Minutes.

It was noted that the agenda contained an error for this item. It should have read "August 8 Regular Session Minutes" as there were no Executive Session minutes for the August meeting. The August Regular Session minutes will be reviewed at the October 2012 board meeting.

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

a. 09-20-C – Kevin O'Brien, DPM: Practice below the standard of care performing improper and unnecessary surgeries; failing to obtain written informed consent from the patient.

Dr. O'Brien was present. Dr. Leonetti recused himself as he was the physician investigator for this case. Dr. Leonetti summarized the complaint as follows: The Board received a complaint against Dr. O'Brien from patient C.D. The Board also received a letter of complaint against Dr. O'Brien from Dr. James Wilson, a subsequent treating podiatrist. The patient complained she underwent two surgeries on both feet to correct bunions and hammertoes and now she is in more pain than before the first surgery and she is going to need to have more surgeries in the future. She has been to two other podiatrists that concur that she needs more surgery and that the first two surgical procedures on both feet have failed. She claims Dr. O'Brien did not remove the bunions completely the first time and then went in and removed too much bone and has permanently damaged her foot. She claims she will never walk normally again. Dr. Wilson alleges that there was no need to perform a subtalar joint implant bilaterally and the notes and radiographs do not support that procedure.

Dr. Leonetti continued with a review of the patient's medical records as follows: the patient's first office visit with Dr. O'Brien was in March of 2006 where she complained of heel pain. X-rays were taken and treatment of the heel was provided. There was no mention of bunions, hammertoes, or flat feet. In November of 2007 the patient returned complaining of a bunion on the right foot and hammertoes of the left second and fourth and fifth toes. It is noted that the patient's third left toe been removed from a previous accident. On April 22, 2008 the patient returned for pre-operative consult. She signed a surgical consent form for a bilateral bunionectomy, hammertoe correction of the left second and fourth and fifth toes, and hammertoe correction of the right fifth toe. Surgery was done on April 24 and the patient returned to the office on April 26 complaining that she bumped her right foot and was afraid that she had moved the pins. It is noted that the patient did not have any pins in her right foot. X-rays were taken and all findings were within the normal postoperative course. On April 29 patient returned to the office complaining of redness over the left second toe incision. She was given a prescription for Keflex. On May 28th sutures were removed, x-rays were taken, and the patient was given a prescription for Vicodin.

Dr. Leonetti continued with his review the medical records as follows: the patient returned to the office on June 20, 2008 and Dr. O'Brien discussed with her the Silver Bunionectomy procedure which was used to correct her bunions. The patient was not happy with the position of the first toes. She was given a night splints to help hold the toes and the straight position. On July 15 Dr. O'Brien noted over pronation and provided the patient with over-the-counter insoles. This is the first mention in the patient's chart of any flattening of the foot. There was also mention in the notes of subtalar implants if the orthotics fail. There was no mention of orthotics prior to this date. On August 12 the patient was having pain in the second left toe, bilateral bunion pain, and complaints that her big toes were not straight. The patient was also having pain in the first MPJ which she did not have prior to her surgery. On October 24 the patient returned to the office complaining of continued pain. Dr. O'Brien discussed with the patient surgery on the bunions and the second MPJ. There was no mention of subtalar implants for the second surgery. On December 23 the patient had a pre-operative consult for hammertoe surgery of the left second and third toes, bunionectomies, and subtalar implant bilaterally. (It is noted that the patient does not have a third toe on the left foot.) The patient signed a consent form for hammertoe correction of the second and third toes of the left foot, bunionectomies, and subtalar joint implant bilaterally. On a foot diagram in the patient's chart the areas circled included the first M PJ bilaterally and second left toe. There were no markings on the diagram for the third or fourth toe on the left foot and no markings for the location of the subtalar implants. The patient underwent surgery on February 12, 2009 on both feet.

Dr. Leonetti continued: the patient had a postoperative visit on February 16, 2009. At that time Dr. O'Brien noted that he removed too much bone from the head of the first metatarsal of the right foot. All plates and alignment of osteotomies appeared to be in good position. On February 23 the patient was complaining of severe pain, and on March 2 all pins were removed and the patient was given a prescription for physical therapy on both feet. On March 10 sutures were removed and the patient was complaining of pain and burning in the feet. The patient also stated that her toes are shifting back out of the corrected position. She was given prescriptions for Percocet and Keflex. On April 8 the patient was still complaining of pain in the feet. At that time Dr. O'Brien recommended removal of the hardware, (which Dr. Leonetti assumed means the subtalar implants), and extensor tendon release at the second toe of the left foot. This was the last recorded visit Dr. O'Brien's office.

Dr. Leonetti then reviewed medical records submitted by Dr. James Wilson for this patient. Patient was seen on April 10, 2009 complaining of painful and stiff toes. X-rays taken on that date of both feet note that the inter-metatarsal angle appears to be increased from the pre-operative position. He noted that he would like to review the first set of pre-operative x-rays. Dr. Wilson also questioned the need for subtalar joint implant in this patient. Dr. Wilson recommended that the patient receive another opinion by Dr. William Fishco in Phoenix. On April 16 Dr. Wilson reviewed both pre- and post-operative x-rays and noted a 15° intermetatarsal angle prior to the surgery and 19° after the surgery was performed by Dr. O'Brien. Dr. Leonetti noted that he had reviewed the patient's x-rays and it does appear that the intermetatarsal angle was not reduced by Dr. O'Brien's surgeries. On April 29 the patient had a pre-operative consultation with Dr. Wilson for surgery on the left foot. The surgery would include removal of the subtalar joint implant, removal of internal plates and screws in the first metatarsal, an arthroplasty of the second MPJ, all on the left foot. Dr. Wilson also thought it might be necessary to fuse the first M PJ's

of both feet in order to reduce the patient's pain. On May 28th 2009 Dr. Wilson sent a letter to the board complaining that he felt the procedures which Dr. O'Brien performed on the patient had failed.

Dr. Leonetti reviewed the records of Dr. Fishco as follows. The patient was seen by Dr. Fishco on April 22, 2009 to receive a second opinion for surgery. Dr. Fishco agreed with Dr. Wilson that the procedures to correct the bunions on the patient's feet had failed and that fusions of the first MPJ's were likely the next course of action. Dr. Fishco also felt it would be appropriate to remove the subtalar implants and perform an arthroplasty of the second MPJ of the left foot.

Dr. Leonetti reviewed his conclusions on the allegations in this case by starting with the second allegation which was simpler. The initial surgery by Dr. O'Brien appears to have the proper consent forms both from the office notes and from the surgical center. The second surgery performed on February 12, 2009 included correction of the third toe hammertoe condition which was noted on Dr. O'Brien's written consent form that the patient signed. It is also mentioned in his preoperative notes that the patient would be having a correction of the third left hammertoe. This was incorrect because the patient does not have a third toe of the left foot. However, the surgery center's consent form does note the proper toes being the second and fourth toes of the left foot. Dr. O'Brien's diagram of the feet for the consent does not include a circle around the third or fourth toes of the left foot or of the subtalar joints bilaterally. In this section of the consent form used in Dr. O'Brien's office for implants or prosthesis, the area was left blank with no initials. Dr. Leonetti stated that even though Dr. O'Brien's consent form is not completely accurate, the surgical center's consent form is accurate. He finds that a continued mention of the third toe and the lack of discussion on the subtalar implants is more of a problem with Dr. O'Brien's record-keeping and documentation than a lack of proper consent from the patient. He finds this allegation to be unsubstantiated.

Dr. Leonetti then discusses findings on the first allegation as follows: Dr. Leonetti stated that it is difficult to determine whether or not Dr. O'Brien practice below the standard of care regarding the surgeries that he performed on the patient. The decision as to whether a Silver Bunionectomy or a more aggressive bunion procedure should have been done should be the surgeon's choice based on the patient and the individual set of circumstances. The decision should be discussed with the patient along with the rationale for the procedure along with its potential risks. Dr. Leonetti stated that he believed Dr. O'Brien met the minimum standard for the first surgical procedures. He noted, however, that the second set of surgeries he is not so certain about. The need for subtalar joint implant is very poorly documented in the chart. There is no mention of the condition which may require the implants or orthotics until three months after the first procedures when the patient was clearly experiencing pain. If the patient had a flat foot condition which was aggravating the formation of the bunions, it should have been addressed or considered before the first set of surgical procedures. Post-operatively Dr. O'Brien did not mention that there was a problem with the implants until he recommended removing them at her last visit with him. Dr. Leonetti stated he believes the implant procedures were not necessary and were not well-planned or explained to the patient.

Dr. Leonetti noted that both Dr. Wilson and Dr. Fishco mentioned pain and degenerative changes at the second MPJ. Dr. O'Brien chose to re-do the hammertoe correction with Swanson implants of the second and fourth toes of the left foot, but he did not address the second MPJ. The decision to perform opening wedge osteotomies of the base of the first metatarsal is one that is usually reserved for a very high intermetatarsal angle or a short first metatarsal. However, neither of these conditions is noted in Dr. O'Brien's notes. Dr. Leonetti stated that every procedure has its own inherent set of risks and complications and that determining whether procedure was done improperly is difficult. However, when the patient starts with an intermetatarsal angle of 15° and ends up with an angle of 19°, (an increase in the angle when the surgeon should be trying to reduce it), it should be considered whether the procedures were done correctly. On the patient's last visit Dr. O'Brien he took x-rays and did not note an increased IM angle or the return of the bunions.

Dr. Leonetti continued: when the patient first sought Dr. Wilson he noted on his x-rays that the IM angle's appear to be high for a post-operative bunion. Dr. O'Brien did note after his second surgery that he removed too much of the first metatarsal head of the right foot. Dr. Wilson and Dr. Fishco agreed that this would likely result in the need for surgical fusion of the first MPJ as a salvage procedure. Dr.

Leonetti concluded that at a minimum, Dr. O'Brien's records fail to show the severity of the post-operative results from the surgical procedures. A more concerning finding is that Dr. O'Brien failed to recognize the severity of the patient's post-operative condition and that he may have added to its severity by improperly performing the procedures he chose to use. Dr. Leonetti stated that he finds the first allegation to be substantiated.

Dr. Leonetti confirmed for Dr. Kaplan that the only x-rays which were available were the post-operative x-rays. Dr. O'Brien stated that the patient's pre-operative x-rays had been given to Dr. Wilson. (Those x-rays are no longer available for the board to subpoena.) The board members reviewed all the x-rays that were available. Dr. Leonetti discussed with Dr. Kaplan the surgical consent forms. Dr. Leonetti noted that Dr. O'Brien's consent forms were not completely accurate regarding the procedures that would be performed on the patient. However, the consent forms at the surgical center were accurate. He is concerned with the use of the subtalar implants because, while they can be helpful in specific circumstances, in this case it led to further complications for the patient. Dr. Leonetti added that the need for the subtalar implants was very poorly documented in the patient's chart.

Dr. Leonetti spoke with Dr. O'Brien regarding the consent forms that were used in this case and asked him if he has made changes to his consent forms since this patient's surgery in 2008. Dr. O'Brien stated that he has completely new surgical consent forms. Dr. O'Brien stated that the patient was aware of the hardware that was going to be placed into her feet; however, Dr. Kaplan pointed out that that was not noted on Dr. O'Brien's consent form. Dr. Kaplan asked if the patient was aware of the complications of the open wedge osteotomy and that it possibly might not hold. Dr. O'Brien stated the patient was aware of that. Dr. Kaplan asked if the patient was aware that her bunions could be worse following the surgery, and Dr. O'Brien stated that she was. Dr. O'Brien stated that he had extensive discussions with the patient regarding her surgeries although his discussions were not documented in his chart. Dr. O'Brien confirmed for Dr. Kaplan that the patient was approximately 63 years old at the time that the subtalar implants were placed and that he does not do that type of procedure on very many patients of that age. Dr. O'Brien stated that he felt if he could correct over-pronation in the patient's feet that it would assist in correction of the bunions. Dr. O'Brien confirmed for Dr. Kaplan that he did discuss the orthotics with the patient; however, because of the patient's insurance she was only able to use over-the-counter shoe inserts.

Dr. Campbell asked Dr. O'Brien if the patient had been treated for these conditions previously or if she had utilized any type of alternative treatments such as changing her shoe gear. Dr. O'Brien stated that he always considers alternatives including changing her shoe gear prior to surgical procedure but he does not remember the specifics in this case because of the time that has elapsed. Dr. Campbell asked Dr. O'Brien how many arthrodesis procedures he's done in his career. Dr. O'Brien stated approximately 40. Dr. Campbell then asked how many base wedge procedures and how many fusion procedures he was performed. Dr. O'Brien said approximately 10 and approximately 30, respectively. Dr. Campbell noted in the patient's blood work that her blood glucose level was 159 and asked why that was not addressed prior to the surgery. Dr. O'Brien stated that the anesthesiologist reviewed the blood sugar level and was fine with it. Dr. Campbell also reviewed the patient's extensive history of smoking and asked Dr. O'Brien if he addressed that with the patient prior to surgery and he stated that he did. Dr. Campbell then asked if Dr. O'Brien had reviewed the patient's medication history or had any concerns that she was receiving too much medication. Dr. O'Brien stated that in the post-operative period he did receive a notification from "Medco" and after that he only wrote the patient one more prescription for pain medication. Dr. Campbell asked if Dr. O'Brien was aware of the patient's living situation at the time of the surgeries the patient was living alone. Dr. O'Brien stated that he would not normally do bilateral foot surgery at the same time, so he would have checked to make sure that the patient had some type of help at home following surgery.

Dr. Campbell asked Dr. O'Brien why in the second surgery he removed more of the first metatarsal bones. Dr. O'Brien stated that he was trying to get a better reduction of the joint but obviously he took too much. Dr. Kaplan reviewed the patient's IM angle prior to surgery and asked why Dr. O'Brien did not perform a distal osteotomy instead. Dr. O'Brien stated that at the time he liked using opening base wedge plates because he thought they would provide good reduction and help maintain good correction of the joint. Dr. O'Brien added that he has not performed an open base wedge procedure in over two years and does not plan to do them again. Dr. Kaplan advise Dr. O'Brien that due to the patient's age

and the fact that she was disabled he found it to be risky to perform these types of procedures bilaterally at the same time. Dr. O'Brien agreed but stated that the patient wanted to have the procedures done at the same time to get them over with quicker. Dr. Kaplan asked Dr. O'Brien if he was aware of the patient's IM angle prior to the first surgery and that a Silver Bunionectomy is not recommended for an IM angle of 15°. Dr. O'Brien stated he was aware of that. Dr. O'Brien asserted that the patient was aware that the Silver procedure would not fully correct her bunions and that additional surgery may be needed down the road.

Dr. O'Brien advised the board that he has been enrolled in a program called the Center for Personalized Education for Physicians since October of 2010. The program involves education on things such as record-keeping and surgical decision-making. He has a preceptor who was an orthopedic surgeon who goes over all his cases with him and makes recommendations to him. Dr. O'Brien stated that he has completed this program and met all of the requirements. He added that the program included a podiatry panel which reviewed his cases and advised him on a course of continuing medical education which he completed on a monthly basis. He spoke with his preceptor every week to review his current cases. Dr. O'Brien provided the board members a copy of a document from this program which included an educational intervention plan, progress report, and summary report. Dr. O'Brien also explained to the board that in this program he was not allowed to perform any surgeries by himself during the initial approximate six month period. He was required to perform 40 procedures with the supervision of his preceptor before being allowed to return to surgery on his own under the guidelines of this program. Dr. Leonetti asked Dr. O'Brien if the supervision of his surgeries included meeting prior to the surgery to review the case or actual supervision within the operating room. Dr. O'Brien stated it included both.

Dr. Kaplan reviewed that the board has previously offered a consent agreement to Dr. O'Brien in a previous investigation case which included circumstances similar to the present case. The terms of the consent agreement concluded additional CME and restrictions from performing certain types of surgical procedures. Dr. Kaplan suggested the possibility of consolidating the present case with the previous case, adding the information from this incident. Ms. Froedge stated that would be possible. (The other investigation case number is 11-01-C.) Ms. Penttinen confirmed for Ms. Miles that the previous board action included offering a consent agreement and if it was not accepted by Dr. O'Brien then to proceed to an informal hearing. Dr. Kaplan stated that the program which Dr. O'Brien has already completed is along the lines of what he would have suggested via a consent agreement in this case. He feels that Dr. O'Brien should agree to stop performing open and closed wedge osteotomies of the first metatarsal as well as subtalar implants.

MOTION: Ms. Miles moved to consolidate the present case with case number 11-01-C and add findings of fact and conclusions of law as indicated in the present case, (regarding allegation number two which was substantiated), to the consent agreement terms offered by the board in case number 11-01-C. Ms. Miles included in her motion the stipulation that the Order portion of the agreement include a prohibition on open and closed wedge osteotomies of the first metatarsal as well as a prohibition on subtalar implants. If the consolidated consent agreement is not accepted by Dr. O'Brien, the cases will remain consolidated and be referred to an informal hearing. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. 10-24-C – Jerome Cohn, DPM: Improper injection in left foot causing complications and injury to the foot.

Dr. Cohn was present. Dr. Dedrie Polakof was the investigator for the case and summarized the allegation as follows: the board received a complaint against Dr. Cohn from patient C.W. On November 24, 2009 the patient sought Dr. Cohn due to pain in her right foot. On that date the patient received steroid injections in both of her feet. She did not know why Dr. Cohn wanted to inject her left foot because she was not having any problems with it. On the way home from her appointment her left foot began to swell. The patient applied ice and the next day she called and spoke with Dr. Cohn's on-call doctor who told her to go to the emergency room in case she had a blood clot. According to the patient

the emergency room physician told her that the injection on her left foot was not done properly. The patient alleges that since then she has experienced ongoing problems with her foot requiring her to be non-weight-bearing or to use a walking boot. She is not been able to work. She also states she has developed spinal problems due to the walking boot affecting her gait.

Dr. Polakof reviewed the patient's medical records as follows: the patient's initial office visit with Dr. Cohn was on November 11, 2009 at which time she reported she had been having pain in both heels for one year. The patient had X-rays of only the right foot and an injection was given to the right heel. On November 24 Dr. Cohn reviewed x-rays of the left foot. The patient was experiencing pain in both heels and injections were done into both heels. On December 8 Dr. Brian Neerings received a call from the patient who stated that her foot was swollen and that she was on crutches and was experiencing pain. Dr. Neerings instructed the patient to go to the emergency room. On December 16 the patient was seen by Dr. Samuel Cox who provided her with an air cast and advised her to continue using her crutches. The patient continued to see Dr. Cox through May 4, 2010 during which time she had multiple x-rays and MRI's taken. The patient was diagnosed as having thickening of the plantar fascia, was given injections to the tarsal tunnel, and the pain was noted to be greater in the left foot than the right foot. Dr. Cox had the patient use a cam walker. The patient was seen in emergency room again in June of 2010 due to a primary complaint of leg cramps. She was diagnosed with peripheral neuropathy and a venous Doppler exam was negative.

Dr. Polakof continued: she spoke with the patient by phone who stated she is still experiencing pain every day. The patient said she can no longer wear high heels and she has tingling sensations in her heels every day. The patient told Dr. Polakof that she went to another doctor who recommended heel surgery to remove a bone but she no longer has health insurance so she cannot do that. The patient told Dr. Polakof that her right heel did not hurt and she did not want the shot so she does not know why Dr. Cohn did it. The patient had one additional ER visit on July 28, 2010 due to a reported groin strain; there was no mention in those records of any heel pain. Dr. Polakof concluded that she does not find the allegation in this case to be substantiated. The patient is continuing to experience pain; however, she could be experiencing RSD which is a known complication of injections in the foot or from another cause.

Dr. Kaplan asked Dr. Polakof to clarify the dates of service and when the patient's x-rays were taken on each foot. Dr. Polakof explained that due to the patient's insurance she had to get x-rays taken at a separate facility then brought them to her appointments. On November 11 the patient brought x-rays of her right foot to Dr. Cohn's office, but the records reflect that she reported pain in both heels at that time. When the patient returned on November 24 she brought with her the x-rays of her left foot. Dr. Campbell noted that in her review of the patient's records from the primary care physician she found that the patient had been diagnosed with Spina Bifida as well as restless leg syndrome and a history of fibromyalgia, all of which could be contributing factors to her foot pain. Dr. Kaplan confirmed that the patient was approximately 38 years old at the time she was treated by Dr. Cohn. He added that he found nothing in the emergency room records to support the patient's claim that the ER physician told her the injection was done incorrectly.

Dr. Leonetti reviewed the fact that when the patient first presented to Dr. Cohn she complained of pain in both her heels, therefore injections were given into both feet. When the patient went to see Dr. Cox he diagnosed her with a number of problems, and her MRI showed bilateral plantar fasciitis. Dr. Leonetti stated that he does not find any deviation from the standard of care for the treatment that Dr. Cohn provided to this patient. Dr. Kaplan pointed out that there is documentation from Dr. Cox, who treated the patient after Dr. Cohn, that he did not see any problems with the care provided by Dr. Cohn.

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.

c. 11- 08-C – Deo Rampertab, DPM: Charging or collecting an excessive fee.

Dr. Rampertab was not present. Dr. Jerome Cohn was the investigator for the case and summarized the allegations as follows: the board received a complaint against Dr. Rampertab from M.W. The complainant stated that in October 2008 he went to see Dr. Rampertab and receive custom orthotics. His insurance company which was Blue Cross/Blue Shield of Arizona paid the allowable amount and the complainant was responsible to pay \$174.38 per orthotic. In December 2008 M.W. sent his son to see Dr. Rampertab for custom orthotics as well. However, his sons insurance, which is also a Blue Cross/Blue Shield plan, stated that the orthotics would not be covered and he would have to pay \$270.00 per orthotic. Dr. Rampertab asked for payment in that amount but the complainant did not feel he should have to pay more than what he paid for his own orthotics. The complainant felt that Dr. Rampertab charged an excessive fee for his son's orthotics. When the complainant was interviewed by board staff, he explained that his son's insurance plan was actually Blue Cross/Blue Shield of Philadelphia. The complainant advised that he filed a complaint with that insurance plan after which Dr. Rampertab decided to adjust the amount due and the complainant paid only \$174.38 for each orthotic. The complainant told board staff that the matter had been resolved.

Dr. Cohn continued: the complainant's son was initially seen by Dr. Rampertab on December 31, 2008. At that time the patient was diagnosed with plantar fasciitis and several systemic congenital deformities which contributed to the patient's foot pain, and there was some decreased vascular status. The patient underwent a biomechanical examination and was casted for orthotics. Strapping also was applied to the patient's feet. The medical records reflect that the patient's father was notified that it was a different insurance plan and that the coverage for custom orthotics was different; however, the patient's father requested that the office proceed with the orthotics. The patient returned on January 22, 2009 at which time the custom orthotics were dispensed. The orthotics appeared to fit and function well and the patient described comfort with the orthotics.

Dr. Cohn stated that he did speak with the complainant in June of 2012 at which time the complainant confirmed that his concerns were satisfied and the matter had been resolved. Dr. Cohn also reviewed all the patient records including the EOB's and he did not feel that there was any excessive fee charged to the patient. Dr. Kaplan asked how this matter was resolved to the complainant's satisfaction. Dr. Cohn and Ms. Penttinen explained that the complainant did not realize that there were differences in the allowable amounts and co-pay amounts between the two different Blue Cross/Blue Shield plans; the complainant thought that Blue Cross/Blue Shield was essentially a universal plan. Once this was explained to the complainant he had a better understanding of why there was a different amount charged to him for the same DME product. Dr. Rampertab had decided to only charge the patient what the complainant paid for his own orthotics and wrote off the difference. The complainant was satisfied after that. Dr. Campbell noted that in her review of the patient's chart she found two letters written to the complainant from Dr. Rampertab staff and she feels that his office handled this matter very appropriately.

MOTION: Dr. Kaplan moved to dismiss this matter finding no violations. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

d. 11-13-C – Paul Woodward, DPM: Lack of sterile technique while trimming nails; improper trimming of nails by cutting into nail bed; failure to treat bleeding nails; charging an excessive fee.

Dr. Woodward was not present. Dr. Jerome Cohn was the investigator on the case and summarized the allegations as follows: the board received a complaint against Dr. Woodward from patient M.A. the patient stated that on January 5 and February 11, 2011 Dr. Woodward came to her home to assess an infected toe and clip her toenails. She stated that on both occasions Dr. Woodward caused a great deal of pain while clipping her toenails and refused to stop when she told him that she was in pain. In addition, on the February 11 visit Dr. Woodward cut into the nail bed of her right first and second toes which caused bleeding. She stated that Dr. Woodward did not use gloves, did not try to stop the bleeding or clean the wounds, and did not sterilize his equipment before putting it back into his bag and leaving. The patient stated that she is diabetic and that it took several days for the bleeding in her toes to stop. She said that her daughter J.M. and her hospice caregiver both witnessed each of these incidents. In addition the patient feels that Dr. Woodward overcharged Medicare for the services he provided to her. When

board staff contacted the patient to interview her, the patient's daughter stated that the patient was not very coherent. The patient's daughter stated that she did witness both incidents as described by her mother's written complaint and she confirmed all details of the complaint. She added that her mother did have occasional ingrown toenails but not on the dates that Dr. Woodward trimmed her nails; there was no anesthetic applied or tourniquet, only trimming of the nails.

Dr. Cohn reviewed the medical records submitted by Dr. Woodward as follows: Dr. Woodward was initially contacted to see this patient on January 3, 2011. At that time the foot problem was described as an ingrown toenail. He was advised that the patient was diabetic but was not on Coumadin. When he saw the patient on January 5, 2011 he conducted an initial evaluation which describe the patient is having vascular disease and associated issues which resulted in the elevated home visit billing code. Care for the patient at that time consisted of an avulsion of the left hallux nail plate with initiation of local wound care. There was no description in the records of any of the remaining nails being debrided it at that visit. There was notes of a follow-up phone call to the patient on January 10 at which time the patient was described as "doing okay with a crust on the side of the big toe." The patient was instructed to continue wound care and contact the office if there were any changes. The patient was then seen for a second visit in her home on February 11. In the medical records the visit was described as both a re-examination for the hallux in which there was noted to be good healing from the nail avulsion. Examination at that time appeared to be consistent with dystrophic mycotic nails, possible fungal infection to the skin as well as calluses on the feet. The records described foot care with debridement of the dystrophic nails and lesions. The patient also was prescribed ketoconazole. Dr. Cohn stated that the billing codes used on the initial visit were 99243 for a home consultation and 11730 for nail avulsion. The billing codes used on the second home visit were 99348 for a follow-up home visit, 11721 for nail debridement, and 11000 for surgical skin cleansing.

Dr. Cohn stated that he spoke with Dr. Woodward by phone and asked if an advanced beneficiary notice was completed with the patient because he did not find one the patient's records. Dr. Woodward stated there was not but it is noted within his office policy that the patient and her family were told there would be no coverage by Medicare and that there will be financial obligations. Concerning billing code 11000, this was described as cleansing of the skin associated with not only the calluses the possible dirt and accumulation of dead skin seen in many geriatric patients due to the need for podiatric care. This required debridement and further treatment associated with the patient's diabetes and vascular disease. Dr. Cohn concluded that he did not find any of the allegations to be substantiated. He feels the level of care provided to the patient was appropriate and that there was appropriate billing.

Dr. Kaplan stated that he is aware Dr. Woodward's entire practice consists of home and facility visits. Dr. Woodward has demonstrated to the board in the past that he does use sterile techniques and cleaning his instruments and there has never been an issue with this in the past. Dr. Leonetti asked if the use of anesthetic is required in order to bill with the code 11730. Dr. Polakof, who is a certified coder, was still present and advised the board that if the patient has any condition which causes decreased sensation to the area such as neuropathy then anesthetic would not be needed as long as it is documented as such in the patient chart. Dr. Leonetti stated he does not find proper documentation in the patient's chart regarding the use of this billing code and the reason that no anesthetic was used. He also feels there is a lack of documentation with regard to code 11000 regarding the extent of cleansing that was done to justify the code. Ms. Miles suggested that a Letter of Concern might be appropriate for the lack of documentation for the billing codes used. Dr. Leonetti agreed. Dr. Kaplan asked Dr. Cohn if in his practice he uses the code 11000. Dr. Cohn stated that he would only use that code in a much more extensive cleaning of a patient's foot. Dr. Cohn also noted that in Dr. Woodward's written response he noted that the patient had neuropathy in the toes. Dr. Kaplan pointed out that the neuropathy was not documented in the patient's chart anywhere. Dr. Polakof added that she has not seen billing code 11000 used in an office setting; she has only seen it used in an operating room setting where there is extensive cleansing of the area with proper drainage available. Dr. Kaplan agreed that a Letter of Concern for the billing would be appropriate.

MOTION: Dr. Leonetti moved to issue a Letter of Concern for lack of proper documentation regarding no need for anesthetic in using code 11730, and for lack of documentation

regarding the extent of cleansing done to the patient's foot needed to justify the use of code 11000. Dr. Kaplan seconded the motion.

DISCUSSION: Upon discussion, Dr. Kaplan asked Dr. Cohn if there was any documentation in the patient chart regarding what substance was used for the cleansing of the patient's foot. Dr. Cohn stated there was no such documentation. Mr. Rhodes asked how much the patient's insurance was billed. There was brief discussion among the board members about the charges that were submitted to Medicare, the allowable amount that Medicare paid, and the amount that was applied to the patient's deductible. For the foot cleansing Dr. Woodward charged \$90.00 and was reimbursed \$51.33. There was no further discussion.

VOTE: The motion passed 4-1 by voice vote with Mr. Rhodes dissenting.

e. 11-21-M – Robert Fridrich, DPM: Practice below the standard of care for failing to remove a tourniquet following a nail avulsion; improper billing.

Dr. Fridrich was not present. Dr. Jerome Cohn was the investigator for the case and summarized the complaint information as follows: August 2011 license renewal application, Dr. Fridrich disclosed that a malpractice claim had been filed against him by the parents of patient A.P. the board subsequently received a report from Dr. Fridrich's malpractice insurance carrier indicating that a settlement was made on his behalf. The patient had undergone a nail avulsion of the left great toe and when the bandage was removed two days later it was discovered that the tourniquet had not been removed from her toe. On the malpractice insurance report the nature of the claim was stated as, "patient alleged that our insured failed to remove the rubber band/tourniquet causing the injuries outlined above as well as gait difficulty, difficulty in using the foot to walk or play sports (although she had returned to participation in the marching band), and subsequently deformed re-growth of the toenail." Upon review of the patient's chart in this case Dr. Cohn added a second allegation for improper use of billing code 99205 for an initial office visit.

Dr. Cohn continued as follows: the patient was a 13-year-old female who presented to the office on an emergency basis because of pain in her left great toe and discomfort for more than four months. Several other physicians had evaluated and attempted to treat the patient including prescription of antibiotics; however, the patient stated she did not have any improvement or relief from this treatment and the foot was extremely painful and sore. Dr. Fridrich performed an evaluation and determined that a nail avulsion would be appropriate. He discussed this with the patient and her mother, a consent form was signed, and the nail avulsion was performed. The patient's mother also signed an advanced beneficiary notice regarding the injection. While performing the procedure Dr. Fridrich identified that there were two separate nail plates which might have been the source of the patient's symptoms. Both nail plates were avulsed been sent for pathology. The operative report for the procedure indicates that a digital block had been performed with lidocaine 1% and 9cc of carbocaine 1% and that the patient tolerated the procedure well. Bandages were applied and the patient left the office.

Dr. Cohn continued: in his written response to the complaint Dr. Fridrich stated that the patient had been very frightened and was literally screaming even after the anesthesia had been applied. Dr. Fridrich admitted that he had forgotten to remove the tourniquet and that this was below the standard of care. Dr. Fridrich added that his follow-up on the incident included referring the patient to a vascular surgeon. The codes which Dr. Fridrich charged for this office visit included code 99205, code 11730, as well as pathology an injection charges. There was an advanced beneficiary notice signed for the injection. The time spent evaluating the patient was documented at 45 minutes. However, in his review of the CPT guidelines Dr. Cohn finds that code 99205 requires a comprehensive history and examination as well as medical decision-making at a high level. He did not find these two components documented to the level required by the CPT guidelines. A third required component is the severity of the presenting problem must be moderate-to-high. Although the patient was in a great deal of pain, he does not feel this examination reached all the appropriate levels in order to be billed with the code 99205. Therefore the second allegation of improper billing was added.

Dr. Cohn stated that he spoke with Dr. Fridrich concerning his techniques and the protocol he had explained in his initial response to the complaint. Dr. Fridrich indicated that he has set several new

policies in place in order to prevent this type of incident from happening again. This includes documentation in the operative report of both the application and removal of the tourniquet and monitoring the neurovascular status of the patient. He also has introduced the use of a checklist for his medical assistants review prior to discharging the patient as well as utilizing a large instrument such as a hemostat attached to the tourniquet in order to be certain that he visualized the tourniquet was removed. In conclusion Dr. Cohn stated that Dr. Fridrich admitted that this incident was below the standard of care but has made adjustments within his practice to prevent this from reoccurring. Dr. Cohn also finds the second allegation to be substantiated based on his review of the records and the CPT guidelines.

Dr. Campbell noted that she found in the patient's records that Dr. Fridrich had charged for a surgical tray and an anesthesia tray which she feels should be included in the cost of the procedure. Dr. Cohn noted that the patient's parents did sign the advanced beneficiary notice for the cost of the injection. Dr. Kaplan asked Dr. Cohn if he normally charges for injectable anesthetic in the toe and Dr. Cohn stated he did not; he considered it part of the overall billing code for the procedure. Dr. Kaplan asked why the nail plates were sent for pathology as there was no evidence of a problem with fungus in the toe. Dr. Cohn stated he believes the pathology was done due to the patient having pain in the toe for such an extended period of time and he would have considered pathology for this patient as well. Dr. Kaplan noted that the patient's pediatrician had treated her for a toe injury several months prior. He feels it is possible that the toenail was self-avulsing but remains somewhat intact and the new nail grew up from underneath of it causing the ingrown condition. The physician board members all agreed that it was not appropriate to leave the tourniquet on the patient's toe for 48 hours and they were very concerned with this. Dr. Cohn confirmed for Dr. Kaplan that Dr. Fridrich used an actual rubber band on this patient's toe. Dr. Kaplan stated he has never used a rubber band for this use. Dr. Kaplan stated he also was concerned with the amount of local anesthetic that was injected into the patient's toe as he believes 3 to 4 cc of anesthetic is all that is necessary. Drs. Leonetti and Campbell agreed. Dr. Kaplan stated that feels an in formal hearing would be appropriate in this case and he would like Ms. Penttinen to gather Dr. Fridrich's his previous board actions for review. Upon discussion with Ms. Miles and Dr. Kaplan that, Ms. Froedge advised that previous board actions could only be taken into discussion or consideration after the board reviews this case separately and is determining, if applicable, what level of disciplinary action to impose.

MOTION: Dr. Kaplan moved to refer this matter to an informal hearing at the next available date.
Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

- f. 11-32-M – Scott Price, DPM: Practice below the standard of care for improper trimming of toenails which resulted in infection.

Dr. Price was not present. Dr. Dedrie Polakof was the investigator for the case and summarized the allegations as follows: the board received a malpractice report from PICA indicating a claim had been made against Dr. Price by patient C.B. The nature of the claim was stated as, "insured trimmed patient's toenails. She alleges he clipped the skin around the big toe of her right foot which became infected and required to trips to the ER. She wants ER bills paid." Dr. Polakof noted that in his written response Dr. Price stated that the treatment he provided to the patient was appropriate and that when the patient left his office there was no indication of any problem. The patient first saw Dr. Price in July 2006. There were several office visits for nail care including one on July 14, 2011 which is the date the patient alleges the improper toenail trimming was done.

Dr. Polakof noted that the patient's two emergency room visits were also on July 16 and July 18. On July 16 the emergency room records indicate that there was slight redness to the tip of the toe but there was no drainage and there was no ingrown toenail present. The emergency room physician prescribed clindamycin and ibuprofen, and advised the patient to soak the toe. On July 18 patient returned to the emergency room. On that date x-rays were taken which ruled out osteomyelitis. The ER physician did not notice any change in the condition of the patient's toe but added a prescription for Cipro in addition to the clindamycin. The patient later sent a demand letter to Dr. Price to recoup the costs of her emergency room co-pays. It also was noted that at one time the patient called Dr. Price's office and was very upset and hung up on his staff. Dr. Price tried to call her back however the phone number they had on record

for her was disconnected so they could not reach her. Dr. Polakof noted that in the patient's records submitted by Dr. Price there is no mention of any cut to the toe or any type of problem with the toenail trimming on July 14. Dr. Polakof concluded that she does not find any violations in this case.

Dr. Kaplan stated that in his review of the patient's emergency room records he does not find that there was any sign of infection in the toe. Ms. Penttinen also clarified that after this investigation case was opened by the board she received another report from PICA indicating that this claim has been abandoned by the patient.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

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

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

Ms. Penttinen reviewed the monthly update submitted to the board by Dr. Bui which indicates that he did not have any charges for durable medical equipment in the last calendar month. Ms. Penttinen also advised the board members that she sent a letter to Dr. Bui's attorney regarding the subpoena which was previously issued for copies of 10 patient charts. Ms. Penttinen's letter advised that the scope of the subpoena would not be altered and that the board would pursue enforcement of the subpoena in Superior Court if necessary. The records are expected to be received prior to the October board meeting.

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

Ms. Penttinen advised that the most recent quarterly report from Dr. Sucher was received in August, so the next report is due in November. Ms. Penttinen also has issued a subpoena to the laboratory which conducts Dr. Brown's drug screens to obtain copies of all of the quantitative values of Dr. Brown's test results for the last year.

VI. Review, Discussion and Possible Action on Administrative Matters

a. Review of new license application for Dr. Rachel O'Connor.

MOTION: Dr. Leonetti moved to approve Dr. O'Connors license application and allow her to sit for the oral exam in December. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. CME approval request from AzPMA.

Dr. Todd Haddon submitted a request on behalf of the Arizona Podiatric Medical Association for approval of five hours of CME for an event planned on November 10, 2012.

MOTION: Dr. Leonetti moved to approve the CME request. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

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

Barbara Aung
Scott Boggs
Joel Bowen
J. David Brown
Steven Burns
Patrick Farrell

Michael Fox
Jared Hall
John Harlan
Noland Jones
Jeffrey Kleis
Bjorn Lawson

Ivan McLaws
Spencer Niemann
Vivian Seater-Benson
Glenn Silverstein
Karen Smith
Chad Westphal

Dr. Niemann submitted with his license renewal application a request for the board to waive the late renewal fee which the board members reviewed.

MOTION: Ms. Miles moved to deny Dr. Niemann's request to waive the late renewal fee and sends Dr. Niemann a notice of substantive deficiency for the late fee. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

MOTION: Ms. Miles moved to postpone consideration of Dr. Niemann's license renewal until the late renewal fee is submitted. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

MOTION: Dr. Kaplan moved to approve the remainder of the license renewal applications as listed above. Dr. Leonetti 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 reviewed the report which indicates that there are currently 57 open complaints including those that were on today's agenda. Ms. Penttinen also provided the following information regarding open case number 07-11: she attempted to contact agent Jeffrey Morgan at DEA to find out what the status of their investigation is. She got Mr. Morgan's voicemail and left a message. She also sent a letter by certified mail asking for an update so that the board can decide how to proceed with its investigation of this matter. Ms. Penttinen has received the return receipt card but has had no further contact from DEA.

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

VIII. Call To The Public

There were no requests to speak during the call to the public.

IX. Next Board Meeting Date:

a. October 10, 2012 at 8:30 a.m.

X. Adjournment

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the meeting was adjourned at 10:44 AM.