



Janice K. Brewer
Governor

State Of Arizona Board of Podiatry Examiners

"Protecting the Public's Health"

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

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

BOARD MEETING MINUTES

March 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 8:31 a.m.

II. Roll Call

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

(It is noted that Ms. Miles departed the meeting when recess was taken at 10:02 a.m. Dr. Leonetti departed at 10:55 a.m. Those items for which Ms. Miles and or Dr. Leonetti were absent are noted as such.)

III. Approval of Minutes

a. February 12, 2014 Regular Session Minutes.

MOTION: Ms. Miles moved to approve the minutes with typographical corrections. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. February 12, 2014 Executive Session Minutes.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

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

a. 09-20-C and 11-01-C – Kevin O'Brien, DPM: Review of proposed consent agreement and request from Dr. O'Brien's attorney to modify Conclusions of Law.

Dr. Leonetti recused from review of this agenda item as he was the investigator for one of the cases.

MOTION: Dr. Kaplan moved to go into Executive Session for the purpose of 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 9:18 a.m.

The Board returned to Regular Session at 9:30 a.m.

Ms. Miles agrees with the request by Dr. O'Brien's attorney to remove the citation of A.R.S. §32-854(5) in the Conclusions of Law for each case, but keep paragraph (6) of that section and the references to A.R.S. §32-854.01(16)&(20). Dr. Kaplan agrees. Regarding the CME for record-keeping and surgical evaluation and management, the draft agreement states 20 hours, but the original motion was for ten hours, and all CME should be pre-approved. Dr. Kaplan noted that fusion was one of the problems identified by the Board but also ankle procedures in general. The Board members reviewed the minutes for each case. Dr. Kaplan and Ms. Miles reviewed that the 2009 case dealt with ankle surgery. Dr. Kaplan wants to amend the previous motion for the consent agreement to include a restriction on all ankle surgeries. Ms. Miles stated she wants to make sure the facts support such a restriction. The previous minutes were reviewed for the facts of each case. There was discussion regarding specifying "ankle fusion" as a restriction in addition to stating "all fusions." Ms. Miles also stated there should be a specific CME requirement for all listed procedures because Dr. O'Brien could petition the Board at any time to lift any of the restrictions.

MOTION: Ms. Miles moved to go into Executive Session for the purpose of obtaining legal advice. 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 9:44 a.m.

The Board returned to Regular Session at 9:54 a.m.

Ms. Miles reviewed the consent agreement and discussion so far: the Conclusions of Law for each case will be amended to remove the citation for A.R.S. §32-852(5). Dr. O'Brien's attorney requested additional information be added to the Findings of Fact regarding the post-operative infection, but she also said it is fine as drafted. In the Order portion, Dr. O'Brien would be required to complete ten hours of pre-approved CME in the areas of record-keeping and surgical evaluation and management, and he must submit his plan to complete that CME within 60 days of the effective date of the agreement. Based on review of the minutes for each case, the practice restrictions listed in paragraphs 28 and 30 of the draft will be combined and will include all fusions, all ankle surgery, all open and closed wedge osteotomies of the first metatarsal, and subtalar implants until further ordered by the Board. If Dr. O'Brien wishes to lift the restriction for any of the listed procedures, he may petition the Board in writing and must have completed 20 hours of CME specific to that procedure within the six months immediately preceding the request to lift the restriction. Mr. Tellier confirmed that Dr. O'Brien could "piece meal" lifting the restrictions at separate times for separate procedures. Ms. Miles clarified for Ms. Penttinen that if a practice restriction is lifted for any particular procedure, then the probation period (18 months) as stated in draft paragraph 29A would begin and Dr. O'Brien would be required to submit charts for the procedures involving the area of practice that was restored. Also to be added is the stipulation that Dr. O'Brien bears all costs for complying with the agreement.

MOTION: Ms. Miles moved, based on review of all minutes and previous discussions, to offer Dr. O'Brien the consent agreement with amendments as discussed. If he does not accept the agreement within 30 days then the matter will be referred to a formal hearing. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. 11-30-B – Kevin O'Brien, DPM: Improper billing.

Ms. Miles was not present during review of this case. Dr. O'Brien was present. Dr. Dedrie Polakof was the investigator for the case and was present. Dr. Polakof provided the following summary: This case was based on a settlement between Dr. O'Brien and the U.S. Department of Justice in relation to the misuse of billing code 99301 (for Medicare patients). In her experience it was the most commonly misused code among healthcare practitioners when they provided services at nursing homes. In 1998 or 1999 the code was changed to only allow primary care providers to use it. Other practitioners had to find another code to use and it was difficult for podiatrists in particular to find the proper codes to use for nail care and follow-up visits.

Dr. Polakof clarified for Dr. Leonetti that this code is for a new patient evaluation at a skilled nursing facility. In 2006 Medicare discontinued use of the code altogether because nurse practitioners and physician's assistants had been using it as well. Dr. O'Brien was just out of residency at that time and used that code because his billing company advised him it was the correct code to use. Dr. O'Brien also had called Medicare to verify the code and was told it was appropriate, although there is no documentation of that communication. Then Dr. O'Brien was audited, but his misuse of that code was inadvertent and also was not caught by the billing company he used. Dr. O'Brien is ultimately responsible and paid a large fine but was not sanctioned in any other way.

Dr. Polakof clarified for Dr. Kaplan that code 99301 was first instituted in the 1980's when ICD-9 was first introduced. Sometime in 1998 or 1999 the code was changed to only allow primary care physicians to use it. However, Dr. O'Brien was just coming out of residency and did not receive the notification from Medicare about this change because he did not have an established practice. The code was still in use for several years until 2006 when Medicare deleted it completely due to widespread misuse from many healthcare practitioners. The Medicare audit for Dr. O'Brien covered 2002-2005.

Dr. O'Brien addressed the Board and stated that in 2003 Medicare audited his nursing home charts and nothing was mentioned at that time about this billing code. He was not aware of any problem until the investigation in 2007. He stated he is aware that it is ultimately his responsibility but he had made frequent calls to his billing company and was assured it was a proper code to use. Dr. O'Brien confirmed he paid a financial settlement but was not excluded from Medicare or Medicaid participation or sanctioned in any way. He confirmed for Dr. Leonetti that he still sees nursing home patients but very rarely. Also, after this he brought his billing in-house and paid for his staff to become certified in billing. He stated he also uses Coding Line as a reference and now has a new billing service based in Texas that has experience specifically in podiatry billing.

Dr. Leonetti agreed that Dr. O'Brien used the wrong code, but that was already addressed by Medicare. Technically there may be violations but Dr. Leonetti feels there are some extenuating circumstances in this case.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles absent.

c. 11-39-M – Kevin O'Brien, DPM: Practice below the standard of care for improper surgical correction of ankle fracture.

Ms. Miles was absent. Dr. O'Brien was present. Dr. Dedrie Polakof was the physician investigator for this case and provided the following summary: There were no x-rays to review. (Ms. Penttinen confirmed that none were submitted.) The films from Dr. O'Brien were given to the patient without copies being made. It is possible they were given to Dr. James Wilson's office. (That office has since been closed and many records were destroyed by the property owner.) The patient was seen in the emergency room and diagnosed with a trimalleolar fracture. The ankle was set by manipulation and the patient was placed in a posterior cast. The next day the patient was seen by Dr. O'Brien who eventually performed surgery to correct the fracture. She reviewed the report of Dr. Gerbert, the hired expert for the plaintiff, which stated that the internal screw penetrated into the lateral gutter of the ankle. The report also stated the fibula plate may not have been placed properly. Based on that alone she would substantiate the allegation but she was not able to review any of the x-rays. Dr. Gerbert found instability in the joint which resulted in complications.

Dr. O'Brien stated he has a letter from attorney Bruce Crawford who represented him in the malpractice case which was filed in 2009. The letter states that the patient probably would have needed a fusion of the joint at some point because the fracture was so complicated. Dr. O'Brien confirmed for Dr. Leonetti that this was Mr. Crawford's opinion. Dr. Polakof explained for Dr. Leonetti that there was apparently evidence, according to Dr. Gerbert, that the fibula plate was not used properly because the screw went into the lateral gutter and did not engage the opposite side of the joint. However, she did not give any

value to the remainder of Dr. Gerbert's subjective opinions because he was the paid expert for the plaintiff. She confirmed for Dr. Kaplan that she did not have any x-rays to review. Dr. Polakof also confirmed for Dr. Campbell that there were indications of patient non-compliance (in the post-operative period), but the complications of non-compliance would be reduced if they plate had been properly placed.

Upon questioning from Dr. Leonetti, Dr. O'Brien stated it would be hard to say whether or not he agrees with Dr. Gerbert's findings because he has not seen the x-rays recently and it has been five years since he did this surgery. Dr. O'Brien stated that subsequent treating physicians also had problems with this patient. He stated he did not recall whether a screw was placed into the lateral gutter of the ankle but he did use a tightrope procedure to try to correct the diastasis in the joint. Upon questioning from Dr. Campbell, Dr. O'Brien stated that prior to this patient he had done approximately 15-20 ORIF procedures on ankles but he does not have ABPS board certification. Dr. O'Brien stated to Dr. Leonetti that at the time of the procedure he believed he had reduced the ankle fracture properly. The Board members and Dr. Polakof reviewed a letter that Dr. O'Brien sent to the patient's primary care doctor approximately four months after the surgery which stated there was a 2mm gap in the joint. Dr. Kaplan asked whether there was a surgical consent form because it was not included in the chart submitted to the Board. Dr. O'Brien stated there would be one as well as an intake form (from the first office visit).

Dr. Polakof stated that she did not know how Dr. Gerbert could have come to the conclusion he did unless he had seen (post-operative or intra-operative) x-rays. Dr. Leonetti agreed that Dr. Gerbert could not form an opinion that the fixation was done wrong unless he saw x-rays. There was discussion as to whether the patient had taken the original post-operative x-rays and that any intra-operative films would have shown improper correction of the fracture. Dr. Leonetti added that without the x-rays it would be very difficult for the Board to make any determination regarding the allegation. He suggested tabling this case to try to obtain any available x-rays.

Dr. O'Brien confirmed for Dr. Kaplan that he was represented by Bruce Crawford for this malpractice case, and at one time Mr. Crawford was in possession of some x-rays but he does not know where they came from. Dr. Leonetti noted that the patient was seen by multiple doctors so there may be many sets of films, but the most important would be the intra-operative films and immediate post-operative x-rays of Dr. O'Brien's. The Board reviewed documentation submitted in the patient chart which indicated the patient picked up the original films from Dr. O'Brien's office and they were never returned. Ms. Penttinen clarified that she did not ask Mr. Crawford for x-rays because Dr. O'Brien was asked to provide the complete chart and she was never made aware that Mr. Crawford ever had them. Dr. O'Brien stated he does not know if the x-rays Mr. Crawford had were his, just that he had some films and the patient took their original films from his office. Also, since this incident he is no longer releasing original films. Dr. Leonetti stated that Dr. Gerbert must have had x-rays at some point to come to the conclusion he did so the Board must make every effort to obtain them prior to making a decision.

Dr. O'Brien stated he is no longer doing any type of ankle fracture repairs. He confirmed for Dr. Kaplan that he did have a surgical consent form for this patient but he did not have the complete chart with him today; he will locate that form and submit it to the Board. There was general agreement among the Board members that additional information needs to be obtained. Dr. Polakof provided the name of the plaintiff's attorney as Thomas Slack. Ms. Penttinen will contact Mr. Slack as well as Mr. Crawford to try to locate the post-operative films, and intra-operative films if any are available.

MOTION: Dr. Leonetti moved to table this matter for further investigation as discussed. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles absent.

- d. **12-01-C – Steven Born, DPM: Insurance fraud for billing for orthotics; improper use of billing codes / insufficient documentation to support billing codes. (Review of proposed consent agreement terms.)**

Dr. Born was not present but was represented by attorney James Cool. Mr. Cool stated that Dr. Born has already completed two CME courses in billing and coding in anticipation of the Board's decision today. The Board members reviewed the draft consent agreement prepared by Ms. Penttinen based on the discussion in last month's meeting. Dr. Kaplan wanted to add the specific billing codes which were misused for the orthotics to the Findings of Fact. (Codes L300 KX RT & LT.) Regarding submission of charts, Ms. Penttinen clarified for Dr. Kaplan that only Medicare patients were included because only Medicare charts were audited and that was also the context of the discussion last month. Dr. Kaplan also wanted to add that Dr. Born should bear all costs of complying with the agreement and the proof of DMERC certification should go back to the beginning of 2010.

Ms. Miles offered the following changes: Make the probation period "at least" 18 months, (in relation to payment of the civil penalty to be discussed later), that the Board-approved mentor in billing and coding should be obtained within 60 days, and keeping the suggested time with the mentor at two hours per month after the first month. Regarding the progress reports from Dr. Born and the billing mentor, Ms. Miles suggested reports after the first three months, then after an additional six months; after that Dr. Born could request to terminate the billing mentor at the Board's sole discretion. If the Board did not agree then progress reports would be required after an additional three months after which Dr. Born may again request to terminate that activity. Regarding the CMED, MS. Miles suggested adding that all CME must be Board-approved; the Board usually pre-approves CME but she does not want to penalize a licensee who takes remediation efforts prior to the final disposition of a case. She proposed requiring that half the CMED hours be specifically pre-approved. The Board members agreed that all CME should be face-to-face or in-person and that internet-based courses would not be accepted. Mr. Cool stated that due to personal illness Dr. Born may have difficulty completing in-person CME courses. The Board members agreed to go ahead with the in-person requirement at this time and it may be amended in the future if Dr. Born can show good cause.

Ms. Miles reviewed the civil penalty requirement as follows: She is not set on any particular amount but it should be substantial enough to reflect the amount of billing errors. She suggested the full amount (of \$10,000.00) be paid in full by the end of the probation and if not paid in full then probation would continue until it is paid; she is also okay with leaving it as it and taking the "at least" wording out of the 18 months of probation. Dr. Campbell asked what would happen if Dr. Born does not renew his license during the period of probation. Mr. Tellier confirmed for Ms. Miles that the Board cannot require him to renew his license but failure to pay the civil penalty would be like any other debt and can be referred to the Attorney General's office for collection. Ms. Penttinen clarified for the Board members and Mr. Cool that a civil penalty is paid to the Board but is assigned a particular revenue code so that it is deposited in the State general fund and not the Board's revenue. Mr. Tellier confirmed for Mr. Rhodes that the civil penalty could be paid in assigned installments. Mr. Rhodes suggested that a substantial portion of the civil penalty should be paid immediately and the remainder paid prior to the end of probation. Ms. Miles stated she understands Mr. Rhodes' opinion but she is not in favor of managing installments of payments. Regarding the amount, she stated that if it is based on the number of violations and amount of money collected improperly then she feels \$10,000.00 is a fair amount. Ms. Penttinen confirmed for the Board members that improper billing was found in 37 charts over a three-year period, many of which had multiple dates of service/improper billing. All Board members were in agreement that the Board could assess a penalty of \$2,000.00 per violation and there were well over one hundred violations so the civil penalty amount could be much higher, so \$10,000.00 is appropriate.

Mr. Cool asked about the time frame for obtaining a Board-approved mentor (for billing and coding). It was clarified that Dr. Born would have 60 days from the effective date of the agreement to find a mentor and submit their name to the Board for approval. Ms. Miles agreed to remove her suggestion of "at least" 18 months of probation and all Board members were in agreement that if Dr. Born does not renew his license during the probation period then any unpaid portion of the civil penalty must be paid in full immediately. Mr. Tellier asked the Board what would happen, regarding the billing mentor, if after 12 months the Board does not approve Dr. Born's request to terminate that activity. Ms. Miles suggested and the Board members agreed that another set of progress reports would be required at the 15-month mark (three months prior to the end of probation). There was brief discussion regarding the billing mentor with agreement that they could be in or out of state but must be a certified coding expert. All

Board members also agreed that Dr. Born has 30 days to accept the consent agreement or the case will go to an Informal Hearing.

MOTION: Ms, Miles moved to offer the consent agreement to Dr. Born with modifications as outlined above. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

e. 12-10-C – Cathleen McCarthy, DPM: Charging an excessive fee.

Dr. McCarthy was not present. Dr. Polakof was the investigator for the case and provided the following summary: the patient saw Dr. McCarthy for heel pain that was diagnosed as a possible stress fracture. The doctor recommended a boot to immobilize the fracture. However, the patient has arthritis and previous hip and knee surgery so she was concerned that the boot would complicate those issues. The patient did inquire about the price of the boot which Dr. McCarthy gave her along with price information for a brace that was less costly. The patient agreed to the brace which would work well when worn with a rigid shoe. The patient was asked to sign an ABN with an estimated cost of up to \$250.00. She thought that was excessive and went online and found that the brace retails for \$59.95. The patient feels the charges to Medicare of approximately \$111.00 plus her copay was excessive. Dr. McCarthy's notes indicate she ordered the brace and conducted the brace fitting, gait analysis and instructions to the patient on proper use of the brace. Additionally Dr. McCarthy often gives reduced prices to patients whose insurance does not cover certain devices. Given all that Dr. McCarthy performed for this patient Dr. Polakof does not feel the charges were inappropriate and she finds no violations. Dr. Polakof confirmed for Dr. Kaplan that the doctor's staff explained two different ABN's to the patient – one for the brace and one for the boot. That may have led to confusion for the patient regarding the actual price. Dr. Kaplan agreed that there are no violations.

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

DISCUSSION: There was not discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Dr. Leonetti and Ms. Miles absent.

f. 12-22-C – Kevin O'Brien, DPM: Practice below standard of care for improper surgery; improper treatment of post-operative infection; failure to maintain adequate records/loss of pre-operative x-rays.

Ms. Miles was absent. Dr. O'Brien was present. Dr. Polakof was the investigator for the case and stated the following: she spoke with the patient who stated she never wanted to file a complaint but it was suggested to her several times by Dr. Killian who treated her after Dr. O'Brien. At Dr. Killian's advice the patient requested all record and x-rays from Dr. O'Brien. Dr. Killian told the patient that because he did not have pre-operative x-rays there was nothing he could do and that Dr. O'Brien may have ruined her while foot. The patient asked Dr. Killian to request the pre-op films from Dr. O'Brien, but Dr. Killian only continued to make negative comments about Dr. O'Brien, both personally and professionally, to the point that the patient stopped seeing him after six office visits because too much time was spent gossiping about Dr. O'Brien. The patient told Dr. Polakof she was not upset with Dr. O'Brien, she just wishes her foot had turned out better.

Dr. Polakof continued: regarding allegation number three, she received all x-rays so none of them were lost. She does not know why Dr. Killian told her he never received them. Regarding allegation number two, the patient's daughter in a nurse and wanted her to go to the emergency room. Dr. O'Brien told the patient he would take blood studies and a culture to see if it was necessary to change antibiotics. According to Dr. Killian the patient could have lost her foot because she did not go to the emergency room. The antibiotic was changed and the patient eventually did heal, but she cannot say if IV antibiotics would have helped. Regarding allegation number one, the patient saw Dr. O'Brien due to a large lesion on the bottom of the second metatarsal head and the toe was pulling up. The third toe also was pulling up but not as bad. Pre-operative x-rays show a large spur on the bottom of the second metatarsal head. Dr. O'Brien chose to do a planing of the cartilage surface, but other procedures would have been more beneficial for this patient. Planing the cartilage surface reduces the gliding mechanism of the joint resulting in potential arthritis which this patient later developed. Dr. Polakof feels the allegation of

improper surgery is substantiated because she feels he chose the wrong surgical procedure. Dr. Polakof stated the other option would be to lift the metatarsal and remove the spur and, if needed, shortening of the surgical neck instead of the cartilage surface. She confirmed for Dr. Leonetti that the spur was on the plantar side of the metatarsal head and that reducing the cartilage also reduced the length of the bone. Dr. Leonetti asked Dr. O'Brien how reducing the cartilage would reduce the bone spur. Dr. O'Brien asked to view the x-rays. Dr. Polakof confirmed that removing the cartilage did not help the spur and damaged the joint.

Upon questioning from Dr. Campbell, Dr. O'Brien stated that the cartilage looked fine to him. He also explained that he routinely uses a thigh tourniquet because an orthopedic surgeon he has worked with recommended it to him to reduce complications such as blood clots. With regard to the antibiotics he does not recall exactly why he initially prescribed a Z-Pak or if the patient had allergies, but he would usually give a prescription for Keflex. Dr. O'Brien also confirmed that any time anything is removed from a patient it is sent for pathology per the hospital's policy.

Dr. Kaplan asked where the surgical consent form was and Dr. O'Brien stated he could have it faxed; he does not know why it was not sent with the rest of the patient's records. Dr. O'Brien stated to Dr. Campbell that when he saw the patient on 04/03/12 the patient did not have any open wounds (except for the surgical incision) so there was nothing to culture, but the patient was worried about redness so he prescribed Levoquin. He also stated that he does plan his surgeries in a step-wise fashion to evaluate contractures at different levels. Dr. O'Brien said he does not know why the patient would say x-rays were not shown to her because he always uses the view box in the room.

Upon questioning from Dr. Leonetti, Dr. O'Brien said he felt the third toe needed to be corrected because the patient was complaining of second and third hammertoes with associated pain. The patient had previously been treated by Dr. Killian and had tried injections and orthotics to relieve the pain. Dr. Killian had scheduled the same surgery that he did and it is unknown why the patient did not have Dr. Killian complete it. Dr. O'Brien also stated the third toe was contracted and the patient complained that it was rubbing in her shoes. He confirmed that the procedure he did was an arthroplasty of the PIPJ. Dr. Kaplan noted that there was no intake form included in the chart so it is unknown what the patient reported as her chief complaint. Dr. O'Brien stated that form also should have been submitted with the rest of the records, and he added that the surgical consent form did explain everything that would be done.

Dr. O'Brien confirmed for Mr. Rhodes that he reviewed his surgical plan for this patient with an orthopedic surgeon who was in favor of the procedures. Dr. Kaplan again questioned the documentation of the discussion with the patient regarding treatment options and surgical plan. Dr. O'Brien stated all of that was in the surgical consent. All physician Board members agreed that the complete chart is needed before a decision can be made.

MOTION: Dr. Campbell moved to table this case to obtain additional information and missing records as discussed. Dr. Leonetti seconded the motion.

DISCUSSION: There was not discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles absent.

- g. **12-24-C – William Leonetti, DPM: Making false statements in regard to patient's history; making false statements in regard to patient's physical evaluation; making false statements in regard to patient's chief complaint; making false statements in regard to patient's assessment; making false statements in regard to patient's discussion; Deliberately constructing confusion of patient's chronologically ordered physicians list in an attempt to conceal factually accurate medical information in history of injury; conceals and/or omits factually accurate medical information in regard to patient's history of injury; conceals and/or omits factually accurate medical information in regard to patient's discussion; conceals and/or omits factually accurate medical information in regard to patient's chief complaint; conceals and/or omits factually accurate medical information in regard to patient's physical evaluation; conceals and/or omits factually accurate medical information in regard to**

patient's assessment; presents patient with a below standard of care recommendation for improper surgery.

Dr. Joseph Leonetti and Ms. Miles were absent. All references to "Dr. Leonetti" under this specific item refer to Dr. William Leonetti.

Dr. Leonetti was not present. Dr. Jerome Cohn was the investigator for this case and was present. Ms. Penttinen stated for the record that the initial complaint information was extremely vague and she made several attempts to get more detailed information from the complainant. She advised him that sending a stack of records with generalized statement and wanting staff to determine the allegations was not a suitable method of investigation. After numerous contacts via regular and certified mail and email she set a cut-off date to arrange a telephone interview. After that deadline passed the complainant then began sending more information which was still very vague. She advised him that the investigator needed to complete his review and additional information would be given to the Board at the time of review to their determination as to whether or not it would be considered. Dr. Leonetti provided a complete copy of all records he was given for the patient so in the interest of time-appropriate due process for Dr. Leonetti she felt it was appropriate to move forward and let the Board members decide what, if anything, to do with the additional information.

Dr. Cohn provided the following information: because the allegations were so broad he reviewed all of the records very thoroughly and cross-referenced them to determine if anything applied to the allegations. This complaint is based on an IME that Dr. Leonetti did in July 2011 which was requested by SCF Arizona in relation to an injury the patient sustained in 1993 when he was a professional football player for the Arizona Rattlers. All records received from Dr. Leonetti regarding his exam were accurate in their references to records from other providers. On the initial patient history form the patient indicated a date of injury in June 1993 which was an injury to the second toe (left foot). There was nothing mentioned in the records for that time regarding an injury to the first toe. Dr. Leonetti's exam was appropriate and his review of other records was very comprehensive. There were 16 specific points of information that Dr. Leonetti addressed which Dr. Cohn reviewed as well and found all of Dr. Leonetti's notes to be accurate and consistent. The reason for the IME request was for a second opinion regarding surgery associated with the second toe and whether issues with the first toe were related to that injury. The history of injuries in Dr. Leonetti's notes was consistent with other records..

Dr. Cohn continued: he reviewed that the patient also had sustained an injury to the first left toe while playing football in college in 1989. He sustained a fracture of the medial sesamoid which was removed. This seems to be the basis for the present complaint. The review by Dr. Leonetti included a physical exam and the results did not indicate anything that was inconsistent with what other doctors had documented. Dr. Leonetti's exam did describe a bunion deformity and first toe pain, but that is associated with the college injury and not the second toe injury which was the basis for this IME. The radiological findings were consistent with a second toe injury including arthritis and narrowing of the joint. The bunion deformity is the result of the sesamoid removal and is a well-known complication. Dr. Leonetti's assessment addressed the questions raised by SCF/Az regarding the origins of both the second toe injury and that of the first toe as well as continued degenerative changes of both toes. He agrees with Dr. Leonetti's assessment that the bunion deformity is the result of the college injury and is not associated with the second toe injury and was a pre-existing condition. SCF/Az asked Dr. Leonetti for his opinion regarding the need for surgery and if other treatments were recommended. He finds Dr. Leonetti's recommendations were appropriate.

Dr. Cohn stated he conducted a phone interview with Dr. Leonetti who said that when the patient was seen in his office he was very antagonistic. Dr. Leonetti also informed Dr. Cohn of an additional hearing which was recently conducted for the patient's SCF/Az claim. During that hearing the patient was disrespectful to the judge including using profanity. Overall he finds no inconsistencies with Dr. Leonetti's records and feels the exam and documentation were all appropriate. This complaint seems to have arisen because the patient has seen another physician in California who wants to do surgery on the first toe and the patient is trying to tie the problems with that toe into the injury to the second toe. Dr. Cohn stated he would be happy to review any additional records the Board may wish. However, he stated that all the podiatry literature support that bunion deformity is a common complication of sesamoidectomy and is not related to an injury of the second toe as sustained by this patient. Dr. Cohn stated he found

no violations in this case. Drs. Campbell and Kaplan agreed that all the records from Dr. Leonetti were consistent with the complete patient history.

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

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Dr. Joseph Leonetti and Ms. Miles absent.

h. 12-26-C – Peter Myskiw, DPM: Improper billing.

Ms. Miles and Dr. Leonetti were absent. Dr. Myskiw was present. Dr. Polakof was the investigator for the case and provided the following summary: The patient saw Dr. Myskiw for heel pain that was consistent with a diagnosis of bursitis. She was given a boot and when leaving the office she was told by staff that she needed to pay \$250.00 for the boot in addition to her office visit copay. The staff told her the boot would not be covered by her insurance (Cigna) but they would submit the bill anyways. She went home and called in a credit card for payment. The patient later called Cigna and was told that the boot was covered. In a subsequent office visit the patient was told she still owed money for the boot and when she received her explanation of benefits from Cigna she was concerned because the doctor originally billed it for \$400.00 but then resubmitted the same claim for \$800.00. The patient said Cigna told her she had paid the correct amount for her copay and deductible but Dr. Myskiw's staff kept telling her she owed more money. After she filed her complaint with the Board the office staff told her she no longer owed any money. In review of the billings, Dr. Polakof found that Dr. Myskiw used the wrong billing code of L2116 which is for a splint for a tib/fib fracture when what the patient received was a cam walker. In conclusion, the patient felt she was being strong-armed by the office staff with threats of being sent to collections. Eventually the office staff admitted the mistake; however, the concern remains that Dr. Myskiw used the wrong billing code so she finds the allegation substantiated.

Dr. Myskiw confirmed for Dr. Campbell that he uses the L2116 code often because it is for a rigid AFO brace or other pneumatic brace. Regarding the changing of the billed price, Dr. Myskiw stated patients can get upset about any mention of billing. He said the patient was asked to pay her deductible and copay at the time of service as per office policy. The \$250.00 fee was her deductible, not the fee for the boot. Dr. Myskiw added that any bills to Cigna are automatically cut in half by Cigna so his billing staff, who was new at the time, just doubled the billed amount and resubmitted it. He has since spoken with that person to correct that. His office did not know about the complaint with the Board at the time that they resolved the patient's concerns. Dr. Myskiw clarified for the Board members that he does not always use ABN's and that he now knows using the L2116 code was upcoding and it was not the correct code for the type of boot that was dispensed. Dr. Polakof confirmed for the Board members that the correct use of L2216 is for a brace for a stress fracture of the tib/fib that need support for six months or greater.

MOTION: Dr. Campbell moved to dismiss this case with a Letter of Concern for improper use of the L2116 billing code. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Dr. Leonetti and Ms. Miles absent.

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

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

Ms. Penttinen reviewed that the last progress report from Dr. Sucher was received in February and was the relapse prevention evaluation. The next report is due in May. She has received no reports of non-compliance. Also the term of probation will be completed in October of this year.

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

Ms. Penttinen advised that she has opened the new case with the allegation of violating the consent agreement. She just received Dr. Crezee's response and will have it on the agenda for the April meeting.

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

Ms. Penttinen advised that a report of Dr. Stone's counseling services was due this month but it has not yet been received.

Not related to Dr. Stone's probation review, Mr. Rhodes asked Dr. Campbell if the Board could open a complaint investigation on Dr. Killian in relation to the matters discussed for Dr. O'Brien (encouraging patients to file complaints). Dr. Polakof was still present and stated she has learned that Dr. O'Brien has letters from several patients who all report the same thing as the patient in case number 12-22-C, that Dr. Killian continuously speaks negatively of Dr. O'Brien. Dr. Campbell stated there would need to be a complaint case opened if the Board did want to take any action if they feel Dr. Killian's actions are a violation. Dr. Polakof also stated that Dr. Killian has negative comments about Dr. O'Brien in his own patient charts.

MOTION: Mr. Rhodes moved to open a complaint case for Dr. Killian with the allegation of unprofessional conduct in relation to his comments to the patient in case 12-22-C. Ms. Penttinen stated additional patients can be added and re-noticed to Dr. Killian if discovered during the course of the investigation. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles and Dr. Leonetti absent.

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

a. Request from Marcus Yetter, DPM regarding oral examination.

The Board received a request from Dr. Yetter for accommodation to take the oral exam on a different day than the scheduled date of June 12, 2014. The reason given is that he is graduating from residency that day. He is willing to travel to Arizona on any other day. The Board members did not feel that was a sufficient reason to reschedule the oral exam for him.

MOTION: Dr. Kaplan moved to deny the request. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Dr. Leonetti and Ms. Miles absent.

b. Review of information regarding "medical nail technicians."

Dr. Campbell reviewed that Ms. Penttinen was contacted by Dr. Elisons' office regarding a training class they saw and wanted to know if it was something they should invest in to train a person in their office. The course is provided by a company called Medinail. Dr. Campbell reviewed the Board's Substantive Policy Statement regarding medical assistants and the activities they can perform in a podiatry office which includes that they can trim nails if they have been trained by the doctor. Medinail also has other courses to achieve certification as a podiatry assistant, but the certification is issued by their company, not by an accredited body, and it does not result in a regulatory license or certification. Dr. Kaplan asked if a medical nail technician could bill Medicare for services they perform. Dr. Polakof stated that at Cigna each podiatrist has one or two nail techs who trim nails and callouses, then the doctor double-checks it and the billing is done under the doctor's name. Dr. Cohn was still present and offered his position that according to CodingLine a physician should not be charging for any service they don't actually provide themselves. Dr. Kaplan added that the Cosmetology Board is very clear on nail tech certifications and even a certified nail tech cannot touch mycotic nails. There was brief additional discussion with consensus that the Board can offer no opinion on this matter; the Drs. Elison will be advised to consult their malpractice insurance carrier and insurance contracts.

c. Responsibilities / duties of investigative consultants.

Dr. Campbell reviewed the corrected list of duties. Drs. Polakof and Cohn confirmed that they were available after the April Board meeting to review this and have discussion. Ms. Penttinen will forward a copy of the duties to the consultants for them to review ahead of time and she will contact Dr. Forman to ensure he is available that day.

d. Review of new license applications for:

- i. Maria Buitrago, DPM (Reinstatement)

- ii. David Ellsworth, DPM
- iii. Jason Kayce, DPM
- iv. Brandon Mecham, DPM.

MOTION: Dr. Campbell moved to approve all four applicants to sit for the oral exam and issue their licenses upon successful completion thereof. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles and Dr. Leonetti absent.

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 explained that when she ran the report this morning she realized there are numerous errors in things such as complaint cases that were previously dismissed are showing up now as still being open. There was recently a large software update performed system-wide by ADOA and other agencies also noted similar problems. Ms. Penttinen will correct the errors and have the report fixed for the April meeting.

VIII. Call To The Public

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

IX. Next Board Meeting Date:

- a. April 9, 2014 at 8:30 a.m.

X. Adjournment

MOTION: There being no other business before the Board,

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the meeting was adjourned at 12:18 p.m.