ARIZONA STATE BOARD OF PHYSICAL THERAPY
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REGULAR SESSION MEETING MINUTES
March 22, 2011

MEMBERS PRESENT: Mark Cornwall, P.T., Ph.D., President
Lisa Akers, P.T., Vice President
Randy Robbins, Secretary
Melinda Richardson, P.T., Member
Peggy Hunter, P.T.A., Member

MEMBERS ABSENT: James Sieveke, P.T., O.C.S., Member

OTHERS PRESENT IN PERSON: Charles D. Brown, Executive Director
Paula Brierley, Licensing Administrator
Karen Donahue, Investigator
Keely Verstegen, Assistant Attorney General

CALL TO ORDER – 8:40 a.m.

Dr. Cornwall called the meeting to order at 8:40 a.m.

1) Review and Approval of Draft Minutes
   a) February 22, 2011, Regular Session Meeting Minutes

Dr. Cornwall called the Board's attention to the above agenda item. Ms. Richardson requested the minutes be corrected on pages 4 to reflect her nay vote under the Jeffrey Petersen matter. Dr. Cornwall stated he would like the last sentences in the Petersen and Salamat agenda items to be clarified. Dr. Cornwall moved the minutes be approved with the changes requested. Ms. Akers seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X		X		X
Nay						
Recused						
Abstained						
Absent			X		X	

   b) February 22, 2011, Executive Session Meeting Minutes 8:40 a.m. to 8:50 a.m.

Dr. Cornwall called the Board's attention to the above agenda item. No Board member requested any changes. Dr. Cornwall moved the Board approve the minutes as presented. Ms. Akers seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

c) February 22, 2011, Executive Session Meeting Minutes 10:16 a.m. to 10:21 a.m.

Dr. Cornwall called the Board's attention to the above agenda item. No Board member requested any changes. Dr. Cornwall moved the Board approve the minutes as presented. Ms. Akers seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

d) February 22, 2011, Executive Session Meeting Minutes 10:47 a.m. to 10:49 a.m.

Dr. Cornwall called the Board's attention to the above agenda item. No Board member requested any changes. Dr. Cornwall moved the Board approve the minutes as presented. Ms. Akers seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

2) COMPLAINTS, HEARINGS, INVESTIGATIONS and COMPLIANCE

a) Formal Hearing and Possible Action

i) Review of Administrative Law Judge Decision; Sharon Caulder, Applicant

Dr. Cornwall called the Board's attention to the above agenda item. Ms. Caulder was not present. Ms. Verstegen addressed the Board on behalf of the State and requested the Board adopt the Administrative Law Judge's recommendation to deny the appeal by Ms. Caulder. Dr. Cornwall closed the time for statements since Ms. Caulder was not present. The Board entered discussion on the matter. Dr. Cornwall moved the Board adopt the Findings of Fact, Conclusion of Law, and Recommended Order of the Administrative Law Judge. Ms. Akers seconded the motion. Dr. Cornwall took a Roll Call Vote. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

3) **CONSENT AGENDA: REVIEW, CONSIDERATION and ACTION**

a) Applications for Licensure and Certification

Dr. Cornwall asked if any Board member wished to remove a person from the consent agenda. No Board member requested a removal. Dr. Cornwall moved the Board approve the consent agenda as presented and license and certified the listed individuals. Mr. Robbins seconded the motion. The motion carried by unanimous vote.

i) Substantive Review, Consideration and Approval of Applications of Physical Therapist Licensure

Ast, Melody	Bhatt, Radhika	Bransky, Sue
Gacula, Lisa	Godfrey, Brent	Ivy, Jerry
Mangum, Libbie	Mummert, Brenda	Neisen, Heather
Pederson, Heidi	Reese, Jason	Schanzer, Benjamin
Slater, Lisa	Smith, Erik	Sutton, Sundi
Wessinger, Karen		

ii) Substantive Review, Consideration and Approval of Applications for Physical Therapist Assistant Certification

Auger, Rochelle	Beck, Hollee	Cashen, Deborah
Howard, Krystina	VanDenburgh, Heather	Thomas, Matthew

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

Consent Agenda Ends

2) COMPLAINTS, HEARINGS, INVESTIGATIONS and COMPLIANCE

b) Review, Discussion, and Action on Board Order

i) Complaint # 09-29/30; William Perry, PT; Request for Modification of Board Order

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Brown stated that Mr. Perry is requesting modifications to his Board Order to reduce his audits from twice a month to once a month. Mr. Brown stated Mr. Perry's most recent reports of compliance have been provided to the Board for review. In addition, Mr. Brown reported that Mr. Perry has a pending complaint for possible violation of his Board Order. Dr. Cornwall moved the Board table the request until the Board can review the pending complaint. Mr. Robbins seconded the motion. The Board entered discussion. Ms. Akers stated she is not inclined to reduce the audits at this time considering the issue identified in past audits and the complaint pending. Dr. Cornwall called the vote. The motion carried. One member voted nay.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X		X	X		X
Nay		X				
Recused						
Abstained						

Absent					X	

ii) Complaint # 10-09; Gregory Sonntag, PT; Request for Modification of Board Order

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Sonntag was not present. Mr. Brown reported that Mr. Sonntag is requesting modifications to his order to include an extension to complete his continuing education and permission to take some of his continuing education through the APTA online programs. The Board entered discussion. Dr. Cornwall moved the Board modify Mr. Sonntag's Order to extend the period to complete continuing education by 90 days and to allow a maximum of two (2) hours of each continuing education subject to be taken online. In addition, Mr. Sonntag must present Board staff with a short essay describing the online continuing education. Mr. Robbins seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

iii) Review, Discussion and Action on Compliance with Final Consent Agreement and Order
(1) William Sifling, PT; Consideration of Lifting Stayed Revocation

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Sifling was not present. Mr. Brown reported he had recently received an e-mail from Mr. Sifling and provided it to the Board. All Board members acknowledge receipt of the e-mail. Mr. Brown reported that Mr. Sifling is serving a period of probation for violations related to substance abuse through a consent agreement with the Board. The consent agreement has a stayed revocation of Mr. Sifling's license which the Board may lift if Mr. Sifling is found to be in violation of the Order. Mr. Sifling's license was reinstated in November 2010 and all conditions of the probations where to remain in effect. Mr. Brown reported Mr. Sifling had not provided any of the required reports outlined in his probation including reports from his sponsor, chemical dependency counseling, or reports of his compliance with biological fluid testing. On January 25, 2011, Mr. Sifling left Mr. Brown a voicemail stating he was leaving Arizona and had stopped all counseling and testing. The Board met on February 22, 2011 to review his compliance and set the March 2011 Board meeting date to consider lifting the stayed revocation of Mr. Sifling's license.

The Board entered discussion. Dr. Cornwall noted concern with the repeated compliance issues Mr. Sifling has had and with his recent non-compliance with reporting and testing. Dr. Cornwall moved the Board lift the stay of the revocation and revoke license number 3204 belonging to William Sifling, to practice physical therapy in Arizona. Ms. Richardson seconded the motion. Dr. Cornwall called a roll call vote. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

b) Informal Hearing and Possible Action on Complaint:
i) Complaint #10-18; Anthony Harden, PT

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Harden was present and came forward to address the Board. Dr. Cornwall provided a summary of how the hearing would be conducted and the possible outcomes. Mr. Brown provided a summary of the allegations in the case.

Based on the investigation by Board staff and the Board's Initial Review of this complaint it is alleged that Mr. Harden:

1. Failed to create and maintain adequate patient records for patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., D.S., N.Q., M.Z., J.T., J.S., and K.J. for dates of service between April 26, 2010 and April 30, 2010.
2. Billed for services not performed and/or services not documented in the patient record for patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., and D.S. for dates of service between April 26, 2010 and April 30, 2010.
3. Failed to manage patient care to include periodic revaluation of patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., D.S., N.Q., M.Z., J.T., J.S., and K.J.
4. Failed to supervise assistive personnel and delegate tasks or interventions as required by law during the treatment of patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., D.S., N.Q., M.Z., J.T., J.S., and K.J..

Mr. Harden came forward and provided an opening statement to the Board. He stated there where some interventions not documented and services performed but not billed. After a review he identified ways to improve documentation and billing to include bringing billing internal again rather than an outside vendor. Mr. Harden claimed there were many people interacting in billing process noting discrepancies between his record and the record created by the athletic trainer (ATC) that billed for services not documented. Mr. Harden concluded his opening statement.

Dr. Cornwall opened the matter for questions from the Board. Dr. Cornwall noted that there are numerous cases in the patient records that show lack of documentation regarding minimal requirements and billing for services not documented. Mr. Harden noted that he has recognized the documentation issues and is taking steps to correct the problem. Ms. Akers questioned Mr. Harden regarding the communication of services being delegated to the ATC he employs. Mr. Harden noted that delegation was done verbally and not documented and that some conditions just have a standard protocol.

Ms. Richardson question Mr. Harden regarding his process for determining reevaluations. Mr. Harden said he normally has a timeframe to do a reevaluation depending on the patient's condition and also just listens in the clinic while the patient is treated by his assistive personnel to hear if things are changing and a reevaluation is needed. Mr. Harden stated that he is improving the process to ensure patient presentation changes and evaluations are being documented to.

The Board questioned Mr. Harden regarding his billing procedures. Mr. Harden stated that there are cases of billing for services not documented by his former employee, which is part of the reason he has changed the billing to ensure all billing is done in house and they are improving procedures to ensure services are properly documented. Mr. Harden answered addition questions. Dr. Cornwall closed the questioning phase of the hearing. Mr. harden declined a closing statement.

The Board entered deliberations. After discussion by the Board, Dr. Cornwall moved the Board adopt the following Findings of Fact:

1. Respondent (Mr. Harden) was the treating physical therapist for patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., D.S., N.Q., M.Z., J.T., J.S., and K.J. for dates of service between April 26, 2010 and April 30, 2010.

2. Respondent was noticed of allegations as follows:
   a. Failed to create and maintain adequate patient records for patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., D.S., N.Q., M.Z., J.T., J.S., and K.J. for dates of service between April 26, 2010 and April 30, 2010.
   b. Billed for services not performed and/or services not documented in the patient record for patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., and D.S. for dates of service between April 26, 2010 and April 30, 2010.
   c. Failed to manage patient care to include periodic revaluation of patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., D.S., N.Q., M.Z., J.T., J.S., and K.J.
   d. Failed to supervise assistive personnel and delegate tasks or interventions as required by law during the treatment of patients E.V., J.B., F.A., M.C., J.H., K.K., E.H., M.S., D.C., D.S., N.Q., M.Z., J.T., J.S., and K.J..

3. The Board found Respondent did commit acts consistent with all allegations listed in paragraph 4 a-d and provided the following examples of the acts.
   i. Patient E.V.: the delegation of services to assistive personnel is not documented and no co-signature by Respondent is found in the patient record. Patient E.V.'s record for May 7, 2010 demonstrates that manual therapy was billed but not documented in the patient record. On May 10, 2010 Respondent billed for services 97140 and 97110 but did not document the services as performed in the patient record.
   ii. Patient J.B.: Respondent provided electrical stimulation services on April 29, 2010, but did not charge for the services.
   iii. Patient F.A.: Respondent billed ultrasound services on April 27, 2010, but failed to document the service as performed in the patient record.
   iv. Patient M.C.: Respondent billed for mechanical traction services on April 27, 2010, but failed to document the services as performed in the patient record.
   v. Patient J.H.: the patient record demonstrates treatment provided on April 28, 2010, but the record contains no billing for the date of service.
   vi. Patient E.H.: Respondent billed for services, but failed to document services performed in the patient record.
   vii. Patient M.S.: Respondent billed for ultrasound services on April 26, 2010 and April 28, 2010 but failed to document the services were performed in the patient record.
   viii. Patient D.S.: Respondent documented treatment performed on April 26, 2010, but did not provide any billing for services.
   ix. Patients M.Z., J.T., K.J., and N.Q.: Respondent documented changes in the patients' presentation and status, but failed to document or perform a reevaluation of the patients.
   x. Patient J.S.: Respondents discharge documentation on April 27, 2010 did not contain the required components listed in law and within the standards of the profession to include functional status notations, patient progress toward achieving goals in the plan of care, or the patient' plan following the discharge.
   xi. Patient E.V.: Respondent did not properly supervise assistive personnel and did not delegate interventions to assistive personnel as required by law and Respondent admitted during testimony before the Board he did not co-sign the daily interventions provided and documented by assistive personnel.

Ms. Akers seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson

Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

Dr. Cornwall moved the Board adopt the following conclusions of law:

1. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(1) “Violating this chapter, board rules or a written board order”.

2. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(12) “Failing to adhere to the recognized standards of ethics of the physical therapy profession.”

3. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(13) “Charging unreasonable or fraudulent fees for services performed or not performed.”

4. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(20) “Failing to maintain adequate patient records. For the purposes of this subsection, "adequate patient records" means legible records that comply with board rules and that contain at a minimum an evaluation of objective findings, a diagnosis, the plan of care, the treatment record, a discharge summary and sufficient information to identify the patient.”

5. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2042

A. A physical therapist is responsible for patient care given by assistive personnel under the physical therapist's supervision. A physical therapist may delegate to assistive personnel and supervise selected acts, tasks or procedures that fall within the scope of physical therapy practice but that do not exceed the education or training of the assistive personnel.

F. A physical therapist is responsible for managing all aspects of the physical therapy care of each patient. A physical therapist must provide: 2. Periodic reevaluation of and documentation for a patient.

H. For each patient on each date of service, a physical therapist must provide and document all of the therapeutic intervention that requires the expertise of a physical therapist and must determine the use of physical therapist assistants and other assistive personnel to ensure the delivery of care that is safe, effective and efficient. Documentation for each date of service must be as prescribed by the board by rule.

J. A physical therapist's responsibility for patient care management includes accurate documentation and billing of the services provided.

6. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(20) “Failing to maintain adequate patient records. For the purposes of this subsection, "adequate patient records" means legible records that comply with board rules and that contain at a minimum an evaluation of objective findings, a diagnosis, the plan of care, the treatment record, a discharge summary and sufficient information to identify the patient.”

7. The conduct and circumstances described in the above paragraphs constitute a violation of A.A.C. R4-24-303. Patient Care Management

A. A physical therapist is responsible for the scope of patient management in the practice of physical therapy as defined by A.R.S. § 32-2001. For each patient, the physical therapist shall:

1. Perform and document an initial evaluation;
2. Perform and document periodic reevaluation;
3. Document a discharge summary and the patient's response to the course of treatment at discharge;
4. Ensure that the patient's physical therapy record is complete and accurate; and
5. Ensure that services reported for billing, whether billed directly to the patient or through a third party, are accurate and consistent with information in the patient's physical therapy record.

B. On each date of service, a physical therapist shall:

1. Perform and document each therapeutic intervention that requires the expertise of a physical therapist; and

2. Determine, based on a patient's acuity and treatment plan, whether it is appropriate to use assistive personnel to perform a selected treatment intervention or physical therapy task for the patient.

C. A physical therapist shall not supervise more than three assistive personnel at any time. If a physical therapist supervises three assistive personnel, the physical therapist shall ensure that:

1. At least one of the assistive personnel is a physical therapist assistant,

2. No more than two of the assistive personnel are physical therapist assistants performing selected treatment interventions under general supervision, and

3. Assistive personnel other than a physical therapist assistant perform a physical therapy task only under the onsite supervision of a physical therapist.

D. Before delegating performance of a selected treatment intervention to a physical therapist assistant working under general supervision, the supervising physical therapist shall ensure that the physical therapist assistant:

1. Is certified under this Chapter, and

2. Has completed at least 2,000 hours of experience as a physical therapist assistant working with patients under onsite supervision.

E. Before delegating performance of a selected physical therapy intervention or physical therapy task to assistive personnel working under general or onsite supervision, the supervising physical therapist shall ensure that the assistive personnel is qualified by education or training to perform the selected physical therapy intervention or physical therapy task in a safe, effective, and efficient manner.

F. A physical therapist who provides general supervision for a physical therapist assistant shall:

1. Be licensed under this Chapter;

2. Respond to a communication from the physical therapist assistant within 15 minutes;

3. Go to the location at which and on the same day that the physical therapist assistant provides a selected treatment intervention if the physical therapist, after consultation with the physical therapist assistant, determines that going to the location is in the best interest of the patient; and

4. Perform a reevaluation and provide each therapeutic intervention for the patient that is done on the day of the reevaluation every fourth treatment visit or every 30 days, whichever occurs first.

G. A physical therapist assistant who provides a selected treatment intervention under general supervision shall document in the patient record:

1. The name and license number of the supervising physical therapist;

2. The name of the patient to whom the selected treatment intervention is provided;

3. The date on which the selected treatment intervention is provided;

4. The selected treatment intervention provided; and

5. Whether the physical therapist assistant consulted with the supervising physical therapist during the course of the selected treatment intervention and if so, the subject of the consultation and any decision made.

8. The conduct and circumstances described in the above paragraphs constitute a violation of A.A.C. R4-24-304. Adequate Patient Records;

A. A physical therapist shall ensure that a patient record meets the following minimum standards:

1. Each entry in the patient record is:

a. Legible,

b. Accurately dated, and

c. Signed with the name and legal designation of the individual making the entry;

2. If an electronic signature is used to sign an entry, the electronic signature is secure;

3. The patient record contains sufficient information to:

a. Identify the patient on each page of the patient record,

b. Justify the therapeutic intervention,

c. Document results of the therapeutic intervention,

d. Indicate advice or cautionary warnings provided to the patient,

e. Enable another physical therapist to assume the patient's care at any point in the course of therapeutic intervention, and

f. Describe the patient's medical history.

4. If an individual other than a physical therapist or physical therapist assistant makes an entry into the patient record, the supervising physical therapist co-signs the entry;

5. If it is determined that erroneous information is entered into the patient record:

a. The error is corrected in a manner that allows the erroneous information to remain legible, and

b. The individual making the correction dates and initials the correct information; and

6. For each date of service there is an accurate record of the physical therapy services provided and billed.

B. Initial evaluation. As required by A.R.S. § 32-2043(F)(1), a physical therapist shall perform the initial evaluation of a patient. The physical therapist who performs an initial evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's reason for seeking physical therapy services;
2. The patient's medical history;
3. The patient's relevant medical diagnoses or conditions;
4. The patient's signs and symptoms;
5. Objective data from tests or measurements;
6. The physical therapist's interpretation of the results of the examination;
7. Clinical rationale for therapeutic intervention;
8. A plan of care that includes the proposed therapeutic intervention, measurable goals, and frequency and duration of therapeutic intervention; and
9. The patient's prognosis.

C. Therapeutic-intervention notes. Each time a therapeutic intervention is provided to a patient, the individual who provides the therapeutic intervention shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's subjective report;
2. The therapeutic intervention provided or appropriately supervised;
3. The patient's response to the therapeutic intervention;
4. Objective data from tests or measures, if collected;
5. Instructions provided to the patient, if any; and
6. Any change in the plan of care required under subsection (B)(8).

D. Re-evaluation. As required by A.R.S. § 32-2043(F)(2), a physical therapist shall perform a re-evaluation when a patient fails to progress as expected, progresses sufficiently to advance the plan of care, or in accordance with R4-24-202(F)(4). A physical therapist who performs a re-evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's subjective report;
2. The patient's response to the therapeutic intervention;
3. Assessment of the patient's progress;
4. The patient's current functional status;
5. Objective data from tests or measures, if collected;
6. Rationale for continuing therapeutic intervention; and
7. Any change in the plan of care required under subsection (B)(8).

E. Discharge summary. As required by A.R.S. § 32-2043(F)(3), a physical therapist shall document the conclusion of care in a patient's record regardless of the reason that care is concluded.

1. If care is provided in an acute-care hospital, the entry made under subsection (C) on the last date that a therapeutic intervention is provided constitutes documentation of the conclusion of care if the entry is made by a physical therapist.

2. If care is not provided in an acute-care hospital or if a physical therapist does not make the entry under subsection (C) on the last date that a therapeutic intervention is provided, a physical therapist shall make an entry that meets the standards in subsection (A) in the patient record and document:
a. The date on which therapeutic intervention terminated;
b. The reason that therapeutic intervention terminated;
c. Inclusive dates for the episode of care being terminated;
d. The total number of days on which therapeutic intervention was provided during the episode of care;
e. The patient's current functional status;
f. The patient's progress toward achieving the goals in the plan of care required under subsection (B)(7); and
g. The recommended discharge plan.
Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

Dr. Cornwall moved the Board adopt an Order to include one year of probation with possible early termination, continuing education of 8 hours of documentation and billing each, taking and passing the AZLAW examination in six months, and a minimum of one chart audit by Board staff consisting of three records to be completed after the completion of the approved continuing education. Ms. Akers seconded the motion. After review and discussion the motion carried by unanimous vote. Dr. Cornwall conducted a roll call vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

ii) Complaint #10-19; Lacey Hardesty, PT

Dr. Cornwall called the Board's attention to the above agenda item. Ms. Hardesty was present. Dr. Cornwall stated he felt some allegations in the case and possible violations were not noticed and moved the Board pend the hearing to the April 26, 2011 meeting and include possible violations of A.R.S. §32-2042(A), A.R.S. §32-2043(A, F, J), A.A.C. R4-24-303(A)(5), and A.A.C. R4-24-303(4) in addition to the allegations and violations previously noticed. Ms. Akers seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

iii) Complaint #10-24; Jason Ball, PT

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Ball was present. Dr. Cornwall provided a summary of how the hearing would be conducted and the possible outcomes. Mr. Brown provided a summary of the allegations in the case.

Based on the investigation by Board staff and the Board's Initial Review of this complaint it is alleged that Mr. Ball:

1. Failed to create and maintain adequate patient records for patient records of M.R. to include inadequate initial evaluations, daily treatment notes, reevaluations, and discharge.
2. Failed to use the initial "PT" after his name to denote licensure.
3. Engaged in substandard care of patient M.R. to include failing to respond to the patient's complaints following manual therapy intervention on June 18, 2010 and failing to perform a re-evaluation of the patient following a report of adverse reaction to treatment.
4. May have provided false information or altered a patient record after receiving notice of the complaint investigation by the Board.
5. Failed to notify the Board of a change of address within 30 days as required by law.

Mr. Ball provided an opening statement. He stated this was his first job in Arizona and was unaware of the law requiring him to notify the Board of a change in address, but since he has moved twice and notified Board. He stated his initials where the way he had done them since being a student and did not realize he need to include PT after his name and stated he will use PT after his name in the future. He did not alter patient records, but he did create addendums to notes after receiving the complaint and subpoena for records. He wanted to provide clarity to what happened with the patient as he was asked to do so by his supervisors.

Dr. Cornwall opened the matter for questions from the Board. Ms. Akers asked Mr. Ball to describe the procedure that caused the alleged injury. Mr. Ball reviewed his procedure. He stated her pain level reaction to care was not normal so he discontinued treatment and referred her to her physician. Dr. Cornwall asked the purpose of sending the patient back to her physician. Mr. Ball stated it was to see if the physician could identify the cause of the pain reaction. Mr. Ball stated after receiving some additional education he now feels the patient was not a candidate for the treatment provided.

Ms. Richardson asked if Mr. Ball had explained the risks of the treatment and recieved informed consent. Mr. Ball stated he did not explain the risks. Mr. Ball stated he thinks there was confusion on why he referred the patient back to her physician, which is why she elected to continue physical therapy in another clinic. The Board continued questioning Mr. Ball. Mr. Ball provided a closing statement. He feels that there was a misunderstanding with the patient.

Dr. Cornwall closed the questioning phase of the hearing. The Board entered discussion and deliberation. Dr. Cornwall moved the Board adopt the following Findings of Fact:

1. Respondent (Jason Ball) was the treating physical therapist for patient M.R. on June 8, 2010 and Respondent evaluated M.R. on June 8, 2010, but failed to documented symptoms and did not documented the required information of an evaluation. On June 18, 2010 Respondent treated patient M.R. and failed to respond to the patient's complaints following manual therapy intervention. Respondent did not document the patient's compliant.
2. Respondent failed to obtain informed consent from patient M.R. before providing manual therapy treatment.
3. Respondent failed to create adequate patient records to include documentation of evaluations, services provided, and informed consent. Respondent failed to document his referral of patient M.R. to her physician and the reaction of the patient to manual therapy services.

4. Respondent failed to use the initials “PT” following his name in a signature as required by law.

5. Respondent failed to notify the Board of his change of address within thirty (30) days as required by law.

Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

Dr. Cornwall moved the Board adopt the following conclusions of law:

1. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(1) “Violating this chapter, board rules or a written board order”.

2. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(20) “Failing to maintain adequate patient records. For the purposes of this subsection, "adequate patient records" means legible records that comply with board rules and that contain at a minimum an evaluation of objective findings, a diagnosis, the plan of care, the treatment record, a discharge summary and sufficient information to identify the patient.”

3. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2044(23) “Failing to report to the board a name change or a change in business or home address within thirty days after that change.”

4. The conduct and circumstances described in the above paragraphs constitute a violation of A.R.S. §32-2042

A. A physical therapist shall use the letters "PT" in connection with the physical therapist's name or place of business to denote licensure under this chapter.

5. The conduct and circumstances described in the above paragraphs constitute a violation of A.A.C. R4-24-303. Patient Care Management

A. A physical therapist is responsible for the scope of patient management in the practice of physical therapy as defined by A.R.S. § 32-2001. For each patient, the physical therapist shall:

4. Ensure that the patient's physical therapy record is complete and accurate; and

6. The conduct and circumstances described in the above paragraphs constitute a violation of A.A.C. R4-24-304. Adequate Patient Records;

A. A physical therapist shall ensure that a patient record meets the following minimum standards:

1. Each entry in the patient record is:

c. Signed with the name and legal designation of the individual making the entry;

B. Initial evaluation. As required by A.R.S. § 32-2043(F)(1), a physical therapist shall perform the initial evaluation of a patient. The physical therapist who performs an initial evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:

4. The patient's signs and symptoms;

5. Objective data from tests or measurements;

6. The physical therapist's interpretation of the results of the examination;

7. Clinical rationale for therapeutic intervention;

8. A plan of care that includes the proposed therapeutic intervention, measurable goals, and frequency and duration of therapeutic intervention; and

C. Therapeutic-intervention notes. Each time a therapeutic intervention is provided to a patient, the individual who provides the therapeutic intervention shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's subjective report;

2. The therapeutic intervention provided or appropriately supervised;
3. The patient's response to the therapeutic intervention;
4. Objective data from tests or measures, if collected;
5. Instructions provided to the patient, if any; and
6. Any change in the plan of care required under subsection (B)(8).

D. Re-evaluation. As required by A.R.S. § 32-2043(F)(2), a physical therapist shall perform a re-evaluation when a patient fails to progress as expected, progresses sufficiently to advance the plan of care, or in accordance with R4-24-202(F)(4). A physical therapist who performs a re-evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's subjective report;
2. The patient's response to the therapeutic intervention;
3. Assessment of the patient's progress;
4. The patient's current functional status;
5. Objective data from tests or measures, if collected;
6. Rationale for continuing therapeutic intervention; and
7. Any change in the plan of care required under subsection (B)(8).

Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

Dr. Cornwall moved the Board adopt an Order requiring Mr. Ball to be placed on probation for one year, complete 8 hours of continuing education in documentation within six months, take and pass the Board's AZLAW examination within 90 days, and undergo a minimum of one audit of patient records after the completion of the required continuing education. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous roll call vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

iv) Complaint #10-33; James Putman, PT

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Putman was present. Dr. Cornwall provided a summary of how the hearing would be conducted and the possible outcomes. Mr. Brown provided a summary of the allegations in the case.

Based on the investigation by Board staff and the Board's Initial Review of this complaint it is alleged that Mr. Putman:

1. Failed to create and maintain adequate patient records for patient records for J.L. to include inadequate initial evaluations, daily treatment notes, reevaluations, and discharge.

2. Engaged in substandard care of patient J.L. to include failing toensure proper interventions were provided to prevent the buildup of scar tissue and ensure proper range of motion of the patients knee following total knee replacement.
3. May have billed for services not provided or documented on the record on June 23, 2008 and June 24, 2008.
4. Failed to notify the Board of a change of address within 30 days as required by law.

Mr. Putman came forward and provided an opening statement for the Board. He stated the complaint was written 26 months after treatment, the patient did not complain at the time of treatment, he does not understand how the patient came up with the allegations against him, the patient has seen three different rehab facilities since surgery and five physicians. Mr. Putman feels the issue may have been a hardware problem from the knee replacement.

Dr. Cornwall opened the matter to questions from the Board. Ms. Akers questioned Mr. Putman regarding the patient's initial evaluation. Dr. Cornwall asked if the patient received a home exercise program. Mr. Putman stated the patient received the program from the physician after surgery. Mr. Putman reviewed the treatment provided to the patient on the days the patient felt no treatment was provided. Mr. Putman stated the patient was seen on all days documented and the patient progressed before discharge. Dr. Cornwall closed the questioning phase of the hearing.

Mr. Putman did not provide a closing statement. The Board entered discussion and deliberation. Ms. Akers noted that the physician report indicated there was a problem with the hardware. All Board members stated they did not find issue with Mr. Putman's care or documentation. Dr. Cornwall moved the Board dismiss the complaint against Mr. Putman's license and issue a non-disciplinary advisory letter regarding Mr. Putman's failure to change his address within 30 days as required by law. Ms. Akers seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

v) Complaint #10-38; Ann Grab, PT

Dr. Cornwall called the Board's attention to the above matter. Ms. Grab was not present. Mr. Brown verified that Ms. Grab was notified of the hearing. Dr. Cornwall moved the Board offer Ms. Grab the same consent agreement within 20 days to consider the agreement. If Ms. Grab declines the consent agreement the matter is forwarded to a Formal Hearing. Ms. Richardson seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

The Board recessed at 10:53 a.m.
The Board returned to regular session at 11:05 a.m.

c) Initial Review, Discussion and Action on Complaint

i) Complaint # 10-27; Dennis St. James, PT

Dr. Cornwall called the Board's attention to the above agenda item. Mr. St. James was present. Ms. Donahue provided the Board with a summary of the complaint. Board staff received notification of Medical Malpractice Payment Report from the National Practitioner Data Bank in reference to a claim settlement for treatment provided to patient R.F. The patient alleged injury following manual therapy by Mr. St. James.

Mr. St. James came forward and addressed the Board. Dr. Cornwall asked if the Board had questions for Mr. St. James. No questions were asked. Dr. Cornwall moved the Board forward the complaint to an Informal Hearing to include all allegations and possible violations listed in the investigative report. Ms. Akers seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

Ms. Akers asked that the staff to add possible violations of A.R.S. §32-2044(20) and A.A.C. R4-24-304.

ii) Complaint # 10-65; Cynthia Guth, PT

Dr. Cornwall called the Board's attention to the above agenda item. Ms. Guth was not present. Ms. Donahue provided the Board with a summary of the allegations. Ms. Guth failed to respond to her Notification of Audit by November 20, 2010. A complaint was opened December 14, 2010 in regards to her failure to respond. Ms. Guth's response was received by Board staff after the response deadline of January 13, 2011. Included in her response were the items required for review for audit. Ms. Guth was not found in compliance with the 2008-2010 Continuing Competence requirements with a deficiency of 4 hours in Category A.

Dr. Cornwall moved the Board offer Ms. Guth a consent agreement for six (6) months of probation, taking and passing the AZLAW examination and paying a $250.00 civil penalty. Ms. Guth will have 20 days to sign the consent agreement or the case if forwarded to an Informal Hearing. In addition, possible violations of A.R.S. 32-2044(1, 3) and A.A.C. R4-24-401 are to be added to the case. Ms. Richardson seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

iii) Complaint # 10-69; Kimberly Jacob, PT

Dr. Cornwall called the Board's attention to the above agenda item. Ms. Jacob was not present. Ms. Donahue provided a summary of the complaint to the Board. Ms. Jacob was audited for compliance with continuing competency for the 2008-2010 compliance period. After review of the submitted materials, Ms. Jacob was found 8 hours deficient because a lack of validation of courses. A complaint was opened following the noted deficiency. Ms. Jacob subsequently provided compliant documentation.

Dr. Cornwall moved the Board dismiss the complaint and issue Ms. Jacob a non-disciplinary advisory letter advising her to be aware of the continuing competency hours per compliance period to ensure proper amount when renewing her license. Ms. Richardson seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

iv) Complaint # 11-05; Mark Aune, PT

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Aune was present. Ms. Donahue provided a summary of the complaint for the Board. Mr. Aune was noticed of a Continuing Competence Audit and timely responded. However, he provided documentation of a course outside the compliance period. Following notification of the complaint, Mr. Aune provided documentation of his continuing competence that showed compliance with the requirements. Mr. Aune addressed the Board regarding his lack of continuing competence at renewal. Dr. Cornwall moved the Board dismiss the complaint and issue Mr. Aune a non-disciplinary advisory letter advising him to be aware of the continuing competency hours per compliance period to ensure proper amount when renewing his license. Mr. Robbins seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

v) Complaint # 11-10; Craig Steele

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Steele was not present. Ms. Donahue provided a summary of the complaint for the Board. The personal trainers at Snap Fitness were utilizing the credentials of "PT" following their name in advertisements. Ms. Donahue reported the advertising was demonstrated as corrected to not say "PT" following the personal trainers' names. Dr. Cornwall moved the Board dismiss the complaint. Ms. Richardson seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

4) Review, Consideration and Action on Applications for Licensure and Certification

c) Substantive Review of Documentation Related to Disclosure on "Personal Information" Section of Application

i) Physical Therapist Application and Approval to take the AZLAW (Jurisprudence) Exam and Possible Licensure

(a) Mirarchi, Eric

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Mirarchi was not present. Dr. Cornwall noted that the applicant was previously before the Board but the application was pended to clarify information from Indiana regarding denial of licensure there and his failure to notify the Board in Arizona of the denial. The Board entered discussion regarding Mr. Mirarchi's denial of licensure in Indiana and his failure to report it on his Arizona application. Dr. Cornwall moved the Board deny Mr. Mirarchi's application based on A.R.S. §32-2023(B)(1 and 5). Mr. Richardson seconded the motion. After review and discussion the motion failed with four nay votes and one aye vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X					
Nay		X	X	X		X
Recused						
Abstained						
Absent					X	

Ms. Akers moved the Board approve Mr. Mirarchi to take the AZLAW examination and receive licensure upon receipt of a passing score. After review and discussion, the motion carried with four aye votes and one nay vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye		X	X	X		X
Nay	X					
Recused						
Abstained						
Absent					X	

(b) Hanna, Sarah

Dr. Cornwall called the Board's attention to the above agenda item. Dr. Cornwall reviewed the personal disclosure by Ms. Hanna regarding a previous conviction of a misdemeanor. Dr. Cornwall moved the Board allow Ms. Hanna to take the AZLAW examination and receive licensure upon receipt of a passing score. Ms. Hunter seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

ii) Physical Therapist Assistant Application and Approval to take NPTE and the AZLAW (Jurisprudence) Exam and Possible Certification

(a) Lawson, John

Dr. Cornwall called the Board's attention to the above agenda item. Mr. Lawson was present. Dr. Cornwall reviewed Mr. Lawson's reported convictions. Hearing no questions from the Board, Dr. Cornwall moved the Board allow Mr. Lawson to take the NPTE-PTA and AZLAW examinations and be certified upon receipt of passing scores. Ms. Richardson seconded the motion. The motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

d) Review of and Possible Action on Application for Certification and Determination of the AZLAW exam.

(a) Sandoval, Judy

Dr. Cornwall called the Board's attention to the above agenda item. Ms. Brierley reported that Ms. Sandoval has passed the NPTE-PTA and is eligible for certification; however, the passing score for the AZLAW was from 2008. The Board must decide if a new AZLAW examination score is required. The Board discussed the exam and limited change in laws since the exam. Ms. Akers moved the Board certify Ms. Sandoval and have staff suuggest she review the law regarding supervision. Ms. Richardson seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Mr. Sieveke	Ms. Richardson
Aye	X	X	X	X		X
Nay						
Recused						
Abstained						
Absent					X	

The Board recessed at 12:02 p.m.
The Board reentered regular session at 12:19 p.m.

5) BOARD BUSINESS AND REPORTS

a) Executive Director's Report – Discussion and Possible Action

i) Financial Report- Mr. Brown reported the Board's current expenditures and revenue. The Board discussed the pending budget proposal with the legislature for FY 2012. No action was required or taken on this agenda item.

ii) Board Staff Activities- Mr. Brown reviewed the written report. Mr. Brown reported that the transition of data for complaints from 2008 forward has been completed and entered into the database and that staff would now be transferring all data from past disciplinary actions into the database. A copy of the report is available to the public. No action was taken or required on this agenda item.

iii) Legislation- Mr. Brown reviewed the written report and the latest report from the Board's legislative liaison. Mr. Brown noted HB 2194 to establish retired and inactive status for physical therapists and physical therapist assistants was pending a third reading of the bill at the Senate. A copy of the report is available to the public. No action was required or taken on this agenda item.

iv) Rule Activity- Mr. Brown reported that there has been no acknowledgment or response to either of the Board's requests for exception to the rule making moratorium the Board sent to the Governor's Office. No action was required or taken on this agenda item.

v) FSBPT- Mr. Brown provided a summary of the written report to the Board. Mr. Brown reviewed the identified problem associated with changing to fixed date testing of the NPTE after June 30, 2011. Mr. Brown suggested the Board discuss adding additional meeting dates in 2011 to help accommodate applicants for licensure. The Board entered discussion. The Board, through consensus, established the following additional Board meetings for 2011 to be conducted by teleconference:

June 7, 2011 at 8:00 a.m.
August 2, 2011 at 8:00 a.m.
November 8, 2011 at 8:00 a.m.

Dr. Cornwall requested staff to invite representatives from the AzPTA to attend the May 24, 2011 Board meeting and discuss the change to fixed date testing and the possible need to establish a restricted license to lesson delays of graduates entering the workforce.

6) CALL TO THE PUBLIC

Dr. Cornwall asked if any member of the public wished to come forward and address the Board. No person came forward to address the Board.

ADJOURNMENT

The meeting adjourned at approximately 1:16 p.m.

Prepared by,

Charles D. Brown
Executive Director

Approved by,

Randy Robbins
Secretary