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

MEMBERS PRESENT:
Mark Cornwall, PT, Ph.D.; President
Lisa Akers, PT, MS; Vice President
Randy Robbins, Secretary
Melinda Richardson, PT, MA; Member
Peggy Hunter, PTA, CLS; Member
James E. Miller, PT, DPT; Member
Michael S. Clinton, CPA; Public Member

MEMBERS ABSENT:
None

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

CALL TO ORDER – 8:36 a.m.

Dr. Cornwall called the meeting to order at 8:36 a.m. (A recording of the meeting is available through the Board Office)

1) **Review and Approval of Draft Minutes**
a) October 25, 2011; Regular Session Meeting Minutes

Dr. Cornwall moved the Board approve the minutes as amended. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

b) October 25, 2011; Executive Session Meeting Minutes

Dr. Cornwall moved the Board approve the minutes as amended. Ms. Richardson seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Dr. Miller	Ms. Richardson	Mr. Clinton

Aye	X	X	X	X	X	X	X
Nay							
Recused							
Abstained							
Absent							

c) November 8, 2011; Regular Session (Teleconference) Meeting Minutes

Dr. Cornwall moved the Board approve the minutes as amended. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

2) COMPLAINTS, HEARINGS, INVESTIGATIONS and COMPLIANCE

c) Initial Review, Discussion and Action on Complaint

i. Complaint #11-15; Jennifer Harmon, PTA

Ms. Harmon was not present and was not represented by legal counsel. Ms. Donahue provided a summary of the complaint allegations against Ms. Harmon related to her employment at Achievement Therapy Services. It is alleged Ms. Harmon may have engaged in substandard care or worked outside her delegated authority, failed to report to the Board direct knowledge of unprofessional conduct by her coworkers, failed to create and maintain adequate patient records, and failed to document her consultations with supervising physical therapists while providing treatment to patients under general supervision.

The Board discussed the allegation and the investigative material presented. Ms. Hunter moved the Board forward the complaint to an Informal Hearing. Ms. Akers seconded the motion. After review and discussion the motion carried.

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

Dr. Cornwall instructed staff to subpoena patient records from Ms. Harmon's employer and conduct a records review prior to the Informal Hearing.

ii. Complaint #11-17; Clay Robertson, PTA

Mr. Robertson was not present and was not represented by legal counsel. Ms. Donahue provided a summary of the complaint allegations for the Board. The allegations relate to Mr. Robertson's employment at Achievement Therapy Services. It is alleged Mr. Robertson may have engaged in substandard care or worked outside his delegated authority, failed to report to the Board direct knowledge of unprofessional conduct by his coworkers, failed to create and maintain adequate patient records, and failed to document his consultations with supervising physical therapists while providing treatment to patients under general supervision.

The Board discussed the allegation and the investigative material presented. Ms. Akers moved the Board forward the complaint to an Informal Hearing. Ms. Hunter seconded the motion. After review and discussion the motion carried.

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

Dr. Cornwall instructed staff to subpoena patient records from Mr. Robertson's employer and conduct a records review prior to the Informal Hearing.

iii. Complaint #11-47; Michael Cormier, D.C.

Dr. Cormier was not present and was not represented by legal counsel. Ms. Donahue provided a summary of the complaint allegations to the Board. The complaint was initiated by the Board after receipt of information that Dr. Cormier advertised physical therapy services on his website, but did not employ a physical therapist. Ms. Donahue stated Dr. Cormier is attempting to remove the advertising from his website, but is waiting on the developer.

The Board discussed the legal options of resolving the complaint considering Dr. Cormier is not a licensed physical therapist but a licensed chiropractic physician. Dr. Cornwall moved the Board send Dr. Cormier a letter to make changes to his website and cease advertising physical therapy services and for the complaint to be held open for 90 days to allow the changes to be made and have the complaint again presented to the Board. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

iv. Complaint #11-48; Gerald Mitchell, PT

Mr. Mitchell was not present and was not represented by legal counsel. Ms. Donahue provided the Board with a summary of the allegations to include that Mr. Mitchell failed to comply with a Board order when he failed to provide documentation of completing continuing educations courses within the time allowed under the order. Ms. Donahue reported that the investigation found Mr. Mitchell had completed the course, but that the documentation was not sent in by Mr. Mitchell or the instructor. The Board now has all required documentation.

The Board discussed the complaint investigation. Dr. Cornwall moved the Board dismiss the complaint and terminated the probation status of Mr. Mitchell's license. Ms. Akers seconded the motion. After review and discussion the motion carried by unanimous vote.

Vote	Dr. Cornwall	Ms. Akers	Ms. Hunter	Mr. Robbins	Dr. Miller	Ms. Richardson	Mr. Clinton
Aye	X	X	X	X	X	X	X
Nay							
Recused							

Abstained							
Absent							

v. Complaint #11-49; Thomas Webb, PT

Mr. Webb was not present and was not represented by legal counsel. Ms. Donahue reviewed the complaint allegation of improper or fraudulent billing for the Board. The Board discussed the investigation material. Dr. Miller noted that while the total amount billed may not have been greater than the amount owed for services, there was inaccurate billing and Mr. Webb failed to address the patient's concerns when brought to his attention. After further discussion Ms. Akers moved the Board dismiss the complaint against Mr. Webb and issue him a non-disciplinary advisory letter advising him to make every effort to communicate with patients regarding billing issues and strongly recommends that he review A.A.C. R4-24-303(A)(5) which requires the physical therapist to ensure that billing to each patient is correct and accurately reflected in the patient record. Dr. Miller seconded the motion. After review and discussion the motion carried by unanimous vote.

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

d) Review, Discussion and Action on Consideration of Opening A Complaint

i. Wendy Weisflog, D.C.

Dr. Weisflog was not present and was not represented by legal counsel. Ms. Donahue reported the Board had received information that Ms. Weisflog is advertising physical therapy services on her company website and does not employ a licensed physical therapist. Ms. Donahue also reported that Dr. Weisflog was previously disciplined by the Board of Chiropractic Examiners for similar advertising violations.

The Board discussed the presented information. Dr. Cornwall moved the Board not open a complaint, but send a letter to Dr. Weisflog to request she remove the physical therapy services advertising on her website and have the Board staff forward the information to the Board of Chiropractic Examiners to consider a complaint. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

ii. Allen Grover, PT and Steve Kaye, PT

Mr. Grover and Mr. Kaye were not present and were not represented by legal counsel. Ms. Donahue reported the Board had received information regarding Mr. Grover and Mr. Kaye that did not contain allegations within the Board's jurisdiction or summarized matters not in violation of the Physical Therapy Practice Act. The Board discussed the presented information and determined to take no action on opening a complaint.

a) Formal Hearing and Possible Action

i. Complaint #10-56; Mark Barnes

Mr. Barnes was not present and was not represented by legal counsel. Keely Verstegen, Assistant Attorney General was present on behalf of the State of Arizona. Mr. Brown reported that Mr. Barnes was previously offered a consent agreement to resolve this case and surrender his license to practice physical therapy in Arizona. Mr. Barnes denied the offer and the matter proceeded to the Formal hearing; however, Mr. Barnes contacted Board staff and has now accepted the offered consent agreement and provided a signed copy. The Board discussed the proposed consent agreement. Dr. Cornwall moved the Board accept the consent agreement and the surrender of Mr. Barnes license to practice physical therapy in the State of Arizona and vacate the Formal hearing. Dr. Miller seconded the motion. Following review and discussion the motion carried by unanimous vote.

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

ii. Request for Rehearing; Complaint #11-33; Brian Courcy, PT

Mr. Courcy was not present and was not represented by legal counsel. Keely Verstegen, Assistant Attorney General was present on behalf of the State of Arizona. Mr. Brown reported that Mr. Courcy's case was resolved through a Formal hearing on October 25, 2011. He was not present or represented at the meeting. The Board voted to revoke Mr. Courcy's license to practice physical therapy in Arizona. Mr. Courcy has now made contact with the Board and provided copies of 18 hours of continuing competence activity that he had failed to provide as part of the case before the Board. Mr. Courcy is requesting the Board grant a rehearing and claims that he did not receive the Complaint Notice of Hearing. The Board heard from Ms. Verstegen and reviewed the Board's records regarding Mr. Courcy's receipt of notice for the Formal Hearing. Dr. Cornwall asked Mr. Brown why Mr. Courcy was not present. Mr. Brown reported he spoke to Mr. Courcy and he is aware of the Board's consideration of his request, but cannot explain why he is not present since he is working in Arizona. The Board noted that the address on the Complaint Notice of hearing was not the same city as the city of record with the Board, but had documentation that delivery was attempted to the address of record with the Board.

The Board discussed the request for rehearing. Dr. Cornwall moved the Board deny Mr. Courcy's request for rehearing. Mr. Clinton seconded the motion. After review and discussion the motion carried.

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

b) Informal Hearing and Possible Action on Complaint:

i. Complaint #10-70; Angela Kennedy, PT

This matter was tabled for later in the meeting.

ii. Complaint #11-06; Morgan Brown, PT

Mr. Morgan Brown was present and was represented by legal counsel Kelly McDonald. Dr. Cornwall disclosed that Mr. Morgan Brown was a former student of his, but that he can participate in the hearing without bias. The Board members and staff introduced themselves. Dr. Cornwall provided a summary of how the hearing would be conducted and the possible outcomes. Mr. Charles Brown read the allegations.

The complaint alleges that he:

1. Was the treating physical therapist for patient BJS on or about January 13, 2011.
2. Engaged in sexual misconduct by coming into contact with patient BJS's faminine area (vagina) during treatment on January 13, 2011.
3. Engaged in sexual misconduct by massaging patient BJS's gluteal region and inner thigh without following standard procedures for properly explaining treatment and gowning or covering the patient.
4. Failed to follow the recognized standards of ethics in engaging in sexual contact with patient BJS and by making professional judgments not in the best interest of the patient.
5. Engaged in substandard care by:
    a. Patient BJS's records/documentation does not indicate that he performed any evaluation or treatment to the anterior pelvic region or to the hip region. The only indication in the record is "possible iliopsoas involvement" hand written in the assessment portion of the document titled initial evaluation.
    b. Patient BJS's records/documentation does not indicate that he performed any length or strength testing to the iliopsoas to determine involvement with the exception of palpation prior to initiating treatment with STM to this region.
    c. Failing to perform neurological testing on patient BJS.
    d. Providing testimony involving patient BJS's strength testing of hip flexion: "Strength was not an issue. I strength tested her by having her do a straight leg raise in supine with resistance. That is how I assess hip flexion strength", which may be inconsistent with current standards for strength testing. He documented that all muscles tested grossly 5/5 in the hip and LE's.
    e. Documenting that he performed PA joint mobilizations to the lumbar region (see exercise flow sheet), however her documentation does not indicate that an evaluation of joint mobility of the lumbar spine was performed, with the exception of ROM.
    f. Providing testimony that he did not find any symptoms with palpation to the paraspinals. However, he initiated STM to these tissues to decrease "tightness". He has been unable to explain in a phone interview how muscle tightness throughout his treatment was determined.
    g. His understanding of pelvic congestion was stated as: "Pelvic congestion is tightness and tissue irritation of the pelvic region. The whole general area of soft tissue. Palpating the abdominals for tenderness. Tenderness would have indicated tightness of the abdominals and the whole general area including the iliopsoas and pelvic wall and lower pelvic area". He may not have knowledge that pelvic congestion is a condition associated with varicose veins in the lower abdomen and groin region. The rational for treatment of pelvic congestion may not be supported in the documentation.
    h. He did not indicate his rational for treatment in relation to the diagnosis in his documentation.
6. Failed to create and maintain adequate patient records by:
    a. Not documenting rationale regarding his choice of therapeutic interventions.
    b. Not documenting his interpretation of the results of his examination of patient BJS.
    c. Not documenting a discharge summary for patient BJS.
7. Failed to use the initials "PT" following his signature on her typed evaluation of patient BJS.

Mr. McDonald addressed the Board and provided exhibits for review. Mr. McDonald provided an opening statement to the Board and presented his exhibits. Mr. Morgan Brown made himself available for questions. The Board questioned Mr. Brown regarding the alleged violations and allegations made against his license. The Board concluded their questions of Mr.Morgan Brown

The Board recessed at 10:37 a.m.
The Board reentered Regular Session at 10:51 a.m.

The complainant BJS came forward and addressed the Board. She explained her treatment encounter with Mr. Brown and answered questions from the Board. Mr. Morgan Brown and Mr. McDonald addressed the Board and provided a closing statement.

The Board entered deliberations regarding the case. The Board discussed the evidence detailing issues with record keeping and treatment and noted a lack of evidence supporting allegations of sexual misconduct. Following deliberations Dr. Cornwall moved the Board adopt the following Findings of Fact;

1. Respondent was the treating physical therapist for patient BJS on or about January 13, 2011.
2. Respondent's documentation does not indicate that he performed any evaluation or treatment to the anterior pelvic region or to the hip region. The only indication in the record is "possible iliopsoas involvement" hand written in the assessment portion of the document titled initial evaluation.
3. Respondent's documentation does not indicate that he performed any length or strength testing to the iliopsoas to determine involvement with the exception of palpation prior to initiating treatment with STM to this region.
4. Respondent's documentation does not indicate that he performed neurological testing.
5. Respondent's testimony regarding strength testing of hip flexion: "Strength was not an issue. I strength tested her by having her do a straight leg raise in supine with resistance. That is how I assess hip flexion strength" may be inconsistent with current standards for strength testing. Respondent documents that all muscles tested grossly 5/5 in the hip and LE's.
6. Respondent's documentation indicates that he performed PA joint mobilizations to the lumbar region (see exercise flow sheet); however his documentation does not indicate that an evaluation of joint mobility of the lumbar spine was performed, with the exception of ROM.
7. Respondent's testimony states that he did not find any symptoms with palpation to the paraspinals. However, Respondent initiates STM to these tissues to decrease "tightness". Respondent is unable to explain in his phone interview how muscle tightness throughout his treatment is determined.
8. Respondent understanding of pelvic congestion was stated: "Pelvic congestion is tightness and tissue irritation of the pelvic region. The whole general area of soft tissue. Palpating the abdominals for tenderness. Tenderness would have indicated tightness of the abdominals and the whole general area including the iliopsoas and pelvic wall and lower pelvic area". Respondent may not have knowledge that pelvic congestion is a condition associated with varicose veins in the lower abdomen and groin region. The rational for treatment of pelvic congestion is not supported in the documentation.
9. Respondent does not indicate his rational for treatment in relation to the diagnosis in his documentation.
10. Respondent does not document the rationale regarding his choice of therapeutic interventions.
11. Respondent does not document his interpretation of the results of the examination.
12. Respondent's discharge summary is not documented.

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

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

Dr. Cornwall moved the Board adopt the following Conclusions of Law:

1. The conduct and circumstances explained in the Findings of Fact above 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 explained in the Findings of Fact above constitute a violation of A.R.S. §32-2044(4) (Engaging in the performance of substandard care by a physical therapist due to a deliberate or negligent act or failure to act regardless of whether actual injury to the patient is established).
3. The conduct and circumstances explained in the Findings of Fact above constitute a violation of A.R.S. §32-2044(20) (Failing to maintain adequate patient records. For the purpose of this paragraph, "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).
4. The conduct and circumstances explained in the Findings of Fact above constitute a violation of A.A.C. R4-24-304 "A physical therapist shall ensure that a patient record meets the following minimum standards and document: (A)(3)(b) "Justify the therapeutic intervention" (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: (6) "The physical therapist's interpretation of the results of the examination." (E) "A physical therapist shall document the conclusion of care in a patient's record regardless of the reason that care is concluded."

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

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

Dr. Cornwall moved the Board adopt the following Order:

Probation: The Arizona Board of Physical Therapy hereby orders that Respondent, holder of License No. 8515, be placed on probation for a period twelve (12) months to commence upon execution of this Order. The probation may be extended or other enforcement actions taken, after notice and an opportunity for a hearing, in the event Respondent violates this Order or violates the Arizona Physical Therapy Practice Act. Respondent may petition the Board for early termination of probation following completion of all terms of probation. Early termination is at the sole discretion of the Board. The Board orders Respondent to comply with the following terms and conditions of probation:

Continuing Education: Respondent shall complete continuing education courses as prescribed below within the period of probation and must be registered to complete the required education with 90 days of the effective date of this order. Any continuing education approved and credited for use in complying with the conditions of the order are in addition to the continuing competence activities required for renewal of an Arizona physical therapist license

i. Documentation-- Respondent shall complete a minimum of six (6) hours of continuing education in documentation. The course(s) must be preapproved by Board staff and Respondent must provide documentation of completing the course to Board staff upon completion.
ii. Examination correlation- Respondent shall complete a minimum of twenty four (24) hours of continuing education in examination and treatment correlation to include clinical reasoning , assessment, evaluation progression, and treatment related to the spine. The course(s) must be preapproved by Board staff and Respondent must provide documentation of completing the course to Board staff upon completion.

Patient Records Audit**:** Respondent shall undergo audit(s) of his patient records according to the following terms during the period of probation.

a. Respondent shall undergo a minimum of one audit of 3 randomly selected patient records. The patient records must include at least one lumbar spine patient and one other spine patient.

b. The audit of patient records shall be performed by Board staff.

c. The first audit shall begin not less than 30 days following Respondent's completion of all required continuing education in the Order.

d. If Board staff finds deficiencies in the first audit of patient records, Respondent shall undergo one additional audit within three months of the first audit. If a second audit is performed, it will include 3 randomly selected patient records. The patient records must include at least one lumbar spine patient and one other spine patient.

Dr. Miller seconded the motion. After review and discussion the motion carried by unanimous vote.

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

i. Complaint #10-70; Angela Kennedy, PT

Ms. Kennedy was not present and was not represented by legal counsel. Mr. Brown reported Ms. Kennedy has not accepted her invitation to the Informal Hearing. Therefore, the Board cannot conduct the hearing. Dr. Cornwall moved the Board forward the complaint to a Formal Hearing. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

ii. Complaint #11-38; Scott Richardson, PT

Mr. Richardson was present and represented by his legal counsel Terrance P. Woods. The Board members and staff introduced themselves. Dr. Cornwall provided a summary of how the hearing would be conducted and the possible outcomes. Mr. Brown read the allegations.

The complaint alleges that he:

1. Was the treating physical therapist for patient T.S. from March 8, 2011 through March 11, 2011.
2. Engaged in substandard care by:
    a. Not documenting any evaluation or examination of the bilateral lower legs in either the initial evaluation or the follow-up visit with the exception of palpation of the plantar fascia. Does not document the following:
        1. Abdominal strength may be an important consideration in determination of dynamic pelvic instability.
        2. Any strength measurement of the foot or ankle
        3. Any ROM measurements of the foot or ankle

b. Documenting: Patient T.S. has apparent leg length discrepancy with left pelvis posterior inominate. However you also document that the pelvis is level in your examination. The two findings may conflict.
c. Documenting: No gait deviations, normal foot posture. If gait and foot posture are normal, then his argument for hip causing malalignment of the foot may be inconsistent with his findings.
d. Documenting performance of a cranial nerve scan in his initial evaluation. It is undetermined why this test was performed on a patient with bilateral foot pain.
e. Failing to document a clinical rationale for any of the treatment provided to T.S.
f. Failing to document that treatment was provided at the initial evaluation.
g. Engaging in treatment to the talocural joint without documentation of an evaluation of the joint's mobility.
h. Engaging in treatment to the hamstrings and hip joint without documentation of an evaluation of the hamstring length or the hip joints mobility.
i. Developing STG and LTG goals that lack any specific baseline measurement as documented in the initial evaluation.
j. Failing to take or document pain measurements throughout treatment.
k. The patient record not indicating any specific functional limitations.

3. Charged unreasonable or improper fees in that:
   a. The initial evaluation does not document that any treatment was provided to patient T.S. for the 3/8/11 visit. As a result, the charges for 1 unit of 97110, 2 units of 97140 and one unit of 97035 would be not appropriate resulting in over-charging of services not rendered.
   b. Patient T.S. contends that ultrasound was never performed during her two visits.
      i. US was documented as being performed to the SI joint on 3/11/11, however was not billed.
      ii. US was not documented as being performed, however was billed for dates of service on 3/8/11.
   c. Patient T.S. and the documentation indicate that T.S. received Electrical Stimulation to her bilateral feet on 3/11/11; however, this modality was not billed.
   d. The documentation does not indicate specific techniques, duration, and intensity for manual therapy interventions. The billing of 2 units on 3/11/11 may be inappropriate.
   e. Given the analysis of the written patient record the following charges were not supported in the documentation:
      i. 1 unit of 97110 on 3/8/11
      ii. 1 unit of 97035 on 3/8/11
      iii. 2 units of manual therapy on 3/8/11 and potentially on 3/11/11
   f. If the above units were not supported in the documentation, then the insurance company may have been overbilled a total of $202.00 resulting in overcharging of patient's coinsurance out of pocket costs: $75.39.
   g. The patient's record is not accurately represented in the billing record.
4. Failing to create and maintain adequate patient records in that;
   a. The date of the initial evaluation is not indicated in the documentation.
   b. A past medical history is not documented in the patient record.
   c. Medical DX on initial evaluation indicates: 845.10 Foot sprain/strain
   d. Patients signs or symptoms are not documented with the exception of the following statements:
      i. Onset of foot pain in August of last year with significant time on feet which causes pain to worsen
      ii. Patient rates current % of function as 50%. (There is no further description of the patient's functional status.)
   e. Objective data from tests or measurements:
      1. Tests perform indicate:

a) No radicular symptoms in bilateral LE. (Not documented whether tested or the patient's subjective report.)

2. Does not document the following:
   a) Abdominal strength
   b) Any strength measurement of the foot or ankle
   c) Any ROM measurements of the foot or ankle
3. It is uncertain why he performed a cranial nerve scan for this diagnosis.

f. Physical Therapists interpretation of the results of the examination:
   i. "Patient with decreased pelvic stability and chronic foot pain with pelvic malignment with resolves with muscle energy techniques."

g. Clinical rational for the therapeutic intervention:
   i. The initial evaluation does not document that treatment was performed at this visit with the exception of the notation "pelvic malignment resolves with muscle energy techniques".
   ii. There is no clinical rational for treatment documented.

h. Plan of care:
   i. Proposed therapeutic interventions are documented as modalities and manual techniques for foot pain with exercise program for pelvic stability.
   ii. Goals documented are not measureable:
      1. STG:
      a) Increase mobility by 50%. (A baseline was not established for mobility in the initial evaluation. The initial evaluation indicated, "Current % of function is 50%". Qualifying or descriptive documentation that delineates what function is impaired is not documented. The patient does document in the initial paperwork her limitations. It is documented that there are no gait deviations.)
      b) Pain reduction by 50% in 2 weeks. (Pain measurements of subjective functional status forms were not documented in the initial evaluation. Thus, baseline measurements are not available.)
      c) Increase strength by 25%. (Which specific muscles are to increase strength are not documented. It is difficult to determine a 25% increase [which potentially could be less than ¼ grade] in strength when the minimum strength measurement was listed as (4-/5) for bilateral hip abduction.)
      2. LTG:
      a) 100% improvement in ADL function and/or pain. (The initial evaluation does not document any deficits with ADL function nor quantitatively documents pain.)
      b) Increase strength to 5/5. (Which specific muscles to increase strength to normal are not indicated.)
   iii. The evaluation is not signed or dated.
   iv. Treatment is not documented in the initial evaluation.
   v. Ultrasound is not documented in the initial evaluation.

5. <u>The exercise flow sheet:</u>
   a. The patient name is not identified
   b. Who provided the treatment is not identified
   c. Exercise log only documents exercises being performed on 3/11.
6. <u>Objective:</u>
   d. US is documented as being performed at the SI joint. "US to left SI joint F/B manual techniques for pelvic alignment."
      i. Rationale for performance of US to the SI joint is not documented.
   e. Manual stretching for Gastrocsoleus and plantar fascia (15 minutes)

i. Specific documentation regarding which stretching was performed and to which areas are not documented. (patient denies that she did not receive a foot massage this time)
ii. The Gastrocsoleus and plantar fascia length was not evaluated in the initial evaluation or assessed in the follow-up visit.

f. The documentation indicates "talocalcaneal mobilization to bilateral feet"
i. There is no rationale for the performance of this mobilization
ii. There is no documentation that the talocalcaneal joint was evaluated or that this joint lacked mobility.

g. Myofascial release and soft tissue mobilization: performed to bilateral gluteal and piriformis groups.
i. There is no documentation to indicate specific techniques performed

h. Therapeutic Exercises:
i. Hamstring/hip joint stretch:
1. The hamstring length or hip joint mobility was not documented as being evaluated in the initial examination or at this follow-up visit.
2. The type, frequency or duration of the stretching is not documented.
ii. 5 exercises are documented on an exercise log:
1. Side plank X 10
2. Ball bridge leg lift X 15
3. Ham ball roll-ins X 15
4. Supine on back rollouts- leg lift X 15
5. Prone on ball hip extension X 15

i. Electrical Stimulation to bilateral feet is noted in the objective comments, however, parameters and duration of treatment is not documented.

7. <u>Assessment:</u>
j. The DX was changed from that documented in the initial evaluation to:
i. "Chronic pelvic dynamic instability and bilateral piriformis syndrome with pelvic malignment."
ii. Documentation in the POC to indicate a change in DX is not indicated
iii. The DX does not indicate a diagnosis related to the feet, however the Medical DX listed for this treatment note is "845.10 Foot sprain/strain."

k. Patient's response to treatment:
i. with the exception of "malignment again which resolved"
ii. Under the heading Patient's response to Physical Therapy: "good"

l. Rationale for continuation of therapeutic interventions is not documented.

8. <u>Discharge Summary:</u> Discharge summary was documented on 4-11-11.
a. The date on which therapeutic intervention terminated is not documented.
b. The reason that the therapeutic intervention terminated is not documented.
c. Inclusive dates for the episode of care are not documented.
d. Patient's current functional status is documented as "% of function as 50%".
e. Patient's progress toward achieving the goals in the plan of care is documented as "no significant changes".
f. Patient's plan following discharge is not documented.

9. His documented communication with Dr. Shoffer following the initial evaluation may not have met the minimal standard of A.A.C. R4-24-301.

Mr. Woods provided an opening statement and described the matter as primarily a record keeping matter. Mr. Woods noted that the billing has been reviewed and a refund was issued to the patient. Mr. Woods also provided the Board with a copy of a daily note that was missing from the records provided to the Board.

Mr. Woods ended his statement and the Board questioned Mr. Richardson regarding the complaint allegations. After the Board concluded the questioning of Mr. Richardson, Mr. Woods provided a closing statement to the Board.

The Board entered deliberations on the case. After discussion on the matter Dr. Miller moved the Board dismiss the complaint and issue Mr. Richardson a non-disciplinary advisory letter to complete six hours of continuing education in the area of documentation within six months. Ms. Richardson seconded the motion. After review and discussion the motion failed.

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

Dr. Cornwall moved the Board adopt the following Findings of Fact:

1. Respondent is the holder of License No. 2353 to practice as a physical therapist in the State of Arizona and was the treating physical therapist for patient T.S. from March 8, 2011 through March 11, 2011.

2. Engaged in substandard care by:

b. Not documenting any evaluation or examination of the bilateral lower legs in either the initial evaluation or the follow-up visit with the exception of palpation of the plantar fascia. Does not document the following:

1. Abdominal strength may be an important consideration in determination of dynamic pelvic instability.
2. Any strength measurement of the foot or ankle
3. Any ROM measurements of the foot or ankle

l. Documenting: Patient T.S. has apparent leg length discrepancy with left pelvis posterior innominate. However Respondent also document that the pelvis is level in Respondent's examination. The two findings may conflict.

m. Documenting: No gait deviations, normal foot posture. If gait and foot posture are normal, then Respondent's argument for hip causing malalignment of the foot may be inconsistent with his findings.

n. Documenting performance of a cranial nerve scan in Respondent's initial evaluation. It is undetermined why this test was performed on a patient with bilateral foot pain.

o. Failing to document a clinical rationale for any of the treatment provided to T.S.

p. Failing to document that treatment was provided at the initial evaluation.

q. Engaging in treatment to the talocural joint without documentation of an evaluation of the joint's mobility.

r. Engaging in treatment to the hamstrings and hip joint without documentation of an evaluation of the hamstring length or the hip joints mobility.

s. Developing STG and LTG goals that lack any specific baseline measurement as documented in the initial evaluation.

t. Failing to take or document pain measurements throughout treatment.

u. The patient record not indicating any specific functional limitations.

3. Failing to create and maintain adequate patient records in that;

i. The date of the initial evaluation is not indicated in the documentation.

j. A past medical history is not documented in the patient record.

k. Medical DX on initial evaluation indicates: 845.10 Foot sprain/strain

l. Patients signs or symptoms are not documented with the exception of the following statements:

i. Onset of foot pain in August of last year with significant time on feet which causes pain to worsen

ii. Patient rates current % of function as 50%. (There is no further description of the patient's functional status.)

m. Objective data from tests or measurements:

1. Tests perform indicate:

a) No radicular symptoms in bilateral LE. (Not documented whether tested or the patient's subjective report.)

2. Does not document the following:

a) Abdominal strength

b) Any strength measurement of the foot or ankle

c) Any ROM measurements of the foot or ankle

4. It is uncertain why you performed a cranial nerve scan for this diagnosis.

n. Physical Therapists interpretation of the results of the examination:

i. "Patient with decreased pelvic stability and chronic foot pain with pelvic malignment with resolves with muscle energy techniques."

o. Clinical rational for the therapeutic intervention:

i. The initial evaluation does not document that treatment was performed at this visit with the exception of the notation "pelvic malignment resolves with muscle energy techniques".

ii. There is no clinical rational for treatment documented.

p. Plan of care:

i. Proposed therapeutic interventions are documented as modalities and manual techniques for foot pain with exercise program for pelvic stability.

ii. Goals documented are not measureable:

1. STG:

a) Increase mobility by 50%. (A baseline was not established for mobility in the initial evaluation. The initial evaluation indicated, "Current % of function is 50%". Qualifying or descriptive documentation that delineates what function is impaired is not documented. The patient does document in the initial paperwork her limitations. It is documented that there are no gait deviations.)

b) Pain reduction by 50% in 2 weeks. (Pain measurements of subjective functional status forms were not documented in the initial evaluation. Thus, baseline measurements are not available.)

c) Increase strength by 25%. (Which specific muscles are to increase strength are not documented. It is difficult to determine a 25% increase [which potentially could be less than ¼ grade] in strength when the minimum strength measurement was listed as (4-/5) for bilateral hip abduction.)

2. LTG:

a) 100% improvement in ADL function and/or pain. (The initial evaluation does not document any deficits with ADL function nor quantitatively documents pain.)

b) Increase strength to 5/5. (Which specific muscles to increase strength to normal are not indicated.)

iii. The evaluation is not signed or dated by Respondent.

5. The exercise flow sheet:

m. The patient name is not identified

n. Who provided the treatment is not identified

o. Exercise log only documents exercises being performed on 3/11.

6. Objective:

p. Myofascial release and soft tissue mobilization: performed to bilateral gluteal and piriformis groups.

i. There is no documentation to indicate specific techniques performed

7. Assessment:

a. Patient's response to treatment:

i. with the exception of “malignment again which resolved”
ii. Under the heading Patient’s response to Physical Therapy: “good”

b. Rationale for continuation of therapeutic interventions is not documented.

8. Discharge Summary: Discharge summary was documented on 4-11-11.
   a. The date on which therapeutic intervention terminated is not documented.
   b. The reason that the therapeutic intervention terminated is not documented.
   c. Inclusive dates for the episode of care are not documented.
   d. Patient’s current functional status is documented as “% of function as 50%”.
   e. Patient’s progress toward achieving the goals in the plan of care is documented as “no significant changes”.
   f. Patient’s plan following discharge is not documented.

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

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

Dr. Cornwall moved the Board adopt the following Conclusions of Law:

1. The conduct and circumstances explained in the Findings of Fact above constitute a violation of A.R.S. §32-2044(20) (Failing to maintain adequate patient records. For the purpose of this paragraph, “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).

2. The conduct and circumstances explained in the Findings of Fact above constitute a violation of A.A.C. R4-24-303 (A)(4) (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.)

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

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

Dr. Cornwall moved the Board adopt the following Order:

Probation: The Arizona Board of Physical Therapy hereby orders that Respondent, holder of License No. 2353, be placed on probation for a period twelve (12) months to commence upon execution of this Order. The probation may be extended or other enforcement actions taken, after notice and an opportunity for a hearing, in the event Respondent violates this Order or violates the Arizona Physical Therapy Practice Act. Respondent may petition the Board for early termination of probation following completion of all terms of probation. Early termination is at the sole discretion of the Board. The Board orders Respondent to comply with the following terms and conditions of probation:

Continuing Education: Respondent shall complete continuing education courses as prescribed below within the period of probation and must be registered with approved courses within 90 days of the effective date of this order. Any continuing education approved and credited for use in complying with the conditions of the order are in addition to the continuing competence activities required for renewal of an Arizona physical therapist license. Respondent

i. Documentation: Respondent shall complete a minimum of six (6) hours of continuing education in documentation. The course(s) must be preapproved by Board staff and Respondent must provide documentation of completing the course to Board staff upon completion.

Patient Records Audit**:** Respondent shall undergo audit(s) of his patient records according to the following terms during the period of probation.

1. Respondent shall undergo a minimum of one audit of 3 randomly selected patient records.

2. The audit of patient records shall be performed by Board staff.

3. The first audit shall begin not less than 30 days following Respondent's completion of all required continuing education in the Order.

4. If Board staff finds deficiencies in the first audit of patient records, Respondent shall undergo one additional audit within three months of the first audit. If a second audit is performed, it will include 3 randomly selected patient records.

Ms. Hunter seconded the motion. After review and discussion the motion carried.

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

3) CONSENT AGENDA: REVIEW, CONSIDERATION and ACTION

a) Applications for Licensure and Certification

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

Wiedenhoeft, Kara	Wiltz, Cassandra			

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

Crabtree, Lindsay	Cree, Kristin	Ramos, Steven		

Dr. Cornwall pulled Kara Wiedenhoeft from the consent agenda. Dr. Cornwall moved the Board approve license and certification for the applicants on the consent agenda excluding Ms. Wiedenhoeft. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

Kara Wiedenhoft; Applicant for Physical Therapist Licensure. The Board reviewed the applicant's disclosure of disciplinary action while in school related to cheating on an examination. Ms. Verstegen noted that the disclosure is may not be grounds for denial of a license. Ms. Akers moved the Board approve the applicant to take the AZLAW and NPTE examinations and be licensed upon receipt of passing scores. Dr. Miller seconded the motion. After review and discussion the motion carried.

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

Consent Agenda Ends

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

a) Review of and Possible Action on the Following Applications for Physical Therapist Licensure – Foreign Educated Graduates of Programs Not U.S. Accredited.

i. Review of Education, Approval to take the NPTE and the AZLAW (Jurisprudence) Exam, Determination of Supervised Clinical Practice Period (SCPP), and Possible Licensure.

(a) Engracia, Christy

Dr. Cornwall moved the Board find the applicants education substantially equivalent to a U.S. graduates, approve the taking of the AZLAW and NPTE examinations and require the applicant to complete a 500 hour supervised clinical practice period under an interim permit. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

b) Substantive Review of Final Clinical Practice Instrument and Possible Licensure – Foreign Educated Graduate of Program not U.S. Accredited

(a) Smyth, Emma

The Board reviewed and discussed the applicants final CPI. Following discussion, Dr. Cornwall moved the Board approve the applicant for licensure. Mr. Robbins seconded the motion. After review and discussion the motion carried by unanimous vote.

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

c) Substantive Review of Application for Licensure as a Physical Therapist

(a) Johnson, Catherine

The Board reviewed the application and noted the applicant failed to provide a complete work history for the past five years. Dr. Cornwall moved the Board approve the applicant to take the AZLAW examination upon receipt of a complete work history and approve licensure upon receipt of a passing score. Dr. Miller seconded the motion. After review and discussion the motion carried by unanimous vote.

5) **BOARD BUSINESS AND REPORTS**

a) Executive Director's Report – Discussion and Possible Action
   i. Financial Report
   ii. Board Staff Activities
   iii. Legislation
   iv. Rule Activity
   v. FSBPT

Mr. Brown provided a verbal report on the above matters. No action was required or taken.

b) Review, Discussion, and Action on 2012 Board Meeting Dates

The Board reviewed the proposed meeting dates for 2012 and adopted the fourth Tuesday of every month as the meeting date and added a teleconference meeting on August 14, 2012. However, the December meeting is to be scheduled for December 18, 2012.

c) Review, Discussion, and Action on Substantive Policy Statement; Supervision; Inclusion of Students and Interim Permit Holders in Supervision Limitations (Ratio)

The Board reviewed the proposed changes to the above substantive policy statement to include students and interim permit holders in those covered by the definition of assistive personnel and included in the supervision ratio restrictions. In addition, the changes include clarifying language that it is acceptable for students in accredited programs and interim permit holders participate in initial, reevaluation, and discharges documentation. Dr. Cornwall moved the Board adopt the Substantive Policy statement as presented. Dr. Miller seconded the motion. After review and discussion the motion carried by unanimous vote.

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

6) **CALL TO THE PUBLIC**

No person came forward to address the Board.

ADJOURNMENT

The meeting adjourned at approximately 2:19 a.m.

Prepared by,

Charles D. Brown
Executive Director

Approved by,

Randy Robbins
Secretary