



Janice K. Brewer  
Governor

## State Of Arizona Board of Podiatry Examiners

"Protecting the Public's Health"

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

Barry Kaplan, DPM; Joseph Leonetti, DPM; Barbara Campbell, DPM;  
M. Elizabeth Miles, Public Member; John Rhodes, Public Member; Sarah Penttinen, Executive Director

### **BOARD MEETING MINUTES**

December 12, 2012; 8:00 a.m.  
1400 West Washington St., B1  
Phoenix, AZ 85007

Board Members: Barry Kaplan, D.P.M., President  
Joseph Leonetti, D.P.M., Member  
Barbara Campbell, D.P.M., Member  
M. Elizabeth Miles, Secretary-Treasurer  
John Rhodes, Public Member

Staff: Sarah Penttinen, Executive Director

Assistant Attorney General: John Tellier

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

Dr. Kaplan called the meeting to order at 8:05 a.m.

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

All Board members were present as were Ms. Penttinen and Mr. Tellier.

#### **III. Review, Discussion and Possible Action: Informal Hearing (Scheduled for 10:00 a.m.)**

a. 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 present with attorney Neil Alden. This informal hearing was recorded by a court reporter and a transcript is attached to these minutes.

MOTION: Ms. Miles moved to go into Executive Session for the purpose of obtaining legal advice.  
Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the board adjourned into Executive Session at 11:02 AM.

The board returned to Regular Session at 11:08 AM.

MOTION: Ms. Miles moved in favor of Findings of Fact as stated in the investigation report, specifically A.R.S. §32 – 852 (6) via A.R.S. §32-854.01 (20). 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 issue a Decree of Censure including probation for six months during which time Dr. Fridrich must submit complete copies of all charts including x-rays and billing records for all nail procedures not to exceed 10 charts per month. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

The remaining items were not time-specific and were not reviewed in the order in which they appear in the minutes.

**IV. Review, Discussion and Possible Action on Administrative Matters:**

- a. Reconsideration of the license application of Mark Little, DPM and the Board's prior motion to approve Dr. Little to sit for the oral licensing exam.

Dr. Little was present. On November 14, 2012 the board members had reviewed Dr. Little's license application and approved him to sit for the oral licensing exam. However, the board would now like to reconsider the application and the prior motion for approval. Dr. Little confirmed for Dr. Kaplan that he began practicing in California in 1993 and continued to practice until his license was revoked by the State of California in 2004. He has not been practicing for the last eight years. Dr. Little stated he is currently working in the office of Dr. Antonius Su performing back office duties including rooming patients, taking patient histories and setting up for procedures. He plans to work in the office of Dr. Su if he is granted a license. Dr. Little confirmed for Dr. Kaplan that he spent approximately 30 months in jail for his criminal conviction but did not work in any medical capacity while he was incarcerated. He stated he has completed all requirements of his sentencing, including drug testing, but is still in the process of repaying his financial requirement.

Dr. Leonetti reviewed the Order of Revocation issued by the State of California which outlines treatments provided by Dr. Little to several different patients and asked Dr. Little why these particular patients were selected for audit or review. Dr. Little stated that many of those patients were treated in 1997 and 1998 and had since passed away and in his opinion they were selected for review because he could not speak to the patient's regarding the need for the care that he provided. He added that these patients were all diabetic and required a large amount of wound care and the use of particular associated billing codes. Dr. Little asserted that there were only 10 patients mentioned in the California Order out of thousands of patients he treated. Dr. Little stated that with regard to the billing codes he used, he did make mistakes in some of the code modifiers that were used. Dr. Leonetti stated that he felt the treatment provided to these 10 patients was outrageous. Dr. Little agreed and stated that he has since learned that he should have referred the patient's to other providers for wound care and should not have tried to treat them by himself. Dr. Leonetti also reviewed Dr. Little's explanation in his application materials which states that he was a poor record-keeper at the time. Dr. Leonetti stated he feels the issues described in the California Order are more than simple record-keeping problems and being disorganized. Dr. Leonetti added that there were incidents of fraudulent billing including dates when Dr. Little was out of the country. Dr. Leonetti asked Dr. Little what was going on in his life at the time that all this was going on and what has changed now. Dr. Little stated he had been going through divorce at the time and was raising several children. He stated that he was spread very thin having only one employee working for him and that he was trying to manage everything essentially by himself. Dr. Leonetti again reviewed that there were claims submitted by Dr. Little for dates of service when he was out of the country which he feels is more than just a physician being busy but demonstrates a conscious decision and action.

Dr. Leonetti also stated that he does not understand how the issue of substance abuse is involved with this matter. (Under Dr. Little's plea agreement with the US District Attorney he was required to undergo 500 hours of substance abuse education.) Dr. Little explained that he had a motorcycle accident at the age of 17 and has since had a great deal of dental complications and surgeries. He added that he has taken pain medication as needed but he does not feel that his use of pain medication clouded his judgment. Ms. Miles asked Dr. Little what his drug of choice was and his sobriety date. Dr. Little stated it was hydrocodone and his sobriety date was in 2003 but he does not know the exact date. Ms. Miles asked Dr. Little if he participated in a 12-step program. Dr. Little stated he completed the required 500 hours of education while he was incarcerated that he does not know if that would be considered a 12-step program. Dr. Leonetti asked Dr. Little to clarify if what he was saying was that he told the judge that he had been abusing hydrocodone which may have clouded his judgment while he was treating these patients and billing for that treatment. Dr. Little stated that was correct. Dr. Little asserted that he does not feel there was any question about the quality of the care he provided to those patients and the only issues raised were with regard to billing.

Ms. Miles reviewed the portion of the California Order which indicates that Dr. Little submitted fraudulent and/or falsified patient records to that board during its investigation. The apparent reason for doing so was an attempt for Dr. Little to support the billing claims that he filed for these patients. Dr. Little agreed

with this. Dr. Little stated that he is at the mercy of this board to give him a chance to regain his license in order to continue to treat patient and also to fulfill his financial obligations under his plea agreement. Ms. Miles asked Dr. Little to explain how this board could have confidence that he will not engage in the same types of activities here as he did in California. Dr. Little stated that was used had many difficult consequences as a result of his actions. He added that he has completed continuing medical education which includes electronic medical record keeping. Dr. Little also stated that he feels a deep responsibility for his actions and is willing to do whatever it takes to be allowed to practice again. Ms. Miles stated that the underlying issue is not whether or not Dr. Little is a good physician but is more of a question of his character. Dr. Little stated that he understands he has brought a great deal of shame to himself as well as his family and profession. He stated he knows that what he had done was wrong and he will never go down that road again. Dr. Little added that he has support from the many of his former coworkers and colleagues and has learned a great deal in the last several years.

Dr. Campbell questioned Dr. Little about the brain injury he sustained in his motorcycle accident and whether or not that has affected his ability to practice. Dr. Little stated that occurred when he was 17 and since then he has graduated from college and medical school. He said that he was rather desperate in his defense of his license and his attorney utilized his previous brain injury in an attempt to explain some of his actions; however, he does not feel that the brain injury has caused any problems for him as a podiatrist. Dr. Kaplan asked Dr. Little about when he began over utilizing his prescription pain medication. Dr. Little stated it was at approximately 2001 during the time he was being investigated. Dr. Kaplan stated that the hydrocodone use then would not have affected his judgment or actions during 1997 and 1998 when these pilling problems occurred; therefore, the fraudulent billing would have been intentional. Dr. Little stated that he knows he has made many horrible mistakes. Dr. Leonetti addressed Dr. Little and stated that he understands Dr. Little has undergone a great deal because of all of this and there have been many difficult circumstances. Dr. Leonetti added that this board always wants to see competent physicians be able to practice and represent the state of Arizona and the profession well; however, he agrees with the point raised by Ms. Miles regarding the character aspects of this issue. If a physician comes before the board due to poor surgical outcome the board can prescribe continuing education in order for the physician to become a better practitioner. However, when an applicant comes before the board with issues such as in this case, with fraudulent billing and falsification of patient records, it is difficult for the board to determine that that person has been re-educated and will not repeat the same actions. Dr. Little stated that he understands the board's concerns and added that all of the administrative and legal proceedings he has been through have taught him that he made many great mistakes. Dr. Little stated that he knows what he did was wrong but with the help of friends and colleagues he now sees the right way. He added that he has no desire to commit any fraudulent recordkeeping or billing and that he is working very hard to repay his obligations. Dr. Little stated that he feels this is his only chance to regain his professional license.

Dr. Kaplan asked Dr. Little how he planned to regain contracts with insurance companies and hospital privileges. Dr. Little stated that he planned to initially work in an office-based practice and community outreach programs. Upon further questioning from Dr. Kaplan, Dr. Little stated he would most likely have to initiate his practice as a cash-based practice until he is able to conduct with insurance companies. Dr. Little added that he does not plan to conduct any of his own billing; he plans to have staff or an outside company handle his billing for him. Dr. Kaplan also asked Dr. Little when the last time was that he had any actual patient contact. Dr. Little stated it was in 2004 but that he has also been completing CME seminars in addition to his work at Dr. Su's office. Dr. Little stated he does not plan to perform any surgeries initially; he wants to re-enter practice gradually. Dr. Kaplan also stated his concerns that Dr. Little may not be fully up to date in his podiatry education due to the amount of time that he is not been practicing. Dr. Little stated he has completed many seminars and CME programs to try to keep himself as updated as possible and believes he is further along in his education than he was at the time he completed his residency. Dr. Little stated that he may not be as up to date on surgeries as he used to be but he does not plan to perform any surgeries initially, and upon questioning from Dr. Kaplan regarding pharmaceutical issues Dr. Little stated he has been keeping up on that as well. Ms. Penttinen reviewed for the board members the CME certificates which Dr. Little submitted with his application file which indicate that he completed a combined 75 hours of CME in 2008 and 2009, and in 2011 and 2012 he completed approximately 100 hours of CME. All of the courses were through The Podiatry Institute and the ACFAS.

- MOTION:** Dr. Kaplan moved to go into Executive Session for the purpose of obtaining legal advice. Dr. Leonetti seconded the motion.
- DISCUSSION:** There was no discussion on the motion.
- VOTE:** The motion passed unanimously by voice vote and the board adjourned into Executive Session at 8:42 AM.

The board returned to Regular Session at 8:56 AM.

Dr. Leonetti stated that he had some concerns regarding Dr. Little's license application. He would like to see that Dr. Little can pass the National Board Part III exam to make sure he is up to par on his medical knowledge. Dr. Leonetti also stated that he did not want to lead Dr. Little down the path of licensure if it ends up being the board's decision not to grant him a license and asked the other board members for their thoughts. Dr. Kaplan stated there are two issues which could be considered by the board to deny the license application which are moral turpitude and revocation of his California license. Ms. Miles addressed Dr. Little and stated that she understands and appreciates the position that he is in professionally speaking. Ms. Miles stated to the other board members that even if Dr. Little were to pass the oral exam she does not feel he meets the minimum licensing requirements. She stated that the actions committed by Dr. Little which were discussed earlier demonstrate a lack of character and she does not feel that Dr. Little has demonstrated sufficient rehabilitation to address her concerns. Dr. Campbell stated that she agrees with concerns the been raised by the other board members and that she also was concerned with Dr. Little's ability to make a living if he is not able to participate in insurance reimbursement programs. Dr. Little stated that obtaining his license would be the first of many steps that he would need to take. He added that he also has considered working in non--patient care areas of medicine such as consulting and research that he would need a license in order to do that. Dr. Little stated that he believes he's made a great deal of progress since those acts were committed in being able to run a practice and knowing the difference between right and wrong. Dr. Leonetti explained to Dr. Little that the board is not able to issue a license with any type of condition restriction placed upon it; the license would be to practice in whole until such time as an issue were to arise. He stated that he understands Dr. Little's desire to regain a license but he would like to offer Dr. Little the opportunity to withdraw his license application because a formal denial of the application would be reported to the National Practitioner Data Bank. Dr. Little asked if the board could advise him on any course of action he could take which way did enable him to gain a license at some point in the future. Dr. Kaplan agreed that allowing Dr. Little to withdraw his application would be a viable option but told Dr. Little that the board could not advise him on how to proceed with any future application. Dr. Little stated that he would withdraw his application and that he plans to re-apply in the future.

- b. Administration of oral examinations for the following new license applicants:
- |                         |                            |
|-------------------------|----------------------------|
| Daniel Arrhenius, DPM   | Jeffrey McAlister, DPM     |
| Thomas Chambers, DPM    | Rachel O'Connor, DPM       |
| Matthew Hinderland, DPM | Mark Olsen, DPM            |
| Kristina Jezidzic, DPM  | Matthew Pettengill, DPM    |
| John Knochel, DPM       | Daphne Yen-Douangmala, DPM |
| Mark Little, DPM        |                            |

- MOTION:** Ms. Miles moved to go into Executive Session for the purpose of conducting the oral licensing examinations which are confidential. Dr. Kaplan seconded the motion.
- DISCUSSION:** There was no discussion on the motion.
- VOTE:** The motion passed unanimously by voice vote and the board adjourned into Executive Session at 9:11 AM.

The board returned to Regular Session at 9:35 AM.

## V. Approval of Minutes

- a. October 10, 2012 Regular Session Minutes.
- MOTION:** Ms. Miles moved to approve the minutes as drafted. Dr. Kaplan seconded the motion.
- DISCUSSION:** There was no discussion on the motion.
- VOTE:** The motion passed unanimously by voice vote.

b. November 14, 2012 Regular Session Minutes.

MOTION: Ms. Miles moved to approve the minutes as drafted. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

**VI. Review, Discussion and Possible Action –Review of Complaints**

a. 08-25-C – Aprajita Nakra, DPM: Providing improper orthotics and insufficient instruction on their use; failing to properly treat an ingrown toenail.

The Board received a request from Dr. Nakra's attorney Ed Ladley to postpone review of this case until the February 2013 Board meeting due to Dr. Nakra's scheduling conflicts. The Board members agreed to the postponement. Mr. Ladley also had requested to conduct review of this item in Executive Session due to pending litigation against Dr. Nakra in a separate case. The Board members determined that the request does not qualify for proper use of Executive Session.

b. 09-15-M – Aprajita Nakra, DPM: Development of ulcerations which caused permanent scarring to the patient's leg.

The Board received a request from Dr. Nakra's attorney Ed Ladley to postpone review of this case until the February 2013 Board meeting due to Dr. Nakra's scheduling conflicts. The Board members agreed to the postponement. Mr. Ladley also had requested to conduct review of this item in Executive Session due to pending litigation against Dr. Nakra in a separate case. The Board members determined that the request does not qualify for proper use of Executive Session.

c. 11-10-M – Carl Beecroft, DPM: Practice below the standard of care for operating on the wrong foot. Ms. Penttinen was the investigator for this case and provided the following summary: The Board previously received a malpractice report from PICA indicating that a claim had been filed against Dr. Beecroft by patient R.R. The patient filed a concurrent case against Dr. Beecroft's practice partner Dr. Kelvin Crezee and the nature of the claim was stated as performing surgery on the wrong body part. After the claim was filed, and after the Board determined to open a complaint investigation, it was learned that the malpractice claim was filed against Dr. Beecroft in error. Dr. Beecroft was not present during the surgery and had not been involved in any aspect of the patient's care. Ms. Penttinen requested that the Board members dismiss this case.

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.

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

Dr. Nakra was not present. Attorney Bruce Crawford was present on Dr. Nakra's behalf and addressed the board as follows: The patient's attorney is essentially using board proceedings as a legal tactic in the civil malpractice suit. That attorney has asked Dr. Nakra questions about information contained within the board's investigation report which Mr. Crawford advised her not to answer. He would like to propose that the billing questions the board has be addressed in a written supplement from Dr. Nakra. Dr. Nakra would be willing to discuss the concerns with the investigator assigned to the case in order to provide the requested information to the board.

Dr. Kaplan stated that he is uncertain how to address this matter because he does not believe this qualifies for Executive Session. Dr. Leonetti clarified that he believes Mr. Crawford's request is not for Executive Session but to address the board's concerns in writing. Dr. Kaplan stated it was his understanding that what occurs before the board could not be used in civil litigation. Dr. Kaplan also questioned whether the report generated by the investigator is being used as a public document. Ms. Penttinen confirmed that the investigation file, including the investigator's report, is not public record but anything discussed during an open board meeting is public record, so any supplemental response or report from the investigator would have to be discussed in open session. Mr. Crawford stated that the attorney who is representing the patient in this matter advised his client to file a complaint with the board and is using the board's proceedings to gain information to be used during the civil litigation. He said Dr.

Nakra would be willing to discuss any concerns the board has with the board's investigator that he does not want that information used against Dr. Nakra in the civil case. Dr. Kaplan reviewed that both of the allegations in this investigation were discussed in a prior board meeting, and recorded in the minutes, and the board found that both of the allegations were substantiated. Mr. Crawford stated it was his understanding that the board only had some concerns regarding Dr. Nakra's billing. Dr. Leonetti stated that the investigator has already submitted his investigation report which the board has reviewed. At this time the board has questions regarding the billing which they would like to discuss directly with Dr. Nakra. Dr. Leonetti added that having Dr. Nakra speak only with the investigator is going to cause a delay because there will likely continue to be questions from the board members themselves; a supplemental report from the investigator is not likely to satisfy the board members concerns until they are able to speak directly with Dr. Nakra. Dr. Kaplan stated that he does have concerns on both allegations; he is happy to have the investigator speak with Dr. Nakra but the board still has questions which they would like to discuss directly with her. Mr. Crawford stated his belief that none of the physician board members would want to be in Dr. Nakra's position to have issues discussed before the board used against them in civil litigation. Dr. Kaplan agreed but affirmed that he would like to have the billing concerns addressed. Ms. Penttinen asked the board members to clarify exactly which issues they would like the investigator, (Dr. Jerome Cohn), to discuss with Dr. Nakra. Dr. Kaplan stated it would be the billing codes listed in Dr. Cohn's investigation report. Ms. Miles also suggested that the investigator review the board meeting minutes from the prior review of this case to capture the specific concerns discussed by the board.

- e. 11-22-M – Don Shumway, DPM: Practice below the standard of care for improper surgery and post-operative care.

Dr. Shumway was present without an attorney. Dr. Dedrie Polakof was the investigator for this case and provided the following summary: on his 2011 license renewal application Dr. Shumway disclosed that a malpractice suit had been filed against him by patient R.R. The legal complaint in this matter states, "During the course of medical care and attention the patient received on September 19, 2008, defendant Shumway unintentionally lacerated one or more nerves in the patient's right lower extremity." The complaint also states that Dr. Shumway failed to recognize the lacerations thereby failing to render appropriate care for such. The patient has alleged permanent injury. On September 18, 2008 the patient received treatment for plantar fasciitis, Baxters neuritis, tarsal tunnel syndrome and equines. During dissection of the surgery the superficial peroneal nerve was not able to be differentiated from scar tissue and was dissected through-and-through leaving frayed ends. The nerve was dissected out of the surgical field proximally and distally. The patient's husband was advised immediately after surgery of the complication. Later multiple discussions were made with the patient advising her what happened and what her options would be.

Dr. Polakof reviewed the patient's records as follows: on March 10, 2008 patient initially reported severe pain which was described to be different from pain on the bottom of the heel. On April 29, 2008 an MRI was done which displayed a split longitudinal tear in the FDL and a PT tendinitis. The plan was to repair the FDL tendon, a Kidner, and evaluation of the PT tendon and this and is Moses of the PT and FDL tendons in addition to the conical subtalar implant. On May 19, 2008 consent forms were signed for surgery planned on May 23rd. Surgery was performed on May 23rd to repair the FDL tendon, PT tendon dysfunction and gorilloid navicular talipes pes plano valgus repair. The surgery included connection of the FDL and PT tendon and repair of the PT tendon. On September 19, 2008 the patient was reporting difficulty in walking on uneven surfaces and requested the implant to be removed. Surgery was done to remove the hardware from the right subtalar joint and the intermediate dorsal cutaneous nerve was transected while making the initial surgical cut.

Dr. Polakof continued by stating that the patient did not understand why she was in pain when all that was supposed to be done was removal of the implant. Dr. Polakof stated that upon her review of the records she understands that in the surgical procedure it may be difficult to differentiate different anatomical features when there's a great deal of scar tissue present in the area. Dr. Polakof stated that Dr. Shumway acted appropriately in recognizing that he had made contact with the nerve and by trying to repair the area as much possible to minimize the patient's complications. Dr. Polakof stated that the damage to the nerve was a known potential complication of the surgery and she does not find the patient's allegation of malpractice to be substantiated.

Upon questioning from Dr. Kaplan, Dr. Shumway stated that this case is still in litigation. Trial was planned for November or December of this year but has now been postponed. Ms. Miles asked Dr. Polakof to confirm her understanding that even though laceration of the nerve occurred, that would not be something unusual considering the patient's presentation and the amount of scar tissue present in the foot and that sometimes complications can occur not due to the fault of the physician. Dr. Polakof agreed with Ms. Miles. Dr. Polakof stated that sometimes when you go into a surgical site it is difficult to differentiate specific anatomy because of prior procedures and various healing processes. Dr. Kaplan agreed and stated that anatomy can change and that certain anatomical features may be present in places where they are not expected to be. Upon questioning from Dr. Leonetti, Dr. Shumway confirmed that his incision to remove the hardware was at the same site as the initial incision to place the hardware; during the procedure to place the hardware he did not note any nerve. Dr. Shumway added that the scar tissue had encapsulated the nerve and he was not able to see that the nerve had been dissected until after the incision had been fully made.

**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.

- f. 11-31-M – Teisha Chiarelli, DPM: Practice below the standard of care for improper surgery which resulted in single digit amputation.

Dr. Chiarelli was present with attorney Bruce Crawford. Dr. Jerome Cohn was the physician investigator for the case and was present. The board received a report from PICA indicating that a malpractice claim was made against Dr. Chiarelli by patient L.G. the nature of the claim was stated as, "patient underwent hallux repair with implants; arthroplasty, right, on all lesser toes; capsulotomy of the third and fourth metatarsals. She claims surgery resulted in subsequent amputation of second digit, right. NFI at this time."

Dr. Cohn reviewed the case as follows: On review of the medical records the case involved a 69-year-old female who describes herself to be in good health with a negative smoking history positive for diabetes on oral medications metformin and glyburide. She presented to the office initially September 2009 and was seen by Dr. Stone. Her complaint was toes that turned underneath and she was referred by her diabetologist. At that time her evaluation revealed good pedal pulses with a normal vascular evaluation and contracted digits. X-rays were taken at the time and she was diagnosed with contracted digits/hammertoes as well as mycotic nails, Initial treatment consisted of topical antifungal and discussion of surgical intervention. Patient returned for follow-up on September 21, 2009 with Dr. Stone at which time further discussion of surgery and the preoperative evaluation were reviewed including the need for Doppler studies. There was a third visit to Dr. Stone February 3, 2010 at which time patient wished to discuss surgery and would return back to the office in the future for further discussion at her convenience. Last visit with Dr. Stone January 4, 2011 occurred at which time she presented with hammertoes and a request to discuss and proceed with surgical intervention. Evaluation at this visit continued reveals good vascular status as well as musculoskeletal evaluation consistent with contracted digits that would be symptomatic. Additional x-rays were taken and Dr. Stone discuss surgical intervention at which time she explained that she would shift her care to her partner Dr. Chiarelli for further scheduling of surgical procedure.

Dr. Cohn continued: Dr. Chiarelli initially saw the patient on February 7, 2011 which was intended to be a pre-operative evaluation however the patient was not feeling well and therefore the discussion consisted of re-scheduling surgery. Dr. Chiarelli next saw the patient March 29, 2011 for her preoperative evaluation. At this time the discussion was for a total implant of the first MPJ and arthroplasty second, third, fourth, fifth digits on right foot. During this discussion it was determined that the first metatarsophalangeal joint was not that symptomatic and therefore determination was made not to proceed with surgery on the first metatarsophalangeal joint. Consent was therefore discussed and signed without this procedure. It did include x-rays as well as physical evaluation and review of the previous records in which patient had appropriate vascular status and review of previous studies. A note was then included in the chart dated March 27, 2011 (which is likely dated incorrectly but was a telephone note stating patient had requested first MPJ surgery be performed as well as she stated it hurt

more than she originally thought) there is an additional consent for the first MPJ with implant repair but was undated but is signed. The operative report describes a hallux rigidus repair with implant as well as arthroplasty right second, third, fourth, and fifth digits as well as tenotomy and capsulotomy second, third, and fourth metatarsophalangeal joints with K wire fixation to the second. The operative report was complete and there did not appear to be any deficiencies or inappropriate procedure. The description of the procedures was within standard of care including monitoring vascular status for the second digit. First postoperative visit was April 7, 2011. Patient had apparently had some issues over the weekend with vomiting which was controlled with medications and was now improving. Physical examination described purple hue to the second digit. X-rays were taken and appeared to be standard and appropriate. Care consisted of redressing she did not incise and drained the blister formation on the second digit as it did not appear infectious and patient was to return to the office one week for continued evaluation. Second post-op visit was April 14, 2011 patient was described as getting along fairly well. Was only taking pain medication every 12-14 hours. She did still have some nausea from the medication and was utilizing an anti-inflammatory. She did not describe the second toe as becoming more painful. Examination described a large bulla on the second digit the wire was movable blistering and swelling and discoloration appeared to involve the second digit remaining surgical sites appeared stable and at this time decision was made to lance the bulla and culture. The fixation was left in place. X-rays revealed continued placement of fixation and good placement of the first MPJ implant. Wound was redressed and patient to return in one week.

Dr. Cohn continued: Visit on April 21, 2011 which is approximately 3 weeks post-op was described as patient having more blistering and discoloration to the second digit there apparently was an eschar greater than what Dr. Chiarelli expected and the question was raised at this time by patient if she would lose the digit. Dr. Chiarelli did state it was possible. The physical examination described a quite blackened digit from the distal interphalangeal joint distally as well as along the incision dorsally. There appeared to be good color to the digit plantarly. Rest of the digits described as looking healthy with a generalized edema of the forefoot and midfoot. The K wire was removed at this time and good perfusion to the second digit was noted. The culture previously taken was negative and there were no clinical signs of infection. X-rays revealed the K wire to have been removed. Patient was instructed to start range of motion and shoe gear and return in 1 week. The April 21, 2011 visit was the last visit Dr. Chiarelli had with the patient. Next multiple phone calls within the chart are documented. This started April 25, 2011 in which patient had presented to the Wickenburg emergency room and was then referred to Del Webb Hospital. Although Dr. Chiarelli was not on staff at this hospital she did agree the referral was appropriate patient was sent to the hospital and she did attempt to obtain temporary privileges. There were multiple telephone calls documented in which Dr. Chiarelli continue to attempt follow-up with Dr. Esber who is a podiatrist consulted at the hospital and had kept her informed of the patient's progress. There was attempted discussion with the orthopedic physician who did not return phone call for continuity of care. Patient did after an amputation of the right second digit undergo some medical complications which resulted in a stay in the ICU. Patient was discharged May 19, 2011. This hospital stay did involve amputation of the right second digit by orthopedics and patient never returned to Dr. Chiarelli for care upon her discharge.

Dr. Cohn continued: When reviewing patient's billing records she was consistent in terms of the billing charges and procedures performed. An issue was noted involving charges and the modifier used for the surgical procedure. The appropriate code for the first MPJ 28293 was utilized. She also utilized to be 28285 for the second third fourth and fifth digits which was appropriate based on the operative report. Within the CPT book 28285 is part of the CCI. The additional code utilized on the second third and fourth digit was a 28270 described as a capsulotomy at the metatarsophalangeal joints, separate procedure also within the CCI. This is typically included within the 28285 for Medicare guidelines. It was certainly within Dr. Chiarelli's right to bill this code however the modifier "59" should not have been added as this is utilized to describe separate identifiable procedures such as a visit in which a patient presents for follow-up on heel pain but then describes an ingrown toenail. The procedure for ingrown toenail would be modified utilizing a 59 in order to allow for both review of the heel pain and the treatment for an ingrown toenail. The operative report described a separate incision but that alone does not warrant additional charges as it is possible to perform multiple billing code procedures through one incision as well.

Dr. Cohn stated he did not interview the patient because this was a malpractice case which was settled and he did not feel that the patient would be able to provide any additional information required to make

a decision regarding the allegations. Dr. Cohn stated he did contact Dr. Chiarelli on August 7, 2012 to verify that she had reviewed both the Doppler studies pre-operatively and that based on this findings and the consistency in the studies that adequate vascular status was present in order to proceed when combined with the consult that was performed by Biltmore Cardiology. That consultation included both cardiac and vascular evaluation. The findings of the studies were reviewed which included a Doppler study on October 6, 2010 in which the findings included an ankle-brachial index of one on the right. The impression included no hemodynamically significant stenosis, mild to moderate multifocal stenosis bilateral with normal ABI. There was an additional Doppler study performed on September 25, 2009 which described similar findings that was read by a vascular surgeon. A verbal discussion with Dr. Smith was noted in the patient's chart concerning the complications which Dr. Smith described as a probable micro-embolism. In conclusion Dr. Cohn found that the allegation of practice below the standard of care was not substantiated. The patient was diabetic and underwent multiple evaluations and consultations prior to the surgical procedure performed by Dr. Chiarelli. Dr. Cohn agreed that the patient likely experienced a micro-embolism associated with micro-angiopathy and diabetes which could not be predicted. Dr. Cohn concluded by stating that post-surgical complications such as this could arise but would not necessarily be indicative of practice below the standard of care. He feels that Dr. Chiarelli was complete in her care of the patient and attempted to continue with care in the patient's best interest.

The board members did not have any questions for Dr. Cohn. Mr. Crawford addressed the board and explained that the settlement made on Dr. Chiarelli's behalf was a very small amount and was made in the interest of avoiding the cost and duration of litigation. Dr. Kaplan stated that he understood the reasoning behind the settlement. Dr. Kaplan asked Dr. Chiarelli if she would like to respond to the investigator's report or make any statement which she did not. Dr. Leonetti reviewed that Dr. Chiarelli had obtained vascular consultation prior to the surgery and asked her what she thought happened with the patient. Dr. Chiarelli stated that this was a case where there were complications that could not be anticipated pre-operatively. Dr. Chiarelli added that she followed the patient and she feels the post-operative care was very appropriate. Dr. Leonetti asked Dr. Chiarelli about her evaluation of the second toe and asked her at what point she saw devascularization of the digit. Dr. Chiarelli stated that the toe appeared to have been bruised and there may have been additional trauma to the toe due to the patient's multiple surgeries. Dr. Chiarelli stated that she monitored the toe closely and the devascularization did not proceed past the intermediate phalangeal joint. Dr. Leonetti asked Dr. Chiarelli if she considered pulling the pin out of that toe upon the first post-operative visit. Dr. Chiarelli stated she did not because there was nothing in the x-rays or her clinical evaluation which indicated the pin needed to be removed. There were no further questions from the board members.

**MOTION:** Ms. Miles 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.

g. 12-04-C – Bruce Werber, DPM: Practice below the standard of care for improper surgery.

Dr. Werber was not present. Dr. Dedrie Polakof was the investigator for this case and was present. Dr. Polakof provided the following summary: The board received a complaint against Dr. Werber from patient D.M. The patient stated that on May 13, 2009 she had surgery performed on her right foot for a tarsal tunnel release. The patient stated she was told it would be an endoscopic procedure but it ended up being an "open" procedure. The patient states she has had ongoing complications and pain due to surgery performed by Dr. Werber.

Dr. Polakof reviewed the patient's medical records as follows: the patient initially saw Dr. Kerry Zang in April 2007 due to pain in the right ankle. Dr. Zang injected the right tarsal tunnel area and later referred the patient to Dr. Paul Howard, MD who is a rheumatologist. The patient had her first visit with Dr. Werber on January 7, 2009. Dr. Werber provided an injection into the right tarsal tunnel area and dispensed a cam Walker and prescribed anti-inflammatory medication. The patient had another office visit on February 2, 2009 at which time Dr. Stephen Barrett was present with Dr. Werber. In April 2009 the patient had a follow-up visit at which time she stated there was no improvement in her condition. The patient was given literature regarding the risks of surgery, a surgery diagram, and information about the procedure which would be an endoscope pick tarsal tunnel release. The patient was aware that both Dr. Werber and Dr. Barrett would be performing her surgery. On May 13, 2009 surgery was performed by

both doctors and included endoscopic tarsal tunnel release of the right foot and endoscopic decompression. (Dr. Barrett initially followed the patient concurrently with Dr. Werber and later began treating the patient independently as of August 27, 2009.) As of May 19, 2009 the patient's tarsal tunnel symptoms were worsening and the lateral aspect of the foot was increasing in numbness. The patient also had sciatica symptoms which were worsening, right greater than left. On July 7, 2009 the patient had a paravertebral block performed by her pain management doctor, Paul Lynch M.D. The patient also had additional paravertebral blocks and chiropractic treatments performed on July 7<sup>th</sup>, 13<sup>th</sup>, 14<sup>th</sup> and 30<sup>th</sup> 2009. MRIs were performed on July 9 and August 10, 2009, both of which display a small disk protrusions of the L4-L5 and L5-S1 discs. On July 23, 2009 Dr. Paul Lynch diagnosed the patient with RSD. This was confirmed on September 17, 2009 by Dr. Christopher Maloney. On November 24, 2009 the patient had additional surgery for extra corporeal shock wave treatment medical calcaneus of the right foot and injection of the medial calcaneal nerve. Additional paravertebral blocks and chiropractic treatments were performed on August 17, August 25, December 22, and December 31, 2009, December 21, December 23, December 28, and December 30, 2010, and January 3 and January 24, 2011. On May 31, 2012 Dr. Barrett consulted with the patient at which time he advised that additional surgery should not be performed. He referred the patient to Dr. Carroll, (at USC Medical Center), for a desipramine / Botox injection series. His diagnosis was in trapped men to of the medial calcaneal nerve (primary), entrapment of the common peroneal nerve, and entrapment of the metatarsal nerve second and third inner spaces of the right foot.

Dr. Polakof continued as follows: the patient believe her surgery was supposed to be a non-invasive procedure and she specifically wanted endoscope pick surgery, not open surgery. The patient claimed she was told recovery would take approximately 4 weeks. The patient was given literature regarding her surgery from both Dr. Barrett and Dr. Werber which indicated that the planned endoscope the procedure would have to be changed to an open procedure if any complications were encountered. The patient states that she now has additional pain across the arch of her foot on the outside of her foot where she experiences numbness. The patient has had several steroid injections and is now on the medications Lyrica and Cymbalta. The patient also has a TENS unit which she uses at home. In conclusion Dr. Polakof stated that this appears to be one of those cases in which there is an unfortunate outcome which cannot be predicted prior to surgery. Dr. Polakof feels that both Dr. Werber and Dr. Barrett are competent physicians and that the procedure was performed appropriately. Although the patient had a negative outcome she does not find any deviation from the standard of care and does not find any violations in this case.

Dr. Kaplan asked Dr. Polakof to confirm if she had spoken directly with the patient. Dr. Polakof stated she has spoken to the patient on three separate occasions. Overall the patient feels frustrated because she thought she was going to have a relatively simple procedure which would resolve all of the problems she was having with her foot and she would be able to resume normal day-to-day activities. Dr. Polakof also clarified that the patient initially thought the plantar fascia had been cut; however, the patient now understands that the plantar fascia is fully intact and that it has not caused any complications in her foot. Dr. Polakof stated the patient also advised her that she has been seen by two orthopedic specialists who also reviewed her records and confirmed that the plantar fascia was intact. Dr. Kaplan asked Dr. Polakof what he thought the patient's long-term outcome would be. Dr. Polakof stated she has not evaluated the patient but upon speaking with her she believed the patient has a type I CRPS presentation which can be managed by steroids and pain medication. Dr. Polakof added that the patient is getting back to exercising but is currently on disability. Dr. Kaplan asked if the procedure was initiated as an endoscopic procedure. Dr. Polakof confirmed that was true by that the surgical site had to be opened once the procedure was started. Dr. Polakof also added that the patient had a history of sciatica which predated her surgery with Dr. Barrett and Dr. Werber. Dr. Polakof opined that the patient's must've had some type of irritation of her sciatica in that when which caused buildup of scar tissue in the tarsal tunnel area. In conclusion Dr. Polakof did not find any violations in this case. Dr. Kaplan reviewed with Dr. Polakof the patient's MRI studies which revealed lumbar disc protrusion prior to this surgery. Dr. Polakof stated that was correct. Dr. Leonetti asked Dr. Polakof if it was possible that the patient's symptoms, which seemed to be related to a tarsal tunnel problem, could actually have been a problem resulting from lumbar radiculopathy. Dr. Polakof stated that was a possibility and would have been her first thought as to the cause of the pain in the feet. Dr. Polakof confirmed that Dr. Zang did not feel the patient needed surgery but provided her with orthotics and a referral to a rheumatologist. However, that was two years prior to the time the patient saw Dr. Werber and Dr. Barrett and at which time the patient was tired of dealing

with her foot pain and wanted more permanent and rapid resolution. Dr. Leonetti asked Dr. Polakof why the procedure was changed from an endoscopic procedure to an open procedure. Dr. Polakof stated she was not certain why and Dr. Leonetti stated he did not find anything in the operative word indicating why the procedure was changed to an open procedure. Dr. Polakof also confirmed for Dr. Leonetti that the patient continues to take her medications but is also receiving epidural injections and chiropractic treatment which have improved and stabilized the patient's symptoms.

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

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

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

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

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

Dr. Kaplan reviewed the statement submitted by Dr. Bui indicating that he has no charts or records to submit for any DME billing for the months of October or November 2012. Ms. Penttinen advised that Dr. Polakof is still in the process of reviewing the patient charts and medical records which were subpoenaed by the board and will provide an update as soon as it is completed.

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

Ms. Penttinen advised the board that she had spoken by phone with Dr. Sucher regarding Dr. Brown's need for ongoing opiate pain medication more conservative treatment would be appropriate for Dr. Brown's condition. Dr. Sucher indicated that he would be happy to speak with Dr. Brown about this, but she has not received any further update. Dr. Sucher did provide Ms. Penttinen with the name of the practitioner who has been prescribing pain medication to Dr. Brown. Ms. Penttinen is in the process of getting information release forms to that practitioner to obtain the information requested by the board. Dr. Kaplan stated that he thought Dr. Brown had previously been receiving medication prescriptions from multiple providers. Ms. Miles stated her understanding that Dr. Brown's prescriptions were supposed to be centralized under one provider. Ms. Penttinen stated that that was the capacity which Dr. Sucher is supposed to fulfill; Dr. Brown is required to provide copies of all of his prescriptions to Dr. Sucher for his oversight. Ms. Miles suggested that perhaps Ms. Penttinen could conduct a pharmacy survey to ascertain where Dr. Brown is obtaining prescriptions for his pain medication, particularly sends the pain medication in question has been one of Dr. Brown's drugs of choice. Ms. Penttinen stated that she would be able to provide further information when she is able to make contact with the prescribing provider. She also has asked Dr. Sucher to provide his formal opinion regarding Dr. Brown's need for ongoing opiate pain medication.

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

a. Utilization of Nurse Practitioners in podiatric medical practice.

Ms. Penttinen stated that she had received an inquiry from one of the board's licensees regarding whether or not he would be allowed to employ a nurse practitioner in his podiatry practice. Ms. Penttinen contacted the Arizona Board of Nursing goodbyes turned that there would be no problem as long as the nurse practitioner is practicing within their scope; however, that specific scope would depend on the nurse practitioner's scope of training. According to the information provided to Ms. Penttinen by the Arizona Nursing Board, the scope of practice for a nurse practitioner may be very highly individualized, but in general a Family Nurse Practitioner's scope would include providing treatment within a podiatry practice. There was general discussion among the board members regarding the need, or lack of need, for supervision of a nurse practitioner who wishes to perform podiatry-related services and/or procedures. The board members agreed that regulation of nurse practitioners in any capacity would fall under the Arizona Nursing Board. The board members did not find that there was any need for a motion, decision, or policy statement regarding nurse practitioners within a podiatry office setting.

b. Review of proposed Substantive Policy Statements:

i. SPS 12-01 regarding podiatric medical assistants.

**MOTION:** Dr. Kaplan moved to approve the policy statements as drafted. Mr. Miles seconded the motion.

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

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

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

MOTION: Ms. Miles moved to approve the policy statement as drafted. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

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

- a. Open complaint status report.

Ms. Penttinen advised the board that there are currently 53 open complaints including those that were on today's agenda. She has received one new complaint in the last month.

- b. Malpractice case report.

Ms. Penttinen advised the board that she is not received any malpractice case reports within the last month.

**X. Call To The Public**

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

**XI. Next Board Meeting Date:**

- a. January 10, 2013 at 8:30 a.m.

**XII. Adjournment**

MOTION: There being no further business before the board, Dr. Kaplan moved to adjourn the meeting. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the meeting was adjourned at 12:11 PM.

STATE OF ARIZONA BOARD OF PODIATRY EXAMINERS

December 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: John Tellier

Investigator: Jerome Cohn, D.P.M.

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DR. KAPLAN: This is the time and place for an informal hearing for the written complaints involving Dr. Robert Fridrich, holder of license number 0203. The case number is identified as 11-21-M.

This informal hearing is conducted under jurisdiction and authority --

MS. PENTTINEN: That's an incorrect citation. It should be Arizona Revised Statute title 32 Section 801.

DR. KAPLAN: 801?

MS. PENTTINEN: Yes.

DR. KAPLAN: And the second one is the same number?

MS. PENTTINEN: Yeah.

DR. KAPLAN: This informal hearing is conducted under the jurisdiction and authority created by ARS 32-801 in accordance with the procedures required by ARS 32-801.

Is Dr. Fridrich present?

DR. FRIDRICH: Yes.

DR. KAPLAN: Is Dr. Fridrich represented by counsel, and if so, by whom?

MR. ALDEN: Yes, Neil Alden.

DR. KAPLAN: Thank you. Let the record

reflect that board members Mr. Rhodes, Liz Miles, Barbara Campbell, Barry Kaplan, and Joe Leonetti are present, along with assistant attorney general John Tellier. No, Tellier.

MR. TELLIER: Tellier. You had it right.

DR. KAPLAN: Okay. Dr. Fridrich, did you receive the Board's request for this informal hearing?

DR. FRIDRICH: Yes, I did.

DR. KAPLAN: Let the record reflect that Dr. Fridrich was invited to appear before this Board for an informal hearing to discuss the matters outlined in the Notice of Informal Interview.

Dr. Fridrich, are you prepared to address the issues stated in the Board's request for informal hearing?

DR. FRIDRICH: Yes, I am.

DR. KAPLAN: Dr. Fridrich and anyone else who will be providing testimony needs to raise their right hand.

Will the court reporter please administer the oath?

(The parties were duly sworn.)

DR. KAPLAN: We shall now proceed with

the informal interview. Please summarize the investigator's report for this case.

DR. COHN: Should I do it? Did you want me to re-read the whole thing again?

DR. KAPLAN: Yes.

DR. COHN: Okay.

(The investigator's report was read.)

DR. KAPLAN: Thank you. Would you like -- any questions from the Board, first?

DR. LEONETTI: Not right now.

DR. KAPLAN: Would you like to make a response to the investigator's report?

DR. FRIDRICH: Yes, thank you. When I received the investigator's report, I reviewed it in detail and realized I need to thoroughly investigate better documentation for various CPT codes that I use in my office. As you know that over the years there have been various seminars about billing and coding, and I've left it up to my billing company to implement the billing, but I'm the one that makes the decision on which code to use. So after seeing the report, I wanted to review what's called the Proposed Medicare Consult Code Cross Book dated 2009 from Medicare which explains what the different elements are required in order to document and prove that you were using the

appropriate codes. So I spent a great deal of time since reading the investigative report about making sure I understood what all those elements are and how I could make sure they were documented into my practice in a timely manner, so I've done that since I've been reading the investigative report.

Do you want to make another comment about the use of my code?

DR. KAPLAN: It's your place to make comments.

DR. FRIDRICH: The use of the code was based upon my understanding at the time of the overall time and effort required to treat a new patient under those circumstances. So the circumstances were very unusual. The patient was very nervous. She had been infected off and on for approximately four months, and the mother called us, our office that day to try to get her in as an emergency, which we did.

So at the time, I realized that -- I thought the proper code number would be 99205 for this particular new patient evaluation. Since then, I've been reviewing all the required elements that are needed for this code, and I realized I had to have additional documentation to any future treatments that I do in order to justify what I'm doing, so I've been

doing that.

DR. KAPLAN: Okay. Any other statements?

DR. FRIDRICH: Not right now.

DR. KAPLAN: Are there any questions?

DR. LEONETTI: Yes. How often do you bill a 99205?

DR. FRIDRICH: Not often. It's pretty rare.

DR. LEONETTI: So in this case, did you perform all the aspects needed to do a 99205, you just didn't document them, or you didn't do all the things that were required to bill a 99205?

DR. FRIDRICH: According to what I understand now, I didn't do some of the elements required. According to the investigator, two components have not been documented for the level required, I'm quoting. And so when I went back to see what those elements were, I could see that I didn't do some of those decision-making requirements, which I now understand is required.

DR. LEONETTI: Okay. That makes sense, because a 99205 is a difficult code for most podiatrists to reach in an office setting given -- without some unusual presentations. Just spending

time with a difficult patient doesn't qualify for a 99205. Although you probably deserved to get reimbursed at that level, it doesn't qualify, so it sounds like you understand that now.

DR. FRIDRICH: I understand what you are saying because under 8 or 10 or 12 system review is -- most of it is really not related to podiatry except for your initial intake of how is the patient doing, whether they have diabetes, you know, whether their eyes are okay.

DR. LEONETTI: That's why it's very difficult.

DR. FRIDRICH: Correct.

DR. KAPLAN: That's why most podiatrists don't use that code, so you should -- maybe you should drop it a number. It's not going to help you if you get those codes to pop up on you.

Any other questions right now?

DR. LEONETTI: Well, you know, I mean in regard to the digital tourniquet, is it a little --

DR. KAPLAN: He used a rubber hand.

DR. LEONETTI: Oh, a rubber band? I think using a hemostat is a great idea. No one is going to walk out of your office with a hemostat attached.

DR. FRIDRICH: When we were all in school, they gave us choices of different kinds of constricting a toe, and one of the things they said is, yes, you can use a rubber hand. It's probably not a good idea.

DR. LEONETTI: So --

DR. FRIDRICH: So I understand that.

DR. KAPLAN: So I agree with the fact you don't need a rubber band.

The evaluation time spent per the investigator was 45 -- I know we were harping on 99205. I just want to make sure I cover all the bases.

DR. FRIDRICH: That's fine.

DR. KAPLAN: It was 45 minutes per the investigator.

DR. FRIDRICH: I have a question about that.

DR. KAPLAN: I'll ask you the questions.

DR. FRIDRICH: Okay.

DR. KAPLAN: You indicated that it was at least 90 minutes.

DR. FRIDRICH: That included the surgery time.

DR. KAPLAN: Yeah, but that's not what

is included in the 99205.

DR. FRIDRICH: That's correct.

DR. KAPLAN: I just want to make sure you understand that.

DR. FRIDRICH: Yes, that's correct. I understand that.

DR. KAPLAN: So the fact that they are there and you did the surgery and you did all that was not --

DR. FRIDRICH: Correct.

DR. KAPLAN: Made a decision of high complexity with multiple potential diagnoses. So you considered this a high complexity?

DR. FRIDRICH: Yes, I did.

DR. KAPLAN: Why is that? It's a nail. What makes that high complexity?

DR. FRIDRICH: I felt it was high complexity because of the long duration and severity of the problem that the patient had. She also was very nervous, and that contributed to the high complexity. They've been very upset about how nothing had been resolved after seeing other physicians. And if I can make a comment about the 45 minutes that Dr. Cohen mentioned, I reviewed my surgical notes and my patient notes, and I don't see anything that says a

specific time in those notes, so it's my contention that the surgery was approximately 30 minutes and the rest of the time was spent doing an evaluation and management.

On the intake form, even though it doesn't reach the level of the high medical decision-making, on my medical notes I have the patients fill out, Have you ever had A, B, C, D, E, F, G, including lots of those elements. If you want me to be specific, I can tell you what they are. And there are check-offs, no, no, no, no. This is a 13-year-old child. You don't expect to find -- you ask questions, but you don't expect to find anything serious, like those affecting different parts of their body. Does that answer your question?

DR. KAPLAN: I'm just trying to figure out how you think a nail rises to the level of high complexity.

DR. FRIDRICH: The nail treatment itself doesn't, but in my mind, the overall treatment time and effort it took to evaluate, find out what was wrong, try to figure out what was the best treatment for her did rise to what I thought at the time was a proper coding for 99205. Since then I've found out that's not proper.

DR. KAPLAN: As long as you are saying something that indicates that you understand.

DR. FRIDRICH: Oh, I understand very well.

DR. KAPLAN: You are trying to make your point, but it's not coming across.

DR. LEONETTI: I think -- you threw me off there for a minute. You were arguing that this was high complexity.

DR. KAPLAN: He is still. He is still arguing --

DR. LEONETTI: You understand that this doesn't meet the requirements?

DR. FRIDRICH: What you said I'm agreeing with, but the doctor asked me why I thought the nail was high complexity.

DR. KAPLAN: Why you even thought that this was a high complexity problem. It's not. Everything you're saying doesn't answer the question.

DR. FRIDRICH: Now I know it isn't,

DR. LEONETTI: So now you understand it doesn't. And I don't know if you've taken any CPT courses or even if you just go in the book and read, they give you explanations of what's qualified for these different codes.

DR. FRIDRICH: Periodically I do that, yes.

DR. LEONETTI: And clearly this is not in that category.

DR. KAPLAN: As long as you understand that now.

DR. FRIDRICH: Yes, sir.

DR. LEONETTI: If you are still trying to argue that this is a high complexity case, then you really don't understand.

DR. FRIDRICH: I've already admitted that I don't think it is.

DR. LEONETTI: That's all I wanted to know.

DR. COHN: Just for the record, it's on his typewritten notes the date of visit was January 27, 2011. It says the duration of treatment was about 35 minutes.

DR. KAPLAN: Let's talk about, you know, the tourniquet that almost caused this patient to lose her toe.

DR. FRIDRICH: Yes, sir.

DR. KAPLAN: How come you forgot to take the rubber band off?

DR. FRIDRICH: It's a very good

question. I've been thinking about that for two years.

DR. KAPLAN: Then I want you to give me a very good answer.

DR. LEONETTI: Explain to us how you put it on.

DR. KAPLAN: Do we have a rubber band? We must have rubber bands here someplace.

MS. CAMPBELL: Here.

DR. KAPLAN: Is that a good enough rubber band?

DR. FRIDRICH: Sure.

DR. LEONETTI: So you wrap it around the thumb like that, so --

DR. KAPLAN: So you just twist it and wrap it around?

DR. FRIDRICH: Yes.

DR. KAPLAN: So how come you left the rubber band -- have you done that before on other patients?

DR. FRIDRICH: Not in 35 years.

DR. KAPLAN: You've used a rubber band for 35 years?

DR. FRIDRICH: Yes.

DR. KAPLAN: Never a Penrose drain?

DR. FRIDRICH: I tried Penrose drains. I couldn't get the constriction well enough using a Penrose drain, so therefore I stopped using it.

DR. KAPLAN: So let's go back to the question. How did you leave it on?

DR. FRIDRICH: I had my assistant with me. We were doing the procedure. She kept screaming, yelling, even though it's not an excuse. Somehow I was distracted, and I made a mistake. I left it on. I'm not happy about it. I wish it had not happened. Obviously in 99 percent of the cases a simple nail removal usually doesn't result in serious complications like she had. Nobody wants it to happen. We try very hard that it doesn't happen, but it did. So she didn't notice it, my assistant didn't notice it, and I must have been distracted enough where I didn't see it.

DR. LEONETTI: Was it covered with the bandage?

DR. FRIDRICH: Part of it was covered with the bandage. Because she was screaming and yelling -- it was almost two years ago. I remember wrapping it up, adding the internal dressing when you are done with surgery without making sure everything was else was removed.

DR. LEONETTI: And do you use Coban or a gauze with Coban over it?

DR. FRIDRICH: Sometimes I do. Most of my surgeries I put a mild Coban dressing. I don't tie it tight. In her case, I don't recall if I used Coban or not.

DR. LEONETTI: Do you cover the tip of the toe?

DR. FRIDRICH: Oh, yes, with gauze, because otherwise it bleeds -- it bleeds too much, and you have to cover it.

DR. LEONETTI: You wouldn't see the end of the toe, and I imagine the bandage is flesh-colored, whatever color that is.

DR. FRIDRICH: Well, you already have gauze and cling on, so that's white, and so I didn't see it. And the only thing I've been thinking about --

DR. LEONETTI: The band-aid is not white. The band-aid is the same color --

DR. FRIDRICH: I didn't use a band-aid.

DR. LEONETTI: Excuse me. The rubber band.

DR. FRIDRICH: That's right. I didn't see it, so it must have been covered up. It's not

something I wanted to leave there. And the investigator had a good suggestion for me about starting a checklist in my office during surgery to check off tourniquet, blood pressure, vascular status and other things. I added -- I googled information about what schools use for an intraoperative checklist, and I put in time out information there, and I put in whether I dispensed written instructions so that it forces me to double check everything, so his suggestion I thought was great, so I started using a checklist with my surgeries.

DR. LEONETTI: Well, as a point of information, in my office when I do a nail procedure, when the procedure is over the assistant counts the instruments and the tourniquet to make sure it's all there. If it's not there, the patient doesn't leave the room, so...

DR. KAPLAN: The question is what are you doing now for a tourniquet?

DR. FRIDRICH: I'm using a hemostat.

DR. KAPLAN: Just a hemostat?

DR. FRIDRICH: With the rubber band.

DR. KAPLAN: No. You are kidding me. You are still using a rubber band?

DR. FRIDRICH: Well, if you have a

hemostat then you can't possibly manage to leave it on.

DR. KAPLAN: Who is Dr. Meyers?

DR. FRIDRICH: She substitutes in my office when I'm not there for the last couple years.

DR. LEONETTI: Is she a podiatrist?

DR. KAPLAN: Does she live in Moon Valley?

DR. FRIDRICH: She lives in Tucson. She comes once a week or every other week if I'm out of town.

DR. KAPLAN: On 1/31/11, she obviously saw this patient?

DR. FRIDRICH: Yes.

DR. KAPLAN: Can you tell me what treatment she gave this patient?

DR. FRIDRICH: I only know what she told me, what I read, and I assume you have the notes in front of you.

DR. KAPLAN: Do you read the notes? Do you have them?

DR. FRIDRICH: Sure.

DR. KAPLAN: That's why I'm asking because I don't want you to say something that you don't know or you're not sure of.

DR. FRIDRICH: I was gone for a week, and she was substituting in my office.

DR. KAPLAN: I got that.

DR. FRIDRICH: Do you want me to read it over, or do you want me to read it out loud?

DR. KAPLAN: I just want you to tell me what you think.

DR. FRIDRICH: Well, I reviewed this before coming here this morning. And the mother had called my office to say that -- I give patients my home phone number, so I spoke to the patient on the cell phone, so --

DR. KAPLAN: On 1/31/11?

DR. FRIDRICH: It was over the weekend, either Saturday or Sunday.

DR. KAPLAN: I'm just asking what Dr. Meyers did on 1/31/11.

DR. FRIDRICH: So that was a Monday. The mother is told to bring the patient in that day, and she noted --

DR. KAPLAN: "The patient called me over the weekend." Would that be Dr. Meyers or would that be you?

DR. FRIDRICH: Where are you?

DR. KAPLAN: On 1/31/11.

DR. FRIDRICH: Where does it say mother called me?

DR. KAPLAN: It says, "Patient called me over the weekend." I want to know what that means.

DR. FRIDRICH: Okay. If you are looking at the computer notes from 1/31 --

DR. KAPLAN: I don't know. I'm looking at this.

DR. FRIDRICH: Okay. So when I get back to the office, I document what Dr. Meyers had done. So this says Dr. Meyers had written some notes. Oh, "called me." So that's me. She called me on my cell phone over the weekend because I gave her my number, so me is me.

DR. KAPLAN: That's what I asked. It's not Dr. Meyers?

DR. FRIDRICH: Right.

DR. KAPLAN: Okay. So where is Dr. Meyers' notes for that?

DR. FRIDRICH: Right here.

DR. KAPLAN: Okay.

DR. FRIDRICH: I thought you were asking about these notes.

DR. KAPLAN: No. It says here "duration of treatment." Who writes that?

DR. FRIDRICH: Which copy are you reading?

DR. KAPLAN: On this.

DR. FRIDRICH: Over here. I wrote that down when I got back to the office a week later.

DR. KAPLAN: How do you know it took 30 minutes?

DR. FRIDRICH: Because that's what she told me.

DR. KAPLAN: Do you always do path reports on nails?

DR. FRIDRICH: Not always, but in this case I didn't know what was going on, so I did it this time.

DR. KAPLAN: Why?

DR. FRIDRICH: Because I didn't know what was happening with her toe and her nail, and I wanted a report.

DR. KAPLAN: What was happening with her toe and her nail that made you concerned?

DR. FRIDRICH: She had been -- she had an infection off and on of her great toe for four months.

DR. KAPLAN: Did she ever have an injury to that toe?

DR. FRIDRICH: I don't recall what she told me about that.

DR. KAPLAN: Somebody reported that that toe had been injured.

DR. FRIDRICH: I don't recall whether she told me that.

DR. KAPLAN: Okay. We'll find it. Dr. Cohen states that she was having problems with the toe.

DR. FRIDRICH: I don't recall the initial incident that made her come in after the other doctors had seen her. So you are asking why I did a pathology report. It was such an unusual case, I wanted to send the nail for pathology to see if there was any problem with the nail, and you don't know unless you send a report in.

DR. LEONETTI: By problem with the nail, do you mean the presentation of the nail? The color of the nail?

DR. FRIDRICH: Anything it could possibly be.

DR. LEONETTI: So you look at this nail, other than an ingrown nail that was infected, what -- well, you said something about a double nail. Was that a nail that had been injured and a new nail was

growing out?

DR. FRIDRICH: It looked like there were two nails sitting in the same area, so when I took off the one nail, there was a second nail there.

DR. KAPLAN: Did you hear the question? Have you ever seen a nail that has been injured where a new nail grows and pushes eventually the old nail that was injured out?

DR. FRIDRICH: All the time.

DR. KAPLAN: And this didn't look like that?

DR. FRIDRICH: No. It looked like one nail was there. That was it.

DR. LEONETTI: Until you got back to the matrix, and then it looked like two nails?

DR. FRIDRICH: And then when I took off the one nail, I saw the second nail. So something unusual like that, you want to do a pathology report.

DR. KAPLAN: On the path report, did it give you any information that was surprising?

DR. FRIDRICH: No. Do you have it in front of you?

DR. KAPLAN: I have it in front of me. What I have in front of me I would hope you have in front of you.

DR. FRIDRICH: I didn't see anything that was unusual.

DR. KAPLAN: "There are additional features that suggest that trauma has played a role in the development of this patient's nail changes." Did you read that part?

DR. FRIDRICH: Yes. I'm seeing what you are reading.

DR. KAPLAN: Okay. So that's why I asked you, you know, was there any --

DR. FRIDRICH: I would have to go back to my notes and see if she presented with anything that she actually had a problem with the toenail on the first incident.

MS. CAMPBELL: Your initial visit on 1/27/11 doesn't indicate any other notation about any trauma.

DR. FRIDRICH: She may have said something. I don't recall. You are talking about an emergency visit where you try to find out whatever you can from the patient. I don't recall if she told me she had trauma prior to those two office visits with the other doctors, so I don't know what started it.

DR. KAPLAN: So when you saw the patient -- and I don't know which doctor this is. One

of the doctor's notes -- oh, the vascular surgeon's notes, History of Present Illness --

DR. FRIDRICH: Yes.

DR. KAPLAN: -- paronychia.

DR. FRIDRICH: Which date are you looking at?

DR. KAPLAN: Which date? It's just the Arizona -- I guess it would be -- there is no date on it.

DR. FRIDRICH: Okay.

DR. KAPLAN: So there was an injury or there might have been a problem with it, and the infection was recurrent. The decision for toenail extraction was made and was done on 1/27/11. So back on 10/20/10, it looks like this vascular surgeon saw a paronychia, so there was obviously an injury.

DR. FRIDRICH: Can you tell me what date you are reading.

DR. KAPLAN: It doesn't have a date. Let me see. 1/31/2011, so that was the day that apparently she went over there. It says here, "Developed left first toe paronychia, 10/20/10," not 1/31/2011.

DR. FRIDRICH: I don't understand --

DR. KAPLAN: What I'm trying to figure

out is why --

DR. FRIDRICH: I don't understand the question.

DR. KAPLAN: -- why you make such a big deal out of removing two nails when in fact it was probably an anomaly due to the injury where a new nail was growing back, so I'm just making statements. So I do believe that there was an injury to the nail, that paronychia was there, and I have a question then on one of your notes which is dated January 27, 2011.

DR. FRIDRICH: Okay.

DR. KAPLAN: It says here, and I'm just questioning the typo --

DR. FRIDRICH: Okay.

DR. KAPLAN: "Patient came to the office today with longstanding toe problem for four months. She was scared to go to the doctor even though she is in the nursing profession."

DR. FRIDRICH: Could I see what you are looking at.

DR. KAPLAN: It's your operative report.

DR. FRIDRICH: I reread this this morning, and it's a typo. I think it refers to the mother who was in the nursing profession.

DR. KAPLAN: Just checking.

DR. FRIDRICH: Yeah, I saw that this morning. Thank you.

DR. KAPLAN: On one of your -- I guess on 1/27/11, one of your notes --

MR. ALDEN: He's looking at handwritten notes.

DR. FRIDRICH: Oh, okay.

DR. KAPLAN: This is typed, but it says, "Previous infection of loose toenail, first toe, left foot." So obviously when you saw her on that date you recognized that there was something going on with that nail.

DR. FRIDRICH: Yeah. I think that was a typed note I put on another piece of paper. That's from my medical notes.

DR. KAPLAN: And what I'm going to ask you next is very unusual, in my estimation. On a 13-year-old girl who has, you know, little toes, how do you use 9 CCs of anesthesia in the toe?

DR. FRIDRICH: If you have a screaming girl who says -- who expresses the fact that they don't -- that the anesthesia is not working, you have to put in some more. That's how you do it.

DR. KAPLAN: That's how you do it?

DR. FRIDRICH: Normally I only need 4 or

5. How much do you use usually?

MR. ALDEN: You don't get to ask questions.

DR. FRIDRICH: I'm sorry. I didn't mean it.

DR. KAPLAN: That's okay.

DR. FRIDRICH: I'm not trying to be --

DR. KAPLAN: You don't have to be. That's why I didn't answer you. I ask the questions; you answer them.

DR. FRIDRICH: Okay.

DR. KAPLAN: So she had a hammertoe as well? You put a code down for that.

DR. FRIDRICH: Are we talking about the --

DR. KAPLAN: I don't know. It's on the operative report. Toe diagnosis, toenail deformity with pain, first toe, left foot, hammertoe deformity. Was this hammertoe deformity of the first toe or hammertoe deformity of another toe?

DR. FRIDRICH: I don't recall. It was probably the first toe, but I don't recall.

DR. KAPLAN: So why is that on your operative report?

DR. FRIDRICH: I wrote that two years

ago. I don't remember.

DR. KAPLAN: So in your op report, in your previous statement, you indicated that, you know, there might have been some nervousness evident, and you left the tourniquet on and distraction and things like that. Correct? But in your dictation of your op report, "Patient tolerated all procedures well. Left office alert and in good condition." So it doesn't indicate that the patient was hypertensive or difficult.

DR. FRIDRICH: I didn't think that was required to be put in an op report. I've been told you put in information regarding the surgery. You don't put in information about what hair color -- I'm not trying to be mean -- what hair color they have or what clothes they're wearing, you know, whatever extraneous information.

DR. KAPLAN: Okay. Your instructions for home care after surgery --

DR. FRIDRICH: Yes.

DR. KAPLAN: Do you have that in front of you?

DR. FRIDRICH: Yes.

DR. KAPLAN: Is that your typical instructions for home care for nails?

DR. FRIDRICH: No. I have a different form that's less involved.

DR. KAPLAN: But on that day, at that time you use this where it says, "Don't eat food after midnight before surgery."

DR. FRIDRICH: This was done -- this was given to me right after we saw her, yes, so that doesn't apply.

DR. KAPLAN: Can you go to the patient's intake form.

DR. FRIDRICH: Are you talking about medical history?

DR. KAPLAN: Medical history. Can you read to me, if you can, because I can't read it, what is -- what is "you main complaint"?

DR. FRIDRICH: I'm sorry. What is --

DR. KAPLAN: What is "you main" --

DR. FRIDRICH: There has to be an R, I know.

DR. KAPLAN: Can you tell me what it is? I can't read it.

DR. FRIDRICH: You want me to read what she wrote?

DR. KAPLAN: I want you to read what's there.

DR. FRIDRICH: Okay. I think it says, "Big toe treated for infection months ago. Nail coming off, but it seems to be stuck and," something, "fall off completely."

DR. KAPLAN: Won't fall off completely?

DR. FRIDRICH: Maybe won't fall off completely.

Is that your interpretation, also?

DR. KAPLAN: I can't read it. And the patient has Blue Cross/Blue Shield?

DR. FRIDRICH: I'd have to look and see.

DR. KAPLAN: I can tell you that's what you put down, so if you want to look, that's fine.

When you do your billing, I see you charge \$25 for the anesthetic, which is a local.

DR. FRIDRICH: Yes.

DR. KAPLAN: And is that something that would be billed to the insurance company?

DR. FRIDRICH: We bill them. If they don't allow it, then the patient pays for it.

DR. KAPLAN: So you are saying you bill for it?

DR. FRIDRICH: Yes.

DR. KAPLAN: Can you tell me where?

DR. FRIDRICH: Well, I have a superbill.

I have -- I only have a summary of what was billed. I don't have what the billing services do.

DR. KAPLAN: And you collect -- you bill the insurance, also, for the path report?

DR. FRIDRICH: Well, that varies. Well, as you know, insurance companies have different ways of doing things as far as allowing certain services, so I don't recall what I did in this case. Sometimes we do the billing for the pathology and tell the patient, you know, if they don't allow it, your insurance doesn't allow it, then you will have to pay the pathology report. Sometimes -- most of the time, we bill for pathology and let the patient know that sometimes the insurance doesn't allow it and they would have to pay directly to the pathology.

DR. KAPLAN: Pay who?

DR. FRIDRICH: Pay directly to the pathology lab.

DR. KAPLAN: So they send the patient a fee -- a bill, or they send you the bill?

DR. FRIDRICH: I don't get a bill. They send it to them. If they send it to me, I call them and tell them it's supposed to be billed to the patient.

DR. KAPLAN: Did you collect \$60 from

the patient?

DR. FRIDRICH: For what?

DR. KAPLAN: For the pathology report.

DR. FRIDRICH: No. I don't recall collecting any money for that.

DR. KAPLAN: You did collect the \$25. Right?

DR. FRIDRICH: Yes.

DR. KAPLAN: And --

DR. FRIDRICH: I don't recall if they had a co-pay, either. Co-pay was \$40.

DR. KAPLAN: And did you get paid by the insurance company for the injection?

DR. FRIDRICH: I don't recall.

DR. KAPLAN: And on January 27, 2011, there is a check here for \$40.

DR. FRIDRICH: That was the co-pay.

DR. KAPLAN: That was the co-pay?

DR. FRIDRICH: Yes, sir.

DR. KAPLAN: So my question is that this bill comes to you from Baco (phonetic) for \$60. It says pay 4/15/11, 337289. I guess that's a check number. So do you pay it on behalf of the patient?

DR. FRIDRICH: Can I see what you are looking at?

DR. KAPLAN: You have it in your records.

DR. FRIDRICH: That's my handwriting. I think I paid this one.

DR. LEONETTI: Why did you pay the path report?

DR. FRIDRICH: Because I was worried about a malpractice suit and decided to pay for the path report.

DR. KAPLAN: Well, again, my question is -- I don't understand. How do you know the insurance doesn't pay for those reports?

DR. FRIDRICH: I don't recall whether -- what happened with the insurance. I'd have to check with my billing company what they do.

DR. KAPLAN: Well, I think I'm finished with my questions. What insurance company are you insured with?

DR. FRIDRICH: Me?

DR. KAPLAN: You.

DR. FRIDRICH: It's called Century.

DR. KAPLAN: Century?

DR. FRIDRICH: Yes.

DR. KAPLAN: And where are they located?

DR. FRIDRICH: Here in Phoenix.

MS. CAMPBELL: Who is your billing company?

DR. FRIDRICH: They're a local company in Tucson. It's called ProMed, and they were just bought out by another company called Affinity out of Colorado a couple of months ago.

DR. KAPLAN: Do you submit the billing somehow? You tell what they should bill for?

DR. FRIDRICH: I have a supervisor --

DR. KAPLAN: I'm not -- I know you didn't bill for it for those questions that I'm asking you, because it's not on your form, it's not on your billing form, it's not on the EOB that comes from them, but I don't want to pursue all this.

DR. LEONETTI: I think in review of this case, there is a lot of little things that are bothersome in regards to the billing, the codes, the amount of local you used, the path report thing. But I think the reason you are here is because you left the tourniquet on. That's the big problem in my eyes. Without that incident, all this other stuff would have probably just run its course. I mean, I don't have a concern that for 35 years that you don't know how to treat an ingrown nail. I'm pretty confident you know how to do that. The reason you are here is you left

the tourniquet on, and that's what led to the complications and that's what potentially left permanent damage to this young girl.

So my question to you is: How do we make sure that this doesn't happen again?

DR. FRIDRICH: The answer is that I put in place techniques in my office so that never could happen again.

DR. LEONETTI: And those techniques are?

DR. FRIDRICH: I use a tourniquet with a rubber band. If your suggestion is not to use a tourniquet but to use a Penrose drain, I will do that.

DR. LEONETTI: I'm not making suggestions. I want to know what you've done, and I need you to prove to the Board that you've taken steps that this won't happen again. If you have a checklist, I'd like to see that checklist.

DR. FRIDRICH: Sure. I understand your concerns, and I'm concerned about the same thing. With the tourniquet, I use a hemostat now. Now, this is a checklist I put together after looking it over and thinking what would be appropriate for my office.

DR. LEONETTI: Okay. So this is for all surgeries?

DR. FRIDRICH: This is for anything I do

in the office.

DR. KAPLAN: Are there any other questions from the Board for the investigator or Dr. Fridrich?

(No reply.)

DR. KAPLAN: Okay, no questions. Is there anyone else in attendance who wishes to make a statement and answer questions under oath concerning the issues raised in the Request for Informal Interview?

(No reply.)

DR. KAPLAN: Dr. Fridrich, do you have any closing comments?

DR. FRIDRICH: Yes. If I do an op report and there is an injection, I usually put that on either a superbill or the op report so it indicates to the billing company to charge for an injection. Other than that, I appreciate your time to be here, and hopefully I've explained everything in detail to make you comfortable with the fact that I'm still competent enough to take care of patients.

DR. KAPLAN: Dr. Fridrich and other interested parties may remain to hear the Board's deliberations but may not interrupt, comment or participate. Board members should not interrupt

deliberations to ask further questions of the witness.

Thank you for coming, and you can sit back there now.

Is there a motion for discussion from any of the Board members?

DR. LEONETTI: Well, you know, I think I stated my concerns are, you know, the billing issue and billing for the local and the amount of local that was used and the CPT code are all issues to me, but they are second in nature to the tourniquet problem. This is a 13-year-old girl, and that could have led to -- you know, could have led to amputation very easily. And it's a very simple procedure that every one of the doctors on this Board does every day, every day that we practice. It's a mistake. Shouldn't happen. Things happen; I understand that. I'm thankful that there's not a loss of a digit here, but I'm more interested in making sure that this doesn't happen again.

I like the little checkoff sheet that he provided. I think it's a good idea. I'd possibly like to see that in use, maybe have him submit ten or so cases of where it's been effective, that he's using it on a regular basis, not just showing this to us, so that he satisfies us there has been something done.

I'm not interested in reviewing hundreds of charts here. I'm just interested to make sure that this policy that he's put forward into action is being used to prevent this from happening in the future.

DR. KAPLAN: So would you say that you would like to see this just on nail surgery?

DR. LEONETTI: I think that in essence that's the type of case that this accident is going to happen on, a digital surgery, a digital tourniquet. Now, you know, it is almost impossible to leave a digital tourniquet on when you are using a hemostat. It's a big -- it looks like a giant scissor clip. You can't walk out of the office with that on, almost impossible. I'm not going to say impossible because I never cease to be amazed. But I will say that --

DR. KAPLAN: You can put on a surgical boot.

DR. LEONETTI: I think that it goes a long ways to prevent this from happening in the future. I'd like to see it in use in his office with this policy and maybe come up with some type of a probationary status or consent agreement where he agrees to shows us ten or so cases. Nothing outrageous, just to show us that he's using this system on a regular basis, and I think I'll be

satisfied with that.

DR. KAPLAN: Along with the billing.

DR. LEONETTI: Along with the billing. You know, I don't want to make the billing seem like it's unimportant. Billing 99205 shows me that someone doesn't understand billing. Billing this as high complexity shows me you don't understand what a high complexity case is. Seriously, all you have to do is look in the CPT book where they have examples, and it gives you a great example of what qualifies for a 99205, and this isn't -- we are talking multiple system failure, a detailed examination that most of us do not perform in our offices. Granted, this is a difficult patient and took a lot of time. That in itself does not qualify for a 99205.

And I -- I don't want to make light of the billing issue, but my main concern is that he doesn't do permanent damage to another patient.

DR. KAPLAN: Agreed.

MS. CAMPBELL: I think it's important maybe for attendance at some regulated billing CMEs.

DR. LEONETTI: I think sometimes you should -- here is another issue we have. We're talking about billing seminars. A lot of times these seminars are set up to try and generate as much income

from the doctors as possible, and they almost are on the edge of upcoding. You know what I mean?

MS. CAMPBELL: You're right. You have to be careful.

DR. LEONETTI: I don't want that as part of our -- but I agree with Barb. I think some type of coding program is not a bad idea. Reading about it sometimes isn't enough.

MS. CAMPBELL: What you need is an interactive kind of situation to make sure that it's understood.

MS. MILES: We're kind of putting the cart before the horse because we haven't made a determination that there has been a violation.

DR. KAPLAN: We're having a discussion.

MS. MILES: We're having a discussion about penalties. I would be more comfortable if we would have an initial discussion about what the violations are and then move to what the penalty is. I mean, it just --

DR. KAPLAN: So you want to have a motion for --

MS. MILES: I'm just thinking that might be the right thing to do.

DR. LEONETTI: Well, what's the code

that we're dealing with here?

DR. KAPLAN: It's standard of care for failing to remove a tourniquet.

MS. MILES: The billing code is 99205.

DR. LEONETTI: No, the ARS code.

MS. PENTTINEN: It would be --

DR. KAPLAN: 32-5401?

MS. MILES: I'm happy to give it a shot if you all are interested.

DR. LEONETTI: Go ahead.

MS. MILES: I move that we have a finding of fact of statements in the investigator's report about the facts that occurred in this case.

Sarah, can you remind me if we usually do any more than that in an informal hearing?

MS. PENTTINEN: I don't think so.

MS. MILES: The primary issues I'm concerned about is the finding of fact that he left the tourniquet on and the incorrect billing which led to an excessive fee.

As far as the conclusions of law, I believe that there has been a violation of 32-852, number 6, guilty of unprofessional conduct as defined in Section 32-5401. I'm going to move it as defined as number 20, any conduct or practice which is or

might be harmful or dangerous to the health of the patient, and no other citations contained in the investigative report.

MS. PENTTINEN: Okay.

MS. MILES: Oh, wait. I take that back. Well, let me ask you, on his Notice of Informal Hearing, can you help me recollect what was the billing code that was noticed -- or the potential violation for the billing, what that citation was?

MS. PENTTINEN: Unfortunately, in the Notice of Informal Hearing, the only potential violations that were highlighted were 854.01, 16 and 20, and the violations regarding improper billing were not specified. It would have been 854.01, paragraph 23, charging or collecting a clearly excessive fee. But that was not highlighted as potential violation in the notice.

DR. KAPLAN: But it was an allegation.

MS. MILES: I move to go into executive session for legal advice.

DR. LEONETTI: I second.

MS. PENTTINEN: Did you already have a motion on the floor regarding the --

MS. MILES: I'm going to hold the motion. I haven't finished it.

MS. PENTTINEN: Who seconded?

DR. LEONETTI: Me.

MS. PENTTINEN: All in favor?

(Aye.)

(A recess was taken from 11:00 a.m.  
to 11:07 a.m.)

MS. MILES: The findings -- I think it's important to have in the findings of fact that the findings are indicated -- the facts that are indicated in the investigator's report, I think, were basically substantiated by today's testimony.

As far as violations, the violations or, you know, what would be conclusions of law, as I initially stated, it has to do with leaving the tourniquet on, so it's --

MS. PENTTINEN: So it's 854.01, paragraph 20?

MS. MILES: Paragraph 20, correct.

MS. PENTTINEN: Proposed?

MS. MILES: Let's start with that. I want to do something after that, please.

DR. KAPLAN: Say it out loud so we know what that number is.

MS. MILES: The violation would be 32-852, which is --

DR. KAPLAN: 854.01?

MS. MILES: -- that you are guilty of unprofessional conduct as defined in section 32-854.01, and the definition of unprofessional conduct in 854.01 that's relevant is number 20, any conduct or practice which is or might be harmful or dangerous to the health of a patient.

DR. KAPLAN: Is that seconded?

DR. LEONETTI: Second.

DR. KAPLAN: All in favor?

(Aye.)

DR. KAPLAN: All opposed?

(No reply.)

DR. KAPLAN: Motion passes.

MS. MILES: Sarah, do you have Dr. Fridrich -- does Dr. Fridrich have any former disciplinary actions in front of this Board?

MS. PENTTINEN: Not related to billing.

MS. MILES: Related to anything?

Patient care?

MS. PENTTINEN: I'm sorry. Actually, I just -- the only disciplinary action issue you had was in September of 2005, voluntary disciplinary agreement for probation for six months, submission of monthly records, X-rays and billing documentation for all bony

surgical procedures. And this was -- I'm not able to pull up the document. The allegation was standard of care due to an infection for poor presurgical sanitation of the surgical site.

MS. MILES: So it's a surgery-related matter.

MS. PENTTINEN: Yes.

MS. MILES: Okay. I'm going to kick off discussion, if you all don't mind, with the suggestion for penalty based on the violations and also based on -- taking into consideration Dr. Fridrich's prior disciplinary history with the Board which did involve another surgical matter, and I'm going to move to issue a decree of censure and place his license on probation for a six-month period during which time he shall submit to the Board complete files, including billing, for any nail surgery not to exceed ten cases per month. So if he does two cases, he'd submit two cases. If he does 20 cases, he'd submit ten.

DR. KAPLAN: And that would be all a complete charge billing as well?

MS. MILES: Correct.

MS. PENTTINEN: And insurance?

MS. MILES: Correct.

DR. KAPLAN: I'll second the motion.

Any discussion?

(No reply.)

DR. KAPLAN: No discussion. All in favor?

(Aye.)

DR. KAPLAN: All opposed?

(No reply.)

DR. KAPLAN: Motion passed. Thank you.

(The informal hearing concluded at  
11:12 a.m.)

## C E R T I F I C A T E

I HEREBY CERTIFY that the proceedings had upon the foregoing hearing are contained in the shorthand record made by me thereof, and that the foregoing 46 pages constitute a full, true, and correct transcript of said shorthand record, all done to the best of my skill and ability.

DATED at Phoenix, Arizona, this 2nd day of January, 2013.



Deborah L. Wilks, RPR  
Certified Court Reporter  
Certificate No. 50849