



Janice K. Brewer  
Governor

## State Of Arizona Board of Podiatry Examiners

"Protecting the Public's Health"

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

### **BOARD MEETING MINUTES**

February 12, 2014; 8:30 a.m.  
1400 West Washington St., B1  
Phoenix, AZ 85007

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

Staff: Sarah Penttinen, Executive Director

Assistant Attorney General: John Tellier

The agenda items were not reviewed in the order in which they appear in the minutes.

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

The meeting was called to order at 8:32 a.m.

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

Dr. Campbell noted for the record that all Board members were present as well as Ms. Penttinen and Mr. Tellier.

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

##### **a. January 8, 2014 Regular Session Minutes**

MOTION: Dr. Kaplan moved to approve the minutes with one spelling correction. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed 4-0 by voice vote with Ms. Miles abstaining due to her absence at the January meeting.

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

##### **a. 12-01-C – Steven Born, DPM: Insurance fraud for billing for orthotics. Update from investigator regarding additional allegation of improper billing, specifically misuse of office visit billing codes.**

Dr. Born was present with attorney Stephanie Loquvam. Investigator Dr. Jerome Cohn also was present and stated the following: he and Ms Penttinen had gone to Dr. Born's office to evaluate charts and billings for orthotics. While there he asked the staff to show him the orthotics that are given to patients and was shown a closet where there were several pairs of Spenco brand orthotics. The charting and billing he reviewed is detailed in the inspection report and the supplemental report he submitted to the Board. The biggest issue found was the use of 99204 and 99214 codes without sufficient documentation in the charts to support those codes. He also noted the same problem with code 99213. Specifically with things like injections, there was a billing code for both the office visit and the procedure, (for the same office visit), but only one code should be billed.

Dr. Cohn formed for Dr. Leonetti that all charts reviewed were for Medicare patients. He added that Dr. Born also treats many patients at the hospital or skilled nursing facilities but those charts were not reviewed because they are at those facilities (not in Dr. Born's office). Dr. Cohn also confirmed that normally Medicare would not pay two codes (such as for an injection and office visit) but Dr. Born was using a "25" modifier. Ms. Penttinen confirmed for Dr. Kaplan that the chart review was for the time

period of 01/01/11 through 12/31/13. She also explained that a total of 267 ledger cards were reviewed, all being Medicare patients, looking for "L" and "A" codes (for orthotics) of which there were extremely few. However, while looking for those codes she and Dr. Cohn discovered the frequency of the level 3 and 4 office visit codes and pulled those charts for review. Dr. Cohn verified for Dr. Kaplan that the charts and billing sheets were reviewed but there were no EOB's available to review.

At Dr. Kaplan's request, Dr. Cohn provided the following information for the Public Board Members regarding office visit billing codes. (All are a five-digit number starting with 992.) The fourth number indicates whether it is an initial office visit or a follow-up, (for example 0 or 1). The last digit, according to the CPT guidelines, ranges from a 1 to a 5 with 1 being the least amount of time and least complexity and 5 being the highest. Medicare provides guidelines to breakdown how the complexity of the office visit can be determined based on the presenting problem, the time spent with the patient and the medical decision-making that is required. A level 4 visit requires a detailed exam, moderate decision-making, and moderate-to-high presenting problem. It also requires 45 minutes of face-to-face time with the patient. Dr. Cohn stated that all the charts he reviewed seemed to be routine exams and none reached a level 4 based on the documentation in the chart. He added that a level 4 may occur occasionally but not on every office visit. Dr. Cohn confirmed for Dr. Kaplan that a level 4 should not be used for a follow-up visit unless the patient also presented with a separate and new problem and this was where the use of the 25 modifier came into effect. He added that a procedure code should not be billed with an evaluation and management code which Dr. Born had done frequently. Dr. Cohn confirmed for Dr. Campbell that certain procedures have a specific time period in which a follow-up visit would be considered part of the global code for the procedure. He also confirmed that if a particular billing code requires a certain amount of time to be spent with the patient then the documentation in the chart must reflect what was done in that period of time which was not done in these charts.

Dr. Kaplan referred back to the complainant in this case whose allegation was that Medicare was charged for custom orthotics but what he received were not custom orthotics. He asked Dr. Cohn if Dr. Born tells patients that orthotics will be covered by Medicare. Dr. Cohn explained that he saw forms in the charts that were correct regarding diabetic shoes for orthotics and he did not see anything stating that they would not be covered. Dr. Cohn also confirmed for Dr. Kaplan that he does not believe Dr. Born does x-rays in his office based on the information documented in the charts. Dr. Cohn confirmed for Dr. Leonetti that Dr. Born does not use an EMR system and his charts are all hand-written. He added that the charts are legible, there just was not sufficient documentation to support the billing codes being used. Dr. Cohn also explained that there was a standard form for first-time patients but the form is not comprehensive enough and some were not completed. Then in follow-up visits there was usually two to three lines of documentation about the visit and nothing of substance regarding the evaluation of the patient. Dr. Leonetti acknowledged that sometimes doctors under-document in their charts, but asked what billing code would be used based on the documentation in these patients. Dr. Cohn stated most visits would be level 2 or possibly level 3 on an initial visit.

The physician Board members reviewed the charts that were audited based on the inspection and which were broken down by individual patient in Dr. Cohn's supplemental investigation report. Dr. Kaplan asked about code 73630 which Dr. Cohn stated was an x-ray code. Dr. Born stated he used a 26 modifier and that code was billed because he read the films. Dr. Kaplan stated that cannot be billed when a report (from the radiologist) is sent. Mr. Rhodes asked what the pricing difference would be between a level 4 code and a lesser code. Dr. Cohn stated he was uncertain what the exact amounts are for Medicare reimbursement but in the charts are copies of the HCFA forms to show what was billed. Dr. Kaplan explained that the higher the code is the higher the reimbursement will be so any code that is too high is inappropriate.

Ms. Loquvam addressed the Board and stated that it would be important to take into account the context of Dr. Born's practice which is in Sun City and is predominantly elderly patients. She stated these patients often require a different type of exam than just a checklist of questions and also require more communication regarding their problem and how best to treat them. In speaking to Dr. Born regarding his documentation, Dr. Born felt that the billing codes were a supplement to his charting and if a certain code was used then he knows that he did what that code requires. Ms. Loquvam stated Dr. Born has already talked about modifying his billing practices to provide separate documentation in the patient chart

to justify the billing codes. She stated Dr. Born has also started using a "time in, time out" ( of the patient room) and doing a more detailed analysis of the exact nature and details of each office visit.

Dr. Kaplan asked Dr. Born if he has a DME number (with Medicare). Dr. Born stated his billing service would know and he is certain he does but he doesn't know the number. He also stated he uses an individual person (rather than a larger company). When asked about the patient who filed this complaint, Dr. Born stated the patient had plantar fasciitis which he determined based on the patient's complaint of pain upon first steps. He took impressions of the patient's feet but did not take x-rays. He stated the patient's primary care doctor took x-rays but admitted he did not see them or a report. Dr. Kaplan asked how, then, he would know what was going on with the patient's feet because in the chart it seems the patient would have benefitted from x-rays. Dr. Born stated that if the patient denies any trauma he assumes that there is a soft tissue problem rather than a boney problem and that there was nothing grossly abnormal in the x-rays. Dr. Kaplan asked Dr. Born if he told this patient that his orthotics would be covered by Medicare which Dr. Born stated he did. Dr. Born stated that Medicare would cover them but Dr. Kaplan stated they do not. There was discussion among the Board members and Dr. Born regarding Medicare guidelines for reimbursement during which time it was found that Dr. Born was referring to a printed guideline from 2009. It also was clarified that orthotics and shoes are only covered if they are an integral part of a covered brace and are medically necessary for the proper function of the brace. This patient did not have any such braces. There was discussion about Dr. Born's use of the KX modifier and Dr. Born confirmed that he billed \$277.61 for each of two orthotics for this patient. Dr. Kaplan stated the KX modifier requires specific documentation which Dr. Born stated was documented the patient that he had plantar fasciitis. Dr. Born confirmed that the patient was not diabetic and did not have neuropathy.

Dr. Born confirmed for Dr. Campbell that he has been practicing since 1978. When asked about the last time he took a course in practice management, Dr. Born stated he takes a risk management course every two years as required by his malpractice insurer, and Dr. Leonetti pointed out that is not the same as practice management. Dr. Born explained that he was the one who casted the patient for the orthotics. A plaster negative was made with the feet in a neutral position. Dr. Born took the casts home and filled the cast negatives with plaster to make positive molds of the feet. He then heated the orthotics in boiling water and fit them to the positive molds and he considers this to be custom orthotics. He also stated the last time he did this type of orthotics was two to three years ago because it takes too much time. Dr. Cohn confirmed for Dr. Leonetti that there were no positive casts seen in Dr. Born's office during the inspection. He also confirmed that everything he has seen in Medicare guidelines shows that the billing code for orthotics, (L3000), is not covered unless the orthotics are attached to a brace.

There was discussion among the Board members and Dr. Born regarding the use of ANB's which Dr. Born stated he uses for post-operative shoes after nail procedures which he does because the bandage he puts on does not allow the patient to wear their normal shoes. He confirmed that he knows Medicare will not pay for them. Dr. Cohn pointed out that there was one patient in the reviewed charts who was billed separately for a post-op shoe following a neuroma surgery but that should have been included in the global fee and the shoe should have been dispensed by the surgical facility.

Dr. Leonetti stated he does not feel what Dr. Born has done with orthotics is considered a custom orthotic; what he is doing is a modification of an over-the-counter product. However, the orthotics received by the patient who filed this complaint do not appear to have been modified at all. He feels the billing demonstrated in these records is outrageous and the documentation in the charts is horrible; billing '204's and '214's with only two sentences of writing in the chart is not appropriate. Ms. Loquvam addressed the Board and stated that Dr. Born wants to resolve the Board's concerns and is willing to undertake a comprehensive review of his billing and documentation. Dr. Leonetti stated that changes may be made, or already have been, but there is still a significant period of time that these issues were occurring, and likely even longer if the Board were to review more charts prior to 2011 for both the orthotic issue and the level 4 billing codes. Dr. Leonetti stated perhaps an EMR system or better billing service would be helpful, but he remains concerned that what happened to this patient happened to others. He feels the KX modifier was clearly misused and feel Dr. Born is fortunate that Medicare has not reviewed his charts. Dr. Leonetti would like to see Dr. Born demonstrate that he has changed his documentation, his billing, or both to ensure that what is billed is what was actually done. He feels some CME in billing and coding also would be appropriate and he would like to see these in effect under a

period of probation during which time Dr. Born would need to submit copies of his charts. Dr. Campbell added that as of October 1 of this year the new ICD-10 codes must be used and it would be important to include that because of the changes in required documentations in patient charts.

**MOTION:** Dr. Kaplan moved to go into Executive Session for the purpose of obtaining legal advice. Mr. Rhodes 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 9:25 a.m.

The Board returned to Regular Session at 9:32 a.m.

**MOTION:** Ms. Miles made a motion to open discussion to refer this matter to an Informal Hearing which could be vacated if Dr. Born were to accept a consent agreement with the following terms: three years of probation, four hours of CME in billing and coding to be completed within six months, four hours of additional CME specific to ICD-10 billing and coding to be completed within one year, obtaining a practice mentor in the area of billing and coding and maintain that for a minimum of one year with progress reports, and a \$10,000.00 civil penalty. Dr. Kaplan seconded the motion.

**DISCUSSION:** Dr. Campbell suggested that Dr. Born also be required to submit proof of his DMERC certification (with Medicare) within 30 days. Ms. Miles agreed and added that the consent agreement would need to be accepted within 30 days of receipt. Dr. Kaplan seconded such amendments. Dr. Leonetti agreed with the CME requirements but stated he feels one year of probation would be sufficient and it may be difficult to obtain a practice mentor because that person would, have to see the actual charts to verify the billing. Ms. Miles feels some one-on-one mentoring would be more beneficial than CME and submitting charts to the Board in order for Dr. Born to learn the proper billing and the mentor would be Board-approved. She added that this person does not necessarily need to be a podiatrist but should be a certified billing and coding expert. There was brief discussion regarding the amount of the civil penalty. It was agreed to leave that amount at \$10,000.00 for now. Ms. Loquvam asked the Board to clarify specifics of the billing and coding mentor as to how much time would need to be spent and how often progress reports would need to be submitted so Dr. Born can understand the potential cost to him to comply with that requirement. After further discussion Ms. Miles offered that the time spent should be at least five hours during the first month and can decrease after that and that any concerns regarding patient privacy could be addressed by requiring the mentor to sign a third party vendor agreement per HIPAA regulations. Ms. Miles accepted, and Dr. Kaplan seconded, the final terms which included: probation for 18 months during which time Dr. Born must submit complete charts including superbills for 15 Medicare patients per month; the CME for the ICD-10 changes must be completed by 09/31/14; the billing and coding mentor and Dr. Born must both submit a report after six months describing the activities and information shared; and all other terms as already discussed. Board members directed Ms. Penttinen to draft the agreement and return it to the Board for review at the March 12, 2014 meeting prior to sending it to Dr. Born.

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

**b. 12-02-C – Barbara Aung, DPM: Billing for services not rendered. Update regarding additional concern regarding patient records.**

Dr. Aung was present. Mark Forman, DPM was the investigator for the case and was present. Ms. Penttinen advised that as of yesterday she received the requested records from Dr. Aung. There had been one date of service that was missing from the chart when previously submitted. (Approximately one month ago Dr. Aung was requested to re-submit the complete chart.) Ms. Penttinen had followed up with the pediatrician who had referred the patient to Dr. Aung and was told that they did not receive any type of report back from Dr. Aung.

Dr. Leonetti asked why it took so long to submit the chart. Dr. Aung stated that at the time she received a copy of the complaint she sent everything she had access to but she was in the process of transitioning from one EMR system to another. The old system was Medinotes which is no longer supported and she is unable to retrieve any data from the records stored in it. Dr. Aung also stated she looked for the hard copy of the chart in storage but could not locate it, and she also obtained all the information she could from her billing service and the company where she ordered the patient's Richie brace from. She did not receive all of that information until February 5<sup>th</sup> and then sent it to Board staff. Dr. Forman added that he also used Medinotes in the past and confirmed that this program is no longer supported. He also has a background in information technology and has tried to retrieve data from his own records in Medinotes and has had many problems. Dr. Aung stated that due to the problems she had with Medinotes she changed to a much better operating platform for her EMR which uses pdf formatting.

Dr. Aung advised the Board that the complainant never raised any question to her with regard to not providing services, nor did she complain to the billing office. She feels the basis of the complaint was that she refused to give the patient a second Richie brace until she was able to observe that the first one was providing relief to the patient which the complainant was not happy with. She did charge a copay for the date of service in question because she did evaluate the patient. The complainant also had signed an ABN and had told her staff that they would call to schedule the next office visit but never did. She stated the complainant never paid the copay.

Dr. Aung clarified for Ms. Miles that she did not specifically recall a complete discussion with the complainant but remembers being asked about why he would not order a second Richie brace. Ms. Miles stated that perhaps there was some miscommunication when the complainant called to schedule the appointment thinking the patient was going to get the second brace, and then when she received a bill she felt it was a charge for services not rendered. She also stated she understands there can be difficulties in changing EMR systems. Dr. Kaplan agreed. Dr. Leonetti asked why the complainant waited four years to file her complaint. Dr. Aung stated she believes this complaint was filed because when she switched to a new billing company they were "cleaning out old files" and sent a letter to the complainant asking for the copay. She wrote off the copay amount and told the billing office not to send any more bills. Dr. Aung clarified for Dr. Leonetti that the billing code used, 99212, was appropriate because she did spend a lengthy period of time evaluating the patient and his complaints of pain.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

**c. 12-25-C – William Leonetti, DPM: Inaccurate documentation in patient chart.**

Dr. Joseph Leonetti recused himself from review of this complaint. William Leonetti, DPM was not present. (All references to "Dr. Leonetti" in this case refer to Dr. William Leonetti.) Dr. Mark Forman was the investigator for this case and provided the following summary: The patient had seen Dr. Rajesh Daulat as well as her primary care physician who diagnosed plantar fasciitis and fungal infection of several toenails including the left 1<sup>st</sup> and 2<sup>nd</sup> toes. He referred the patient to Dr. Leonetti who first saw the patient on 04/02/12. At that time the patient's left 2<sup>nd</sup> toe was ingrown, thickened, discolored and curved sideways into the adjoining toe. Dr. Leonetti documented fungal infection of all right toes and left 2<sup>nd</sup> toe and he recommended a matrixectomy of that toe. The patient agreed and a proper surgical consent form was completed. The nail was removed without complications and the patient was given home care instructions and told to follow-up in six weeks. However, she returned on 04/12 and said the nail had been stepped on several times and Dr. Leonetti also noted sock lint over the nail bed but no infection. He cleaned the nail with peroxide and Hibiclens and dressed the nail with Bactroban and a compression bandage. The patient was told to follow up in one month but returned in four days. The nail was healing but the patient had not been following the home care instructions. She also admitted several additional bumps to the nail. Dr. Leonetti again advised the patient to continue with cleansing and dressing instructions and to return in two weeks. The patient returned one month later with a new issue of a subungual hematoma and fungal nail on the right 4<sup>th</sup> toe. The patient wanted surgery but Dr. Leonetti recommended allowing the nail to grow out and to continue soaking and topical antibiotics. The

patient was seen in June and October for unrelated issues. On 10/01/12 dr. Leonetti noted that the nail in question (left 2<sup>nd</sup> nail) was completely healed.

Dr. Forman confirmed for Dr. Kaplan that he found no inaccurate documentation in the patient's chart. He also confirmed for Dr. Campbell that there was documentation in the charts of other doctors who treated the patient that she did have an infection in the toe. Dr. Forman concluded that he finds no violations in this case. Ms. Penttinen advised that she had spoken to Dr. Leonetti who reported the following: the patient recently went to his office to make a payment and he asked her about the complaint she filed against him. The patient told him she had never filed a complaint but perhaps her son did. Ms Penttinen confirmed that she spoke directly with this patient regarding this complaint as well as the complaint she filed against Dr. Daulat, so it appears the patient may have some confusion or memory issues.

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 with Dr. Joseph Leonetti recused.

**d. 13-01-C – Rajesh Daulat, DPM: Improper toe nail care.**

Dr. Leonetti recused himself from review of this complaint. Dr. Daulat was not present. Dr. Mark Forman was the investigator for the case and provided the following summary: The patient had been a patient of Dr. Daulat's prior to the events which led to the complaint. In May 2009 she presented to his office with paronychia of the left 1<sup>st</sup> toe. Dr. Daulat performed a matrixectomy and gave the patient home care instructions. The patient was seen for follow-up on June 3 at which time Dr. Daulat debrided some necrotic tissue and again gave the patient home care instructions. Following that visit Dr. Daulat continued to see the patient for wound care. On July 22 the wound was healed and the patient was told she could discontinue the home care. In September the patient stated the nail had been stepped on. She had two follow-up visits that she rescheduled. When she returned on December 17 there was an infection in both 1<sup>st</sup> toes. Dr. Daulat performed bilateral edge resections. The patient was told to follow up after Christmas but did not return until February 2010 at which time she had pain and redness in the right 1<sup>st</sup> toe. No drainage was noted. Dr. Daulat recommended antifungal medication and follow-up in one month. The patient returned in May for an unrelated issue. Then in August she returned with pain in the left 2<sup>nd</sup> toe with incurvation. No infection was appreciated. Dr. Daulat discussed total nail avulsion with use of antifungal medications vs. matrixectomy. The patient wanted to wait and returned on the 24<sup>th</sup> at which time Dr. Daulat performed a complete nail avulsion. The patient signed a surgical consent which was appropriate for risks and complications. The patient returned in one week and stated she had bumped the toe several times. Dr. Daulat noted fibronectin tissue but no infection and told the patient to continue with antifungal medication. The patient returned on September 13 at which time the 2<sup>nd</sup> toe was epithelialized but there was no infection. She was advised to continue with the antifungal medication and return in three months. However, she did not return until June 2011. At that time the nail had grown back thick and was painful. Dr. Daulat discussed options and also advised that patient that her insurance (AHCCCS) no longer covered podiatry services. The patient opted for a routine debridement and was advised to continue with the antifungal medication.

Dr. Forman concluded that he found no violations in this case or deviations from the standard of care. Drs. Kaplan and Campbell both noted that the patient was non-compliant with follow-ups and that the complications of the procedures performed by Dr. Daulat were properly advised to the patient on the consent forms she signed.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Dr. Leonetti recused.

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**e. 13-04-C – April Glesinger, DPM: Practice below the standard of care for improper evaluation of feet and improper fitting of orthotics; improper billing.**

Dr. Glesinger was not present. Dr. Mark Forman was the investigator and provided the following summary: The patient was seen on 06/04/12 with a chief complaint of needing new orthotics. He had a previous pair made in 1993 for heel pain which had returned. Dr. Glesinger inspected the old orthotics and determined that they did not provide adequate arch support and she recommended new ones. The patient was advised that Medicare does not cover orthotics but he agreed to pay for them so casts were made of his feet. The patient paid a total of \$480.00 for the orthotics. They were dispensed to him by one of Dr. Glesinger's staff on 06/12/12. The patient was not seen again until 09/18/12 at which time he complained that he could not use the orthotics due to pain. Dr. Glesinger modified them using a heat gun and returned them to the patient that day advising him to return to the office as needed. The patient never returned to the office but called on 01/22/13 and spoke to her staff about his orthotics. They tried to have him come back to the office to have them evaluated but he would not. The patient was told that the return policy for custom orthotics was to refund half the cost. The patient was not happy with that and told Dr. Glesinger's staff that he hoped she had malpractice insurance because he was going to take matters into his own hands.

Dr. Forman continued: He spoke to Dr. Glesinger by phone. She explained her attempts to satisfy the patient and about Medicare not covering the orthotics. There was no office visit note for the date the orthotics were dispensed but she will have her medical assistant do that now. Regarding allegation #1, he felt that based on the records the exam of the patient was adequate and not below the standard of care, although he would recommend increased documentation of gait and posture. Dr. Campbell added that since the patient's last orthotics were made 20 years prior and there had been no other foot care she would have recommended x-rays. Regarding allegation #2, Medicare does not cover orthotics and the patient was made aware of this so he finds there was no improper billing. Dr. Campbell noted that the patient claimed to have found some information online which led him to believe they should have been covered. Dr. Forman confirmed that they are not and referred to the Medicare guidelines which he included in his written report. Dr. Kaplan asked if an ABN is required if the patient is told that the services are definitely not covered. Dr. Forman stated that his understanding based on a legal opinion was that if the doctor knows for certain that the service will not be covered then the ABN is not required. There was brief discussion about the billing code of 99202 for date of service 06/04/12. There was slight confusion about the billed and allowable amounts but nothing that appeared to be improper billing.

MOTION: Dr. Kaplan moved to dismiss the 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.

**f. 13-06-C – Barbara Aung, DPM: Improper care due to indicating use of orthotics that did not provide relief; improper billing due to charging for services that did not provide relief of symptoms. Update from investigator regarding medical records.**

Dr. Aung was present. Investigator Dr. Mark Forman also was present. This was a follow-up from previous review to resolve the question of whether or not the patient ever received a copy of her medical records as requested. Ms. Penttinen advised that she had spoken to the patient and was told there were several delays but the patient eventually did receive them. However, the patient stated there were inaccuracies in her chart such as stating that she was on the medication Crestor which she is not and that she was unhappy with the doctor who treated her prior to Dr. Aung which also was not true.

Dr. Aung explained for Ms. Miles that the patient had called the office several times for various reasons. On the times that she called regarding her records, the patient thought she should be able to come and pick them up immediately. Dr. Aung's staff had printed what they could but again had trouble with accessing records from the old EMR system. On February 21 (2013) called twice regarding her medical records and they were provided within two to three weeks. Ms. Penttinen clarified that, according to the patient, the first records request was made on February 7<sup>th</sup> and she was told to pick them up on the 14<sup>th</sup>. When she went in on the 14<sup>th</sup> she was told they were not ready and to come back on the 21<sup>st</sup>. When she went back on the 21<sup>st</sup> they still were not ready and she was told she had to sign an authorization. She did not and was told to come back in two weeks. Ms. Miles stated this time period was too long. Dr.

Aung replied that all calls to her office are documented and that the patient had initially called requesting a refund for her orthotics but not for a copy of her records. The patient called several days later and was told to come in to sign the authorization form. Dr. Aung also stated that with multiple calls to her office there seemed to be a bit of a personality conflict with the patient and her staff. The patient was called on the 21<sup>st</sup> and told she could pick up her records. Dr. Aung was uncertain what exact day the records were picked up but it must have been before the 26<sup>th</sup> because she also had issued the patient a refund check which was cashed on the 26<sup>th</sup>. Dr. Aung clarified for Ms. Miles that she had no record of a call from the patient on the 7<sup>th</sup>, but on the 8<sup>th</sup> she had called asking about a refund. She added that the first documentation of the patient wanting copies of her records was on the 19<sup>th</sup> when she called asking the status of her refund for her orthotics. Dr. Aung also stated that with her new EMR system her patients are able to access their records at any time on an online portal with individualized passwords.

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

DISCUSSION; There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

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

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

Ms. Penttinen reviewed that the Board had received a relapse prevention evaluation report from Dr. Sucher. Most information appears acceptable although there are concerns about potential relapse triggers or stressors. Dr. Sucher has recommended that Dr. Brown increase his 12-step meetings to three per week. Ms. Penttinen also explained that she did some research regarding the types of metabolites that have appeared on Dr. Brown's drug screens and was advised by two addiction medicine specialists that they are normal for the type of medication that Dr. Brown has a valid prescription for. However, one of those experts was Dr. Brown's pain management doctor who indicated he intends to change Dr. Brown's medication and assess his overall status to determine if medication is still needed. Overall Dr. Sucher's prognosis in the evaluation was good. Ms. Penttinen confirmed for Dr. Leonetti that the pain management doctor is OK with the medication Dr. Brown is taking and there have been no concerns raised about his ability to practice safely. There was brief discussion regarding Dr. Brown's medical history and whether or not there is any duty to inform patients of any possible or potential health conditions which could affect patient safety. Ms. Miles stated there may be an issue of negligence if there is any type of exposure but it is not a standard of care issue. She added that all physicians have a right to privacy regarding their personal health. There was brief discussion about the use of universal precautions. Ms. Penttinen stated she will follow up with Dr. Brown regarding his meeting attendance.

### b. 11-09-M – Kelvin Crezee, DPM: Monthly update.

The Board members reviewed information provided by Dr. Crezee's attorney Bruce Crawford regarding the presentation he did on wrong-site surgery. The plan which the Board approved included a first lecture at the Tucson VA Hospital and "several other lecture assignments" including one hospital each in Florida and Ohio. However, what Dr. Crezee submitted to the Board was a lecture conducted in his personal residence which was attended by a small group of podiatrists from the Phoenix VA hospital and their spouses. Ms. Miles stated she does not feel this satisfies the requirements of Dr. Crezee's consent agreement because it is not what the Board approved based on the plan that Dr. Crezee submitted. Dr. Kaplan agreed and stated he thought the lecture would be open to any podiatrist who wanted to attend.

The Board members reviewed Dr. Crezee's consent agreement which included Board approval of the specific content and intended audience. Ms. Miles stated the content was acceptable but the audience was not. Dr. Leonetti agreed and stated that if this was what Dr. Crezee did had submitted for approval it would not have been approved; however, Dr. Crezee waited until the last minute and has now run out of time. Dr. Leonetti added that the Board was very open-minded in considering what disciplinary action was taken rather than the Decree of Censure which was originally included in the consent agreement.

MOTION: Ms. Miles moved to open a new complaint case with the allegation that Dr. Crezee violated the terms of his consent agreement with the Board. Dr. Leonetti seconded the motion.

**DISCUSSION:** Dr. Leonetti asked to clarify if Dr. Crezee's failure to comply with the consent agreement means that the Decree of Censure previously included in the offered consent agreement (which Dr. Crezee did not accept) would then go into effect. Mr. Tellier stated that the case does not revert to disciplinary options that were previously considered and offered; the specific terms of the consent agreement were the final disposition, (instead of the Decree of Censure), and now the option is to open a new case for possible additional / separate action. He added that the same requirements could be added into the order terms for any new disciplinary action. Ms. Penttinen advised the Board that Mr. Crawford was aware that this matter was going to be discussed today and that she had told him there would likely be questions and concerns from the Board members. Neither Mr. Crawford nor Dr. Crezee was present. Ms. Penttinen stated she will open the new case and she will complete the investigation. There was no further discussion.

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

**c. 13-05-B – Kathleen Stone, DPM: Monthly update.**

Ms. Penttinen advised that the most recent report regarding Dr. Stone's counseling was received in December 2013 so the next report will be due in March.

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

**a. Responsibilities / duties of investigative consultants.**

The Board members reviewed the outline of duties and responsibilities prepared by Dr. Campbell. Dr. Kaplan suggested adding emphasis that the investigator needs to make a specific determination as to whether the allegations are substantiated or not. There was discussion regarding adding guidelines for report writing. Ms. Penttinen stated she could prepare that information. Dr. Campbell stated she had considered a conference call with the investigators but she feels it would be better to present this information to them in person in a group discussion following a Board meeting.

Dr. Leonetti discussed "interpreting diagnostic studies" and suggested that this be modified to state that they should be able to "review" diagnostic studies and understand the associated reports. With regard to billing and coding, he suggested that instead of contacting Dr. Polakof specifically that the investigator should contact "an expert." Ms. Miles suggested that if any expert or additional information is needed the investigator contact Ms. Penttinen who will assist them in finding an appropriate reference. She also suggested that if certain studies such as x-rays are not done the investigator should specifically inquire as to why. There also was discussion regarding the standard of proof, (rather than "burden" of proof), and that the wording "more likely than not" would be a better way to help a lay person, (patient or complainant), understand the measure used by the Board to make a determination on the allegation(s). Dr. Campbell will make the suggested changes and the document will be returned to the Board at a later date for review.

**b. CodingLine article regarding electronic medical records and the use of "copy and paste" functions.**

Dr. Kaplan requested review of an article from the CodingLine website regarding electronic medical records and the use of cut-and-paste features. The information in the article was from the Medicare Office of the Inspector General which has identified that there are significant risks of liability for using this feature. There was brief discussion about the general nature of most EMR systems because most allow the doctor to "roll over" information from one office visit to the next. Ms. Miles stated that ultimately it is the doctor's responsibility to make sure the records are accurate for each date of service. Dr. Leonetti agreed and added that physicians need to be educated and updated on these types of concerns, and a suggestion was made that this would be a good topic for the state podiatry association to distribute the information. The Board members agreed that Ms. Penttinen will forward this article to Alan Discont, DPM for him to distribute to the association members.

**c. Review of updated New License Application form and instruction sheet.**

Ms. Penttinen reviewed that there had been previous discussion about the Board's five-year rules review. The rule-writer that Ms. Penttinen hired had advised that the new license application form would need to be modified to remove such questions as gender and professional association membership because those things were not specifically listed in the Board's laws. Ms. Penttinen was advised last

week that the analyst from GRRC wanted the changes made as soon as possible and posted to the Board's website in place of the current document. Today the Board is asked to review the new form and associated changes in the instruction sheet. Ms. Penttinen also made some wording changes to make some questions more clear such as licensure by comity and completion of national board exams. The Board members agreed with the changes and there were no questions. Mr. Tellier also advised Ms. Penttinen that the Board needs to start retaining things such as mailing envelopes and fax covers for any documents that are deemed "direct source only" or "primary source verification." If the authenticity of such a document is questioned the Board should have the documentation to demonstrate the origin of the document.

**d. Review of new license applications for:**

- i. Eric Lew, DPM
- ii. Jill Peotter, DPM
- iii. Leonard Wagner, DPM

**MOTION:** Dr. Campbell moved to approve all three applicants to sit for the oral examination and to issue their license upon successful completion thereof. Dr. Leonetti seconded the motion.

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

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

**e. Malpractice case report. (None at this time.)**

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

**a. Open complaint status report.**

Ms. Penttinen reviewed the report which indicates there are currently 69 open cases including those on today's agenda. She received several complaints in the last month. There are 15 cases with investigators at this time and another four ready to assign. There have been some cases with significant delays in obtaining subpoenaed records. In one case, in order to obtain records, the Board's legal counsel had to send a letter to a hospital advising that the Board would be filing a complaint in court if they did not respond to the subpoena. There had been a four-month delay in obtaining those records.

**b. Discussion regarding "fee splitting" as defined and referenced by other healthcare regulatory boards.**

The Board members reviewed the statutes of six other healthcare regulatory boards which have some type of definition for fee splitting. The Medical Board and Optometry Board have the most specific language in reference to fee splitting applying to unnecessary patient referral with kickbacks. Ms. Penttinen explained that this information was being provided for the Board members to review should they decide to make a change to the Board's statute regarding fee splitting. Ms. Penttinen confirmed for Dr. Leonetti that, to her knowledge, other Boards are not having the same problem as this agency because they do not consider social media advertising to be fee splitting. Ms. Miles stated that she likes the wording of some of the other Board's definitions. She added that not allowing social media advertising denies patients a method of accessing podiatric care. Dr. Leonetti stated there is still the issue that the payment is still going to a third party first and there should be a way for those companies to modify their merchant agreements. After brief discussion the Board members were in agreement that no action will be taken on this issue right now but the topic should be added to the list of potential statute changes should the Board decide at some point in the future to open a bill.

**c. Review of proposed consumer pamphlets regarding complaint adjudication and Call to the Public.**

Ms. Penttinen explained that she reviewed pamphlets developed by the Medical Board to analyze if doing something similar would be beneficial for this agency. The one for Call to the Public was reviewed simply because the Medical Board had one, but she feels the pamphlet on the adjudication process would be more helpful for both doctors and complainants. The Board members were in agreement that it

would be helpful. Ms. Penttinen will develop a pamphlet for the adjudication process and bring it back to the Board at a later date for review and approval.

**VIII. Call To The Public**

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

**IX. Next Board Meeting Date:**

a. March 12, 2014 at 8:30 a.m.

**X. Adjournment**

**MOTION:** There being no other business before the Board, Ms. Miles 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 11:39a.m.