



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**

October 10, 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: Marc Harris (In place of Ms. Selzer as agendized.)

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

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

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

Dr. Kaplan noted that all Board members were present as well as Ms. Penttinen. Assistant Attorney General Marc Harris was present. Also present observing was Assistant Attorney General Anna Finn.

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

a. August 8, 2012 Regular Session Minutes.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. September 12, 2012 Regular Session Minutes.

Dr. Kaplan offered several typographical corrections with which the other Board members agreed.

MOTION: Dr. Campbell moved to approve the minutes with the noted corrections. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

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

a. 08-25-C – Aprajita Nakra, DPM: Improper prescription of custom orthotics to treat foot pain.

b. 09-15-M – Aprajita Nakra, DPM: Post-surgical scarring which is unsightly to the patient.

Complaint case numbers 08-25-C and 09-15-M were postponed and not reviewed during this Board meeting.

c. 11-15-C – Aprajita Nakra, DPM: Practice below the standard of care for improper surgery; improper billing.

Dr. Nakra was not present. Dr. Jerome Cohn was the investigator for the case and was present. The complaint information is as follows: The board received a PICA report indicating that a malpractice claim had been filed against Dr. Nakra by patient N.H. That report stated the nature of the claim as "surgery to repair a plantar plate/flexor tendon, left foot. Patient alleges insured negligently treated, diagnosed and improperly and/or inappropriately operated on her left foot resulting in permanent injury to the foot." The

patient also filed a complaint directly with the board. In her complaint the patient stated that on October 6, 2009 she had surgery to correct what Dr. Nakra had diagnosed as a partial tear of the lateral plantar plate of her left foot. The patient's foot pain persisted following post-operative physical therapy and Dr. Nakra told her that was normal. The patient sought a second opinion with Dr. Kerry Zang. Following an MRI Dr. Zang told the patient there was no padding in the area of her foot where she was having pain and he recommended Sculptra injections. The patient also alleged that Dr. Nakra billed the surgery improperly for a deformed toe correction and partial removal of her toe which were not done.

Dr. Cohen summarized his review of the patient's medical records as follows: The patient had initially scheduled an appointment with Dr. Nakra August 10, 2009 but the visit was actually performed by Dr. Kenneth Blocher for Dr. Nakra. The initial evaluation describes a 53-year-old female who presented with pain under the second and third metatarsal heads which was present off and on for 3 months. Pain was not constant; there were some good and some bad days. Shoe gear did not make a difference and she denied any history of injury or trauma. The patient did give a previous history of neuroma type symptoms many years prior and described this as a different complaint. She had received cortisone which resolved symptoms on the right side. The remaining portion of the exam included medical history and podiatric evaluation which revealed palpable tenderness along the plantar plate and second metatarsal head pain with plantarflexion of the second MPJ. X-rays did not describe any fractures and overall good alignment was noted of the forefoot. Assessment was a neuroma versus plantar plate dysfunction left foot. Patient was shown taping of the second MPJ and an MRI was ordered with a follow-up in 2 weeks for possible surgical intervention and/or cortisone. The next visit was August 24, 2009 with Dr. Nakra which included a review of the MRI. This was followed with a statement, "Clinically we are dealing with plantar plate dysfunction left second MPJ." Dr. Nakra also stated the patient had symptoms of mild plantar fasciitis. The only objective findings described were mild hallux valgus deformity which did not warrant surgical intervention. The note states that the patient would like to proceed with surgery for the plantar plate dysfunction and was to schedule for a preoperative appointment. The MRI report from Arizona Orthopedic Surgical Hospital dated August 14, 2009 described a partial tear of the lateral plantar plate at the second medial tibial plateau but no convincing Morton neuroma. The body of the report described this as best seen on axial image 9 and does not appear to be a complete disruption as seen on sagittal image. Pre-op evaluation was September 23, 2009 when the consent form was signed for plantar plate repair. The MRI was reviewed and the patient was dispensed a Cam Walker with instructions for activities post-procedure. Dr. Nakra again discussed the bunion and possible need in the future for surgical intervention and scheduled a post-op appointment.

Dr. Cohn continued his review as follows: He reviewed the operative report from surgery October 6, 2009 in which repair of plantar plate/flexor tendon left was performed 2nd MPJ left. Hemostasis was a tourniquet and epinephrine for hemostasis with no mention of the amount of epinephrine 1:200,000. Injectables noted 0.5% Marcaine plain no dosage. The body of the report describes a typical procedure for a repair of the plantar plate in which it is described that an obvious attenuation and strain/tear was appreciated in the lateral aspect of the plantar plate at the level of the second MPJ which was repaired utilizing Fiber Wire. The report described excellent rectus alignment and it should be noted that within the operative report it was deemed appropriate not to perform any osseous work. The first post-op visit was October 9, 2009 and the notes describe normal appropriate findings with x-rays describing good alignment with no bone or joint abnormalities. The patient was to continue with the Cam Walker until follow-up 2 weeks later for suture removal. Next visit October 21, 2009, clinically foot looked excellent, x-rays were taken, the patient's status was changed to partial weight-bearing, and an additional follow-up was scheduled November 4. On November 4, 2009 x-rays were repeated and transition to surgical shoe. The note was not within the chart; only an acknowledgment that a surgical shoe was dispensed. Text visit occurred on November 13, 2009 was described as urgent because of increased pain to the left foot and surgical area. Objective findings included palpable tenderness along the incision consistent with healing and early scar tissue formation in the deep tissues. Motion was pain free and the foot clinically looked good as did alignment. The patient was prescribed an anti-inflammatory gel as well as oral anti-inflammatories and appointment to return November 23, 2009. Follow-up on November 23, 2009 note relates pain had improved but the patient did not get the gel. The objective findings described palpable tenderness with minimal scar tissue. Dr. Nakra's recommendation was physical therapy and x-rays were again taken at this visit. The patient was to return December 14, 2009 for follow up with Dr. Nakra. Visit on December 14, 2009 had no subjective or objective findings. X-rays were taken and revealed rectus alignment of the second digit. She was described to still be in physical therapy which

was providing relief. She was instructed not to go barefoot, to use appropriate shoe gear, continue desk job only and return in 6 weeks. The patient's last visit with Dr. Nakra was January 27, 2010 in which the subjective findings described the foot is 80- 90% better. Incision was healed well. Tenderness described anterior aspect of the ankle therefore will continue physical therapy for an additional month. Patient at this visit stated concerned pain could be representative of RSD. Dr. Nakra's assessment states this was highly unlikely since she is exhibiting no signs or symptoms consistent with RSD although there are no objective findings positive or negative with-in this visit. The patient was advised to continue with comfortable shoe gear as well as physical therapy return to work without restrictions return to the office 3 months.

Dr. Cohn continued as follows: It should be noted that several of the visits within this medical record were performed by Dr. Blocher for Dr. Nakra these included first visit August 10, 2009, October 9, 2009, November 13, 2009, and November 23, 2009. It was difficult to determine if charges were placed to the appropriate physician as within the ledger provided Dr. Blocher appears to be coded as 70 and Dr. Nakra 74. If these are the appropriate codes they do not match to the dictating physician on all visits such as September 23, October 6, October 9, October 24, November 13, November 23. The patient's last visit with Dr. Nakra was January 27, 2010. After this visit the patient sought an additional opinion with Dr. Zang. His initial evaluation was May 2, 2011 in order to be evaluated because of continued pain the findings included incision directly over the second metatarsal head with pain along the incision and marked atrophy of the plantar fat pad in the region of the second metatarsophalangeal joint as well as posterior tibial tendon pain. X-rays were taken and a diagnostic ultrasound was performed which revealed dissolution of continuity of the plantar plate and abnormal fat pad within the area. An MRI was then discussed and ordered with care continuing to be conservative including discussion of possible soft tissue supplementation. Second evaluation was May 10, 2011 reviewed the MRI with no significant subjective or objective changes. Further discussion consisted of dermal filler. The MRI described soft tissue distortion consistent with surgery including scarring and fat atrophy this was performed May 7, 2011. Patient was then seen June 7 and June 14. These examinations describe no changes subjectively. Continued conservative care was discussed no recommendations are made for surgical intervention as it was felt would not provide relief and patient is still considering possible soft tissue supplementation as well as orthotics which were requested but denied by insurance. Dr. Cohn spoke with the patient by phone on July 24, 2012 and questioned patient about possibility of conservative care being initiated first or offered and any other options for treatment that were discussed by Dr. Nakra. Patient stated no other alternatives were given and there was no discussion of conservative care. She stated she was given only surgery as an option. She did confirm she went for an evaluation and treatment; she did not present to the office for a consultation or opinion. Dr. Cohn also reviewed both MRI's as well as the written records of Dr. Kerry Zang which included additional review of x-rays taken in his office and a diagnostic ultrasound.

Dr. Cohn discussed his findings as follows: He finds that the first allegation of practice below the standard of care is substantiated. The initial MRI revealed a partial tear of the plantar plate and the initial recommendation was for surgical intervention to repair that. Dr. Cohn feels there was not an adequate amount of conservative treatment documented such as digital strapping, accommodation or immobilization, or possible cortisone injections which are typically recommended as alternatives to surgical intervention. This was confirmed when he spoke to the patient. Dr. Cohn also feels that an appropriate standard of care would include documentation in the patient's records; i.e. there was minimal-to-no objective findings described in the patient's notes, Epinephrine was used intra-operatively without documentation of the amount and in conjunction with a tourniquet for forefoot surgery. Dr. Cohn also found the second allegation to be substantiated and stated that there were multiple issues associated with improper billing. These issues included coding for the visits such as an initial office visit which was coded as a consult code 99243 which, according to the CPT guidelines, is to be utilized in incidents where patient is referred for consult and is sent back to the referring physician for additional treatment. It is not to be utilized as an evaluation and management code for a patient who presents to the office for such. The actual examination was coded above the level for the documentation provided in the chart; it should be a level two code based on the documentation provided. Dr. Cohn also found that the surgical procedure was incorrectly coded in that there was billing for an osseous procedure, (code 28124), which was not performed as verified within the operative report. A code of 65540 was also billed which is a nerve block when a nerve block is performed at the time of a surgical procedure it is not to be billed separately because it is included in the anesthesia charges. Also, on January 27, 2010 an

evaluation and management code of 99213 was used but was not documented sufficiently. Dr. Cohn also questioned charges for x-rays at every post-operative visit except one. Dr. Cohn stated the surgical procedures performed were entirely soft tissue procedures and therefore he finds it questionable that postoperative x-rays would be needed for evaluation at every visit if the digit was clinically in a rectus position with good motion. The last issue regarding billing charges involved the November 4, 2009 office visit which included x-rays and a code of I3260 for a post-operative boot with no available records for documentation with the exception of a form signed by the patient to accept the surgical shoe. Finally, Dr. Cohn expressed concern that two physicians from the same office were involved in the patient's treatment and it is questionable if the charges were applied to the appropriate physician who performed each date of service.

Dr. Cohn confirmed for Dr. Leonetti that the patient had been given instructions on strapping of the foot. Dr. Cohn stated the patient returned to Dr. Nakra approximately 2 weeks later and he was uncertain if the patient had been doing the strapping during that entire two weeks. It was at that time that the patient decided she wanted to have surgery. Dr. Leonetti expressed concerns regarding the documentation in the patient's chart regarding which physician treated the patient for each date of service and asked Dr. Cohn to clarify. Dr. Cohn stated that it appears that the physician who dictated the office notes does not match to the billing records for each date of service so it is unclear exactly which services were provided by which physician. Regarding the surgery, Dr. Leonetti stated it was apparent that there was a partial tear in the plantar plate and those do not usually heal very well with conservative care. He added that surgical correction is usually the most appropriate treatment and it is unknown to him why the patient continued to have pain several months post-operatively. The post-operative MRI showed that the tear had healed but there was scarring and the fat pad had atrophied. Dr. Leonetti stated that, although the final outcome was unfortunate, he feels the surgical procedure was appropriate and performed properly. However, he does have concerns about the billing, specifically the charge for anesthesia. There was discussion among the physician board members and Dr. Cohn regarding the billing code that was used for this procedure. Dr. Nakra billed for an osseous procedure, but it was actually a soft tissue procedure. Dr. Leonetti also expressed concern about having x-rays taken at every post-operative visit. Because this was a soft tissue procedure, if the bones were in an appropriate position then only one set of post-operative films would be necessary. Dr. Kaplan and Dr. Campbell agreed.

Dr. Kaplan and Dr. Cohn discussed options for treating second MPJ pain. Dr. Cohn stated that it would be appropriate to attempt conservative treatment first before going to surgery. He does not feel that two weeks of conservative care is an appropriate length of time. Dr. Cohn added that he did not find any problems with the technical aspects of the surgery and he felt that Dr. Nakra properly corrected the tear. There was discussion among the physician board members regarding how long conservative care should be attempted if the patient does not want it but wants to proceed with surgery. Dr. Leonetti stated, and Dr. Kaplan agreed, that in most cases it is going to be up to the physician and the patient and the physician has to make the decision on whether or not they feel comfortable moving ahead with surgery more quickly than might be recommended. Ms. Miles questioned whether or not a patient should be allowed to decide what the appropriate standard of care would be by choosing surgery rather than conservative care. Dr. Kaplan pointed out that even though the patient stated in her complaint that she was not offered conservative care, the investigation and review of the patient's records indicates that conservative care was discussed with the patient and attempted prior to surgery. Dr. Leonetti stated that he probably would not have performed surgery on this patient after only two weeks; however, if Dr. Nakra's experience has shown her that conservative care is not very successful then he would not question her decision to move forward with surgery. The physician members agreed that there were concerns about the billing for this patient. Dr. Kaplan asked Dr. Leonetti if he would like to invite Dr. Nakra to appear before the board for an investigational interview.

**MOTION:** Dr. Leonetti moved to invite Dr. Nakra to appear before the board for an investigational interview specifically regarding billing questions for this case. Ms. Miles asked where in the board's statutes there was a provision for an investigational interview. The board members and Ms. Penttinen clarified that this essentially would be an action to table the case for further investigation and hopefully Dr. Nakra will appear to discuss this case with the board. Ms. Miles expressed concern regarding Dr. Nakra being appropriately advised of the potential allegations in the case because the investigation report is incomplete. Ms. Miles noted that there are no specific alleged violations listed for

allegation number two regarding billing. There was discussion among the board members and Ms. Penttinen regarding the process of inviting Dr. Nakra to appear for an interview versus the in formal hearing or formal hearing process. Ms. Miles seconded the motion.

DISCUSSION: Mr. Harris asked to confirm his understanding that the board wishes to table this matter at this time in order to invite Dr. Nakra to continue to review the allegations set forth in the initial complaint. Dr. Kaplan confirmed that that was correct. Ms. Penttinen confirmed that she will amend the investigational reports to specify the alleged violations for allegation number two regarding billing.

VOTE: The motion passed unanimously by voice vote.

d. 11-19-M – Donald Curtis, DPM: Practice below the standard of care for improper surgery.

Dr. Curtis was present with attorney Bruce Crawford. Dr. Jerome Cohn was the physician investigator for the case and provided the following summary: The Board received a report from PICA indicating that a malpractice claim was made against Dr. Curtis by patient S.M. In that report, the nature of the claim was stated as, "Insured performed a debridement and curettage of lesions on both of patient's feet. Patient is claiming this resulted in severe pain, disability, disfigurement. NFI at this time." The allegation is practice below the standard of care for improper surgery. Review of the patient's records demonstrates initial office visit was June 15, 2010. Within these records it is described the patient has had issues with warts on both feet for almost 10 years. He has treated them medically over many years and has utilized multiple over-the-counter medications as well. He was referred to the office for treatment which was initiated on June 15. Complete examination was performed and did describe lesions consistent with verruca bilaterally. Based on the review of this initial visit, treatment alternatives were discussed and ranged from continued conservative care to surgical excision. Initiation of treatment this visit was conservative care utilizing canthacur. The patient was scheduled for continued follow-up and he was seen several times over the next 3 months for continued conservative care in which there appeared to be some improvement with the lesions although they never completely resolved. Coding for these visits did include the initial evaluation as well as topical destruction of the lesions. The CPT codes were appropriate. With the conservative care over the 3 months there was one visit where patient apparently had increased pain noted on August 13, 2010. At this visit canthacur was discontinued and changed to over-the-counter salicylic acid. Patient then returned for evaluation on September 17, 2010 with no further improvement and requested more aggressive treatment as he did have some time available approximately 2 weeks off. Treatment options were discussed and at this time surgical excision was elected. Authorization was obtained and excision/curettage was performed on September 21, 2010. There was no consent available for review; it is assumed that this is a part of the surgical center records. The operative report was reviewed and did describe review and discussion pre-operatively which did include risk and reasoning for surgery. The operative report described a procedure of curettage bilaterally of lesions followed by application of phenol. There did not appear to be any type of complications associated with the operative report and this appears consistent and within the standard of community practice for curettage of lesions. Lesions were taken for pathology and revealed findings consistent with verruca.

Dr. Cohn continued: Office notes revealed a follow-up appointment with a covering physician on September 23, 2010. Subjective description did describe pain, swelling, redness and irritation of the skin of the foot. The patient was taking Vicodin. Examination did reveal splotchy erythema and focal dermal edema of the dorsal and plantar skin. Assessment included post-op pain with possible dermal reaction to material used during surgical procedure as well as possible cellulitis. Treatment included education, Medrol Dosepak, Bactrim and follow-up appointment. It should be noted this was coded as a 99212 but is within the postoperative time for excision of the lesion and post-op care visit with Dr. Clement. There were telephone notes and follow-up on a very regular basis. A telephone note from September 25 right said patient was doing well but the left (foot) remained an issue and patient was referred to urgent care where he was given Rocephin. He was seen for follow-up on September 27 and antibiotic change. There was an additional phone call on September 29 and evaluation October 1 in which right foot was doing well; the left continued to have a rash-like lesion at which time Lamisil was added for possible fungal infection. The patient had also been seen prior to this visit was given Cipro by his primary physician. Patient at this time was also referred for a neurologic consult with an appointment scheduled for October 5, 2010. Consult note was reviewed and patient had also been admitted to the hospital on

this visit. The patient was diagnosed with possible CRPS. Patient had received treatment through October 14, 2010. On the discharge note there did appear to be some improvement and scheduled follow-ups were arranged. On October 20, 2010 the patient requested decreasing frequency with Dr. Curtis to which Dr. Curtis agreed reinforcing he is available and did want to remain involved in care.

Dr. Cohn did not speak with the patient in this case. He did speak with Dr. Curtis by phone and verified that consent was at the surgical facility but did describe excision of lesions bilateral. Dr. Curtis stated as well that the patient appears to have now had resolution of skin changes and after a literature search there is no documentation describing the reaction as alleged to have occurred from the surgical prep. Dr. Cohn concluded as follows: Upon review of the above information the patient had presented to the office with a long-standing history of painful lesions which were treated with conservative care and after an adequate attempt at continued conservative care a decision was made to proceed with debridement and curettement. Further review of the operative report described a standard prep and hemostasis appeared adequate. The subsequent reaction was unforeseen and the postoperative care and evaluation and consultations were made within appropriate times. Based on this review determination is therefore that the allegation is unsubstantiated.

Dr. Kaplan asked Dr. Curtis if he would like to respond to Dr. Cohn's a summary of the case. Dr. Curtis stated he felt the summary covered everything well. Dr. Leonetti asked Dr. Curtis if he felt the patient had CRPS. Dr. Curtis stated he did not know and that was why he referred the patient to a neurology consult. Dr. Kaplan asked if the cause of the skin reaction was discovered because he found it strange that only one foot had a reaction. Dr. Kaplan also asked if the reaction could be caused by something the patient did. Dr. Curtis stated he did not know and that he treated both feet in the exact same fashion. Dr. Curtis confirmed that the same surgical scrub was used on both feet. Dr. Leonetti stated that he felt Dr. Curtis's care of the patient, including the surgery, was appropriate. Dr. Leonetti added that it is difficult to determine exactly what type of reaction the patient had and he doubts that the patient actually had CRPS. However, even if it was CRPS, that does happen occasionally and is not necessarily the doctor's fault. Dr. Leonetti stated that he does not find any violation in this case. Dr. Kaplan agreed. Dr. Campbell stated that she felt Dr. Curtis handled the patient's care very appropriately.

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.

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

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

Ms. Penttinen stated she had not yet received Dr. Bui's monthly update regarding durable medical equipment; it is not due until the 15th. She also advised the board members that she had re-issued the subpoena to Dr. Bui for copies of his patient charts. The scope of the subpoena was not modified and Dr. Bui's attorney was advised that hard copies of the records would be required (instead of electronic copies). The records were received a few days ago and will be forwarded to Dr. Polakof for review of the billing codes.

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

Ms. Penttinen advised that she had issued a subpoena to Southwest labs for copies of all of Dr. Brown's drug test results for the last year. The subpoena specifically requested the quantitative values of any positive test results. (Dr. Brown has a valid prescription for a pain medication which causes positive drug test results. Ms. Penttinen has spoken with Dr. Sucher who is Dr. Brown's monitoring physician and is aware of Dr. Brown's pain medication.) Ms. Penttinen explained that urine drug tests results are recorded in a unit of measurement known as nanograms per milliliter (ng/ml). Most of Dr. Brown's positive test results have been at a level of approximately 1000 ng with the highest being approximately 3600 ng. Dr. Sucher advised Ms. Penttinen that he would not be concerned with the quantitative levels of Dr. Brown's urine drug screens unless the value was 5000 ng or higher; Dr. Sucher considers anything under 5000 ng to be a therapeutic or sub-therapeutic level.

Ms. Penttinen also advised that when she spoke with Dr. Sucher they discussed the length of time that Dr. Brown has been taking the pain medication that he is been prescribed. Dr. Sucher indicated that he would conduct an interview with Dr. Brown to determine the need for ongoing pain medication and whether or not any other conservative, non-pharmaceutical measures would be appropriate for his pain management. Ms. Penttinen confirmed for Dr. Kaplan that Dr. Brown's drug tests are urine tests and not blood tests. Dr. Kaplan asked if the drug tests can pick up alcohol consumption. Ms. Penttinen explained that because of Dr. Brown's prior DUI his consent agreement specifically includes testing for ethylglucaronide which is the metabolite of alcohol and can be detected up to seven days after the consumption of alcohol. Ms. Penttinen also stated that urinalysis is done rather than a blood test because with blood tests most, if not all, substances would be undetectable after a period of 12 to 24 hours. She added that there are a number of factors which can contribute to detection of alcohol and other substances in a person's urine such as amount of use, frequency of use, the person's body fat concentration, and the person's metabolism. Ms. Penttinen confirmed for Dr. Kaplan that Dr. Brown is required to call into the drug testing phone line every day, (color of the day), and if his color comes up he must test that day.

Dr. Leonetti asked who has been prescribing the pain medication to Dr. Brown. Ms. Penttinen stated she was uncertain that she would be able to obtain that information from Dr. Sucher. Dr. Leonetti also asked if the prescriber was aware of Dr. Brown's consent agreement with the board. Ms. Penttinen stated that they should be because the consent agreement requires that Dr. Brown provided a copy of the agreement to any physician who prescribes medication to him. Ms. Penttinen stated she will confirm this.

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

### **a. Review of new license application for the following podiatrists:**

Kristina Jezidzic

Matthew Pettengill

Daphne Yen-Douangmala

**MOTION:** Dr. Kaplan moved to approve each of these three physicians to sit for oral exam on December 12, 2012.

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

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

### **b. CME approval request from Carondelet Health Network.**

The board members reviewed a CME approval request from Carondelet Health Network. The program is a wound care symposium scheduled for October 13, 2012. The number of hours being requested for CME approval is 6.75.

**MOTION:** Dr. Kaplan 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. Selection of 2013 Board meeting dates.**

The board members reviewed a calendar for 2013 and agreed to continue holding board meetings on the second Wednesday of each month. (Oral licensing exams will be administered during the June and December 2013 board meetings.) Dr. Kaplan proposed discussion regarding the frequency of board meetings and the possibility of holding meetings more frequently than one per month in order to reduce the number of open complaints. After discussion among the board members it was decided that board meetings will continue to be held once per month, possibly with longer meeting duration in order to review more complaints at each meeting.

**MOTION:** Dr. Kaplan moved to approve the proposed 2013 board meeting date as follows – January 9, February 13, March 13, April 10, May 8, June 12, July 10, August 14, September 11, October 9, November 13, December 11. Ms. Miles seconded the motion.

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

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

### **d. Request from Dr. Michael Cornfield for exemption from license application deadlines.**

Ms. Penttinen provided the following summary: Dr. Cornfield was previously licensed in Arizona beginning in 1977; however, it is unknown when his license expired. The license was expired at the time that the board's current database was created in 2007, but the only information entered into the database was Dr. Cornfield's address and phone number, issue date, and license number. In addition, Dr. Cornfield's hard copy license file has been archived but cannot be located. Dr. Cornfield has been living and working in California but would now like to return to Arizona. Dr. Cornfield stated that he has an opportunity to sell his practice in the very near future and has a potential job opportunity available to him in Arizona starting in January. Dr. Cornfield would like to sit for the December 2012 oral exam; however, he missed the September 13 application deadline. Dr. Cornfield has submitted a written request to be allowed to begin the application process at this time and sit for the oral exam in December.

Dr. Kaplan asked how long Dr. Cornfield has been out of practice. Ms. Penttinen clarified that Dr. Cornfield's last known address was in California so it is unknown if he ever practiced in Arizona or how long he may have been out of practice in California. Ms. Penttinen added that a license verification from the state of California would be required at the time Dr. Cornfield submits his application to this board, but what Dr. Cornfield would like to know is if he will be allowed an exemption to the September 13 application deadline in order to sit for the December exam. Mr. Harris addressed the board and advised them that they should consider whether or not the board has approved similar requests in the past and the reasoning for doing so. Mr. Harris also stated that he feels the letter submitted by Dr. Cornfield raises a number of questions regarding his health, license status and practice history over the last several years dating back to at least 2007 at which time his Arizona license was expired. Mr. Harris stated that any questions regarding Dr. Cornfield's license history should be explored and answered prior to granting Dr. Cornfield a reinstatement of his license. Dr. Kaplan agreed with Mr. Harris's advice.

**MOTION:** Mr. Rhodes moved to deny Dr. Cornfield's request for an exception to the license application deadline. Dr. Leonetti seconded the motion.

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

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

e. Review of proposed Substantive Policy Statements:

i. SPS 12-01 regarding podiatric medical assistants.

Dr. Kaplan opened discussion regarding the clinical task of "applying bandages to the feet." He stated he felt that there needed to be more specific detail included as to the type of bandages that would be applied. With regard to "taking and developing x-rays," Dr. Kaplan wanted to add the requirement that the medical assistant be properly certified to take x-rays. Dr. Kaplan also wanted to remove "application of casts" and "performance of diabetic foot exams" from the list of approved clinical tasks. Dr. Campbell and Dr. Leonetti agreed. The board members then reviewed the clinical task of "performance of non-invasive peripheral arterial exams." After discussion among the board members it was determined that this task description should be modified to state that a podiatry assistant may perform, but not interpret, non-invasive peripheral arterial exams utilizing equipment such as "Padnet," ultrasound, Doppler, or other similar devices. The board was also agreed that the task of administering oral medications should also include a requirement that such administration would be at the direction of the supervising physician.

The board members then reviewed the specific tasks that podiatry assistants should not be permitted to perform. They determined that the task stated as "any type of injection into the foot" should be modified to state "any type of injection." The board members also agreed to add the following exception: "any invasive procedure except venipuncture." Ms. Miles also suggested removing the capitalization of the term "medical assistant" and the other board members agreed. Ms. Penttinen will make the changes as discussed and re-present the proposed policy to the board of future meeting. Mr. Harris offered discussion regarding the list of three items which were specified as tasks that a medical assistant should not be permitted to perform in a podiatry office. He stated there could be a possibility at some point in the future that a question could be raised because a podiatrist allowed medical assistant to perform a task that was not specifically listed as a task that should not be performed. Mr. Harris suggested to the board the possibility of completely removing this section of the substantive policy statement. Dr. Leonetti stated that he felt those exclusions are broad enough to include any type of procedure which would involve puncturing of the skin and he feels they are appropriate. There was no further discussion.

ii. SPS 12-02 regarding supervision of hyperbaric oxygen therapy.

The board members reviewed the proposed policy statements and felt that it was appropriate regarding the board's position on supervision of hyperbaric oxygen therapy. Ms. Miles suggested adding a statement to the policy as follows: "The board agrees that these guidelines are necessary to protect public health, safety and welfare." Ms. Penttinen will make that modification and will return the policy to the board for approval at a future board meeting.

f. 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:

Parker Gennett

Spencer Niemann

Todd Zang

Ms. Miles was not present during review of this agenda item. Dr. Gennett submitted with his renewal application a request to waive a portion of his CME he completed 20 hours but would like the other five hours waived due to what he explained as family problems.

MOTION: Dr. Leonetti moved to deny Dr. Gennett's CME waiver request. Per the board's statutes Dr. Gennett will have 60 days to complete the additional five hours. 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 renewal applications for Dr. Niemann and Dr. Zang. Dr. Campbell 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. Miles was not present for review of this item. Ms. Penttinen reviewed the open complaint status report which indicates that there are currently 52 open complaints including those that were on today's agenda. Dr. Leonetti referred to complaint number 07-11 for Dr. J. David Brown and asked for discussion. Ms. Penttinen advised the board that she sent a letter to Agent Jeffrey Morgan at DEA by certified mail requesting a status update of their investigation. She has received the return receipt card but has not received any response from Mr. Morgan. Dr. Kaplan and Ms. Penttinen reviewed that DEA submitted a large volume of documents to the board; however, the board is prohibited from using or disclosing those documents until DEA is completed with their investigation. It is unknown what action if any DEA is planning to take or in what time frame. Mr. Rhodes asked if it would be appropriate to dismiss the board's complaint case without prejudice.

MOTION: Mr. Rhodes moved to dismiss this case without prejudice and to advise Dr. Brown that the case may be re-opened when or if DEA takes a final action in their case. Dr. Leonetti seconded the motion.

DISCUSSION: Dr. Kaplan suggested that a letter also be sent to Mr. Morgan at DEA advising him of the board's present disposition of this case. Ms. Penttinen stated she would do so.

VOTE: The motion passed unanimously by voice vote.

b. Malpractice case report

i. Randall Brower, DPM: Claim filed by patient T.D. on 07/15/09 and settled on 07/16/12. (This matter was disclosed by Dr. Brower when he re-applied for his Arizona license in 2010 and no Board action was taken at that time.)

Ms. Miles was not present during review of this item. The board members reviewed the PICA report and NPDB report which indicate that a claim filed by patient T.D. was settled in favor of the patient on September 10, 2012. Ms. Penttinen confirmed for the board members that the incident occurred in New Mexico six years ago and Dr. Brower did disclose this matter on his initial license application; when the board reviewed Dr. Brower's initial license application they decided to defer this matter pending the outcome of any action taken by the New Mexico podiatry board. If that state does take any disciplinary

action then Dr. Brower would be required to disclose that on his next license renewal application. Dr. Kaplan stated that he does not feel the board needs to take any action on this matter at this time. The remaining board members agreed.

**VIII. Call To The Public**

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

**IX. Next Board Meeting Date:**

a. November 14, 2012 at 8:30 a.m.

**X. Adjournment**

MOTION: Dr. Campbell moved to adjourn the meeting. Dr. Kaplan 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 10:53 a.m.