BEFORE THE
PODIATRIC MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: CHARLES ALEXANDER BLAINE, D.P.M. Post Office Box 3174 Glendale, California 91221 Podiatrist License No. DPM 3817, Respondent.	Case No. 500-2017-000504 O.A.H. No. 2020080491

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Podiatric Medical Board, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on APR 0 1 2021.

IT IS SO ORDERED FEB 1 6 2021.

FOR THE PODIATRIC MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
PODIATRIC MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: CHARLES ALEXANDER BLAINE, D.P.M. Post Office Box 3174 Glendale, California 91221-0174 Podiatrist License No. E 3817, Respondent.	Case No. 500-2017-000504 O.A.H. No. 2020080491 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Brian Naslund (Complainant) is the Executive Officer of the Podiatric Medical Board (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of California, by Chris Leong, Deputy Attorney General.

2. Charles Alexander Blaine, D.P.M. (Respondent) is represented in this proceeding by Attorney Peter R. Osinoff of Bonne, Jones, Bridges & Mueller, 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071.

3. On February 24, 1992, the Board issued Podiatrist License No. E 3817 to Charles Alexander Blaine, D.P.M. (Respondent). That license was in full force and effect at all times

relevant to the charges brought in Second Amended Accusation No. 500-2017-000504 and will expire on August 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 500-2017-000504 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 20, 2019. The First Amended Accusation in this case was filed on December 30, 2020. The Second Amended Accusation in this case was filed on January 20, 2021 and is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 500-2017-000504. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

ADMISSIONS

8. Respondent admits to the truth of the Cause for Action in the Second Amended Accusation No. 500-2017-000504, agrees that cause exists for license surrender, and hereby surrenders his Podiatrist License No. E 3817 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation, he enables the Board to issue an order accepting his Podiatrist License's surrender without further process.

RESERVATION

10. The admissions made by Respondent herein are only for the purposes of this proceeding or any other proceedings in which the Podiatric Medical Board or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED THAT Podiatrist License No. E 3817, issued to Respondent Charles Alexander Blaine, D.P.M., is surrendered, effective date, April 1, 2021, and accepted by the Board.

1. The surrender of Respondent's Podiatrist License and the acceptance of the surrendered license by the Board shall constitute the action under section 822 of the California Business and Professions Code against Respondent. This stipulation constitutes a record of the action and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Doctor of Podiatric Medicine in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in the Second Amended Accusation No. 500-2017-000504 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $38,476.25 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Second Amended Accusation, No. 500-2017-000504 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my Attorney Peter R. Osinoff. I understand the stipulation and the effect it will have on my Podiatrist License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Podiatric Medical Board.

DATED: 1-25-2021

Charles Alexander Blaine DPM

CHARLES ALEXANDER BLAINE, D.P.M.
Respondent

I have read and fully discussed with Respondent Charles Alexander Blaine, D.P.M. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 1/25/2021

PETER R. OSINOFF
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order, effective April 1, 2021 is hereby respectfully submitted for consideration by the Podiatric Medical Board of the Department of Consumer Affairs.

DATED: January 25, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

CHRIS LEONG
Deputy Attorney General
Attorneys for Complainant

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Blaine Stipulation revised 1-25-21 (003).docx

Exhibit A

Second Amended Accusation No. 500-2017-000504

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Attorneys for Complainant

BEFORE THE
PODIATRIC MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: CHARLES ALEXANDER BLAINE, D.P.M. P.O. Box 3174 Glendale, California 91221-0174 Doctor of Podiatric Medicine License No. E 3817 Respondent.	Case No. 500-2017-000504 **SECOND AMENDED ACCUSATION**

PARTIES

1. Brian Naslund (Complainant) brings this Second Amended Accusation solely in his official capacity as the Executive Officer of the Podiatric Medical Board (Board).

2. On February 24, 1992, the Board issued Doctor of Podiatric Medicine License No. E 3817 to Charles Alexander Blaine, D.P.M. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2021, unless renewed.

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JURISDICTION

3. This Second Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2222 of the Code states:

> The California Board of Podiatric Medicine shall enforce and administer this article as to doctors of podiatric medicine. Any acts of unprofessional conduct or other violations proscribed by this chapter are applicable to licensed doctors of podiatric medicine and wherever the Medical Quality Hearing Panel established under Section 11371 of the Government Code is vested with the authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses that same authority as to licensed doctors of podiatric medicine.
>
> The California Board of Podiatric Medicine may order the denial of an application or issue a certificate subject to conditions as set forth in Section 2221, or order the revocation, suspension, or other restriction of, or the modification of that penalty, and the reinstatement of any certificate of a doctor of podiatric medicine within its authority as granted by this chapter and in conjunction with the administrative hearing procedures established pursuant to Sections 11371, 11372, 11373, and 11529 of the Government Code. For these purposes, the California Board of Podiatric Medicine shall exercise the powers granted and be governed by the procedures set forth in this chapter.

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the Board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the Board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the Board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the Board.
>
> (4) Be publicly reprimanded by the Board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the Board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the Board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the Board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the Board pursuant to Section 8031.

6. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 22415.

7. Section 822 of the Code states, in pertinent part:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

"(a) Revoking the licentiate's certificate or license.

"(b) Suspending the licentiate's right to practice.

"(c) Placing the licentiate on probation.

"(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

"The licensing agency shall not reinstate a revoked or suspended certificate or

license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be reinstated."

8 Section 2234 of the Code states:

The Board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of Patients 1, 2 and 3, shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 20525.

(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the Board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the Board.

9. Section 2497 of the Code states:

(a) The Board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with Section 2220) in accordance with Section 2222

(b) The Board may hear all matters, including but not limited to, any contested case or may assign any such matters to an administrative law judge. The proceedings shall be held in accordance with Section 2230. If a contested case is heard by the board itself, the administrative law judge who presided at the hearing shall be present during the Board's consideration of the case and shall assist and advise the Board.

10. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

11. Section 2410 of the Code states:

A medical or podiatry corporation shall not do or fail to do any act the doing of which or the failure to do which would constitute unprofessional conduct under any statute or regulation now or hereafter in effect. In the conduct of its practice, it shall observe and be bound by such statutes and regulations to the same extent as a licensee under this chapter."

12. Section 2472 of the Code states:

(a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine.

(b) As used in this chapter, "podiatric medicine" means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

(c) A doctor of podiatric medicine may not administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another licensed health care practitioner who is authorized to administer the required anesthetic within the scope of his or her practice.

(d)(1) A doctor of podiatric medicine may do the following:

(A) Perform surgical treatment of the ankle and tendons at the level of the ankle pursuant to subdivision (e).

(B) Perform services under the direct supervision of a physician and surgeon, as an assistant at surgery, in surgical procedures that are otherwise beyond the scope of practice of a doctor of podiatric medicine.

(C) Perform a partial amputation of the foot no further proximal than the Chopart's joint.

(2) Nothing in this subdivision shall be construed to permit a doctor of podiatric medicine to function as a primary surgeon for any procedure beyond his or her scope of practice.

(e) A doctor of podiatric medicine may perform surgical treatment of the ankle and tendons at the level of the ankle only in the following locations:

(1) A licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(2) A licensed surgical clinic, as defined in Section 1204 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in subparagraph (1) and meets all the protocols of the surgical clinic.

(3) An ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical center.

(4) A freestanding physical plant housing outpatient services of a licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1). For purposes of this section, a freestanding physical plant means any building that is not physically attached to a building where inpatient services are provided.
(5) An outpatient setting accredited pursuant to subdivision (g) of Section 1248.1 of the Health and Safety Code.

COST RECOVERY

13. Section 2497.5 of the Code states:

(a) The Board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the Board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

(b) The costs to be assessed shall be fixed by the administrative law judge and shall not be increased by the Board unless the board does not adopt a proposed decision and in making its own decision finds grounds for increasing the costs to be assessed, not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

(c) When the payment directed in the Board's order for payment of costs is not made by the licensee, the Board may enforce the order for payment by bringing an action in any appropriate court. This right of enforcement shall be in addition to any other rights the Board may have as to any licensee directed to pay costs.

(d) In any judicial action for the recovery of costs, proof of the Board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(e)(1) Except as provided in paragraph (2), the Board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.(2)

Notwithstanding paragraph (1), the Board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the Board to reimburse the Board within one year period for those unpaid costs.

(f) All costs recovered under this section shall be deposited in the Board of Podiatric Medicine Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the Board may direct.

BACKGROUND

14. On April 8, 2017, the Board received a complaint from D.G.,[1] a non-medical professional and a former business associate of Respondent. The complaint alleged that Respondent dictated medical records and billed for a procedure he did not perform.

15. On May 9, 2017, the Board received two letters from D.G. containing additional information related to his complaint. The complaint alleged that Respondent took patients to sporting events and tried to charge the cost of those tickets to the business. The estimated amount was $13,000.00. The complaint also alleged that many cases involve padded billing and over-treatment of patients, including Patient 1 and Patient 2.

16. On January 6, 2014, Major Medical Management, Inc., (MMM) was registered as a California Stock Corporation with the Secretary of State. It was located at 1510 Central Ave. #120, Glendale, California 91204. It was jointly owned by Respondent, D.G., and doctor H.S., an anesthesiologist. Respondent was issued 49% ownership; D.G. was issued 49% ownership; and doctor H.S. was issued 2% ownership. This arrangement remained in effect from January 2014 until about December 2017.

[1] Names are reduced to initials for privacy.

17. On July 1, 2014, MMM, doing business as VRSC, entered into a three-year sublease agreement with Valley Hand Surgery Center, to lease medical offices located at 14624 Sherman Way, Suite 306, in Van Nuys, California 91405. The purpose of the lease was to open a surgery center to practice dermatology, wound care, pain management, and podiatric surgery. The lease agreement provided that Respondent could perform procedures on Fridays and Saturdays at the leased property.

18. On August 20, 2014, MMM registered with the Los Angeles County Clerk, a Fictitious Business Name Statement for "Access Foot Specialist Podiatry Clinic," located at the same address as MMM.

19. On August 20, 2014, MMM registered with the Los Angeles County Clerk a Fictitious Business Name Statement for "Valley Regional Surgery Center" (VRSC). It was located at 14624 Sherman Way, Unit 303, Van Nuys, California 91405. The mailing address was the same as MMM, 1510 Central Avenue #120, Glendale, California 91204.

20. In February 2015, the Accreditation Association for Ambulatory Health Care (AAAHC) accredited VRSC to perform surgeries.

21. Respondent also performed procedures at the Sunset Ambulatory Surgical Center (Sunset) located at 2707 Sunset Boulevard, Los Angeles, California 90026. A podiatrist named S.S. incorporated Sunset. All of the procedures discussed herein occurred at VRSC or Sunset.

22. Around the end of 2016, D.G terminated his business relationship with Respondent. After this, Respondent obtained 98 percent ownership of MMM.

23. On February 13, 2017, Respondent filed a Statement of Information with the California Secretary of State for MMM. Respondent was designated as the Chief Executive Officer. Respondent's wife, K.B., who is not a medical professional, was listed as the Secretary and Chief Financial Officer of MMM, and she managed the finances of MMM.

24. The AAAHC's credentials expired, and VRSC was closed before the end of 2017. On December 21, 2018, MMM was dissolved.

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SUMMARY OF CARE

PATIENT 1

25. From about to May 2016 to October 2016, Respondent performed approximately 11 elective foot surgeries on Patient 1, which presents multiple medical issues. Among them, performing multiple surgical procedures on the patient in a relatively short time, overuse of anesthesia, operating on at-risk patients, not documenting the dosage or the site of injectable medications, and apparent upcoding of procedures. The standard of care regarding multiple surgeries with multiple anesthesia and surgery on a medically compromised patient is that surgical interventions with general anesthesia must be minimized, and up-coding of procedures is not acceptable.

26. Patient 1 was a sixty-four (64) year-old female when she first visited Respondent on February 4, 2015, at the Access Foot Specialist Podiatry Clinic to have a corn removed from her left foot.

27. On October 3, 2015, Respondent performed surgical procedures on Patient 1, which included a partial matricectomy[2] of an ingrown left hallux[3], both borders and exostectomy[4] of bony exostosis of the left hallux. Anesthesia was used. Respondent failed to obtain and document an appropriate history and to perform and document a physical examination of Patient 1. Respondent did not obtain or document any laboratory studies and did not obtain and document an electrocardiogram (EKG)[5] of the patient prior to the surgical procedure. Respondent failed to obtain and document Patient 1's informed consent for the surgery,

28. On October 7, 2015, Respondent performed an office procedure on Patient 1. This included an incision and drainage of an abscess on the left hallux. However, he did not consider

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[2] A matricectomy is a procedure making use of chemicals, surgery, cryotherapy, or laser to remove all or part of the nail matrix, usually as a treatment for ingrown toenails.

[3] Hallux refers to a person's big toe.

[4] Exostectomy refers to the surgical excision of an exostosis or other bony bump.

[5] An electrocardiogram records the electrical signals of the heart, and is a common test used to detect heart problems and to monitor the heart's status in many situations.

the possibility of infection and failed to prescribe, dispense, or to administer antibiotics to Patient 1 in order to treat the abscess.

29. On October 14, 2015, Respondent performed therapy on Patient 1. This included ultrasound, EMS[6], cryotherapy, and manual manipulation. However, he did not consider the possibility of infection and failed to prescribe, dispense or administer antibiotics to Patient 1 in order to treat the abscess. Respondent did not obtain and did not document or perform a podiatric history and physical (history and physical examination) and did not order any laboratory tests prior to this procedure.

30. On October 17, 2015, Respondent performed an incision and drainage of left hallux abscess; partial matricectomy of right hallux, both borders; exostectomy of bony exostosis of the right hallux; a tenotomy[7]; and a capsulotomy[8] of right fifth hammertoe[9] deformity on Patient 1. However, Respondent did not consider and did not document consideration that Patient 1 was suffering from an infection. Respondent failed to prescribe, dispense, or administer antibiotics to Patient 1. Respondent did not document and did not perform a history and physical examination or any laboratory studies of Patient 1's condition before this surgery.

31. On October 28, 2015, Respondent treated an abscess of left and right hallux on Patient 1. Respondent failed to document if he prescribed, dispensed or administered antibiotics to Patient 1.

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[6] Electric Muscle Stimulation.

[7] The surgical cutting of a tendon, especially as a remedy for club foot, a deformed foot that is twisted so that the sole cannot be placed flat on the ground.

[8] A surgical procedure done during or after a bunionectomy, with the intention of realign the toe. The surgeon cuts the tendons on the sides of the large toe. A joint capsule is implanted on the interior side of the toe to adjust the alignment in order to balance the big toe in relation to the other toes.

[9] A deformity that causes your toe to bend or curl downward instead of pointing forward.

32. On November 7, 2015, Respondent performed a left tailor bunion[10] correction and a left bunion correction with screw fixation on Patient 1. Intravenous sedation was used for anesthesia.

33. On December 12, 2015, Respondent performed right bunion correction with screw fixation; right tailor bunion correction; a tenotomy and a capsulotomy of the right fifth hammertoe on Patient 1. General anesthesia was used.

34. On December 23, 2015, Respondent performed an in-office office follow up to the December 12, 2015, surgery. This included an irrigation and debridement (I & D)[11] of abscess in the right hallux, and application of Unna boot[12], on Patient 1.

35. On April 6, 2016, Respondent performed procedures on Patient 1 at the Access Foot Specialist Podiatry Clinic. The procedures documented included removal of painful hardware, vilex cannulated screw, and exosectomy, first metatarsal, left foot. Respondent failed to perform or to appropriately document a pre-operative workup. Local MAC[13] sedation was used.

36. On April 13, 2016, Patient 1 had a follow-up visit with Respondent. Respondent's medical records for this visit are illegible.

37. On April 16, 2016, Respondent performed another procedure on Patient 1. The procedures documented included removal of the cannulated screw; exostectomy of medial first metatarsal, right foot; and intraoperative use of fluoroscopy, right foot. MAC sedation was used.

38. On May 7, 2016, Respondent performed further procedures on Patient 1. The procedures documented included matricectomy second digit, left foot, bilateral boarders;

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[10] A bunion is a bony, often painful hump at the base of the big toe. Bunions form at a joint.

[11] Irrigation and debridement are methods used to clean wounds, removing dead material and flushing the wound to remove organisms and dead cells.

[12] An Unna boot is a special dressing of inelastic gauze impregnated with zinc, glycerin, or calamine that becomes rigid when it dries. It is used for managing venous leg ulcers and lymphedema in ambulatory patients. When the patient walks, the rigid dressing restricts outward movement of the calf muscle, which directs the contraction force inward and improves the calf-muscle pumping action, thereby improving venous flow. An Unna boot does not provide compression and is contraindicated for arterial insufficiency.

[13] MAC stands for Monitored Anesthesia Care.

matricectomy third digit, left foot, bilateral boarders; tendo-Achilles lengthening, left ankle, and application of an Unna boot left ankle. MAC sedation was used.

39. On May 14, 2016, Respondent performed another procedure on Patient 1. The documented preoperative diagnoses were painful exostosis, painful onychocryptosis[14] right third toe, and abscess left second toe. The documented procedures performed were matricectomy, right third toe; exostectomy, right third toe; therapeutic injection, right third toe; postoperative nerve block, right posterior tibial nerve at the ankle; I&D[15] of abscess, left second toe; therapeutic injection, left second toe; postoperative nerve block, left second toe; Unna boot, bilateral; and use of fluoroscopy. A short stay history and physical examination was documented; however, no pre-operative podiatric history and physical examination was documented or submitted. Respondent discussed this surgery during his interview with the Board investigators on August 1, 2017. He confirmed the surgical procedures performed on that date and stated that no antibiotics were given to Patient 1. He explained that after nail procedures, patients oftentimes have "a chemical abscess," which is a side-effect from sodium bicarbonate phenol, or whatever chemical destruction agent was used. He denied that the patient had cellulitis. He stated that the patient had been cleared for surgery by the anesthesiologist and had been seen by Dr. L.T. and other physicians within a few months preceding the surgery. Local sedation with IV was used, he said.

40. On May 21, 2016, Respondent performed still more procedures on Patient 1.[16] The procedures documented as being performed were arthroplasty[17],fourth digit left foot with proximal interphalangeal joint (PIPJ)[18] arthroplasty; arthroplasty PIPJ, fifth digit left foot; and

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[14] Onychocryptosis, otherwise known as an ingrown toenail, is a condition in which the corner or side of a toenail grows into the flesh. The condition usually affects the big toe. People who have diabetes are at greater risk of complications.

[15] I&D is a medical abbreviation for "incision and drainage."

[16] This date was noted in the medical records to be for both surgery and an office visit.

[17] Arthroplasty is a surgical procedure to restore the function of a joint. A joint can be restored by resurfacing the bones. An artificial joint (called a prosthesis) may also be used.

[18] PIPJ refers to proximal interphalangeal joints. They are joints between the bones of the fingers and toes.

exostectomy distal phalanx[19], fifth digit left foot. A consent was signed. A short podiatry history and physical examination was documented. Surgery Center notes were documented appropriately. MAC sedation was used.

41. On June 4, 2016, Respondent performed a matrixectomy of toes three and four on the right foot on Patient 1. Local anesthesia with MAC was used.

42. On June 17, 2016, Respondent had a postoperative visit with Patient 1 Physical therapy was done and an intramuscular (IM) injection of Toradol 30 mg was administered. Respondent noted that "infected skin" was found in the interspaces between the first through fifth metatarsals. At the subject interview, Respondent made the following statement regarding this visit: "...what I mean by infected skin routine in my practice. If a patient has flaky skin that's lifted up from the dermis, and they have some dried blood, and it's not normal skin, oftentimes I will assume that its infected tinea pedis and I will remove that because it's a nidus of infection, but it's not infected skin like on a patient who had a true cellulitis." Respondent also explained how he treated postoperative nail surgeries and would find abscesses at the nail surgery site, would debride them and put the patient on soaks. The standard of care provides that postoperative nail surgery sites heal with drainage and the postoperative debridement of these areas is simply part of the postoperative care and is not billable as an "abscess." These procedures including the June 4, 2016, and June 17, 2016, visits with Patient 1, were documented in such a way as to improperly increase billings.

43. On June 18, 2016, Respondent performed arthroplasties of multiple toes on Patient 1. During the subject interview, Respondent was asked why he did surgery when the patient, the day before, had a skin infection. Respondent replied that it was his opinion that the patient had superficial tinea. He produced a signed copy of the surgical consent form. He denied that the patient had preoperative lab testing, chest x-ray, or EKG. He stated that the anesthesiologist examined and cleared the patient for surgery, and her medical history had not changed since the previous surgery. The standard of care provides that: a podiatric medical history and physical examination are indicated when surgery is performed in the hospital or outpatient surgical center.

[19] A distal phalanx refers to a bone at the end of both the fingers and toes.

Respondent did not document a preoperative podiatric medical history and physical examination. Local anesthesia with MAC was used.

44. On July 9, 2016, Respondent performed a hyalgan injection[20]of bilateral ankles under fluoroscopic[21] guidance on Patient 1. MAC was used.

45. On July 30, 2016, Dr. R.L. performed a surgery on Patient, at which Respondent assisted. The procedure was an ankle arthroscopy with partial synovectomy[22]. Respondent noted that no preoperative labs were done but that the patient had been seen by a Dr. H. for a home sleep study. Respondent did not document a preoperative podiatric medical history and physical examination. Local anesthesia with MAC was used.

46. On October 25, 2016, Respondent had an office visit with Patient 1. The medical records are unclear as to the dosage of Toradol Respondent administered to Patient 1. At the subject interview, Respondent was questioned about the dosage of Toradol administered and he confirmed that the amount of medication was not documented for this visit and also for Patient 1's visits of November 1, 2016 and November 8, 2016. This lack of documentation is reflected in the medical records. The standard of care requires that the dosage of medications administered, dispensed or prescribed must be documented in the patient's chart. The lack of such documentation places patients at risk.

47. On October 29, 2016, Respondent performed another surgery on Patient 1. The procedures included a right ankle arthroscopy and right ankle synovectomy with extensive debridement of medial and lateral gutters. General anesthesia was used.

48. During the subject interview, Respondent was asked if the fact that he performed about 11 elective procedures on Patient 1 in one year was a customary practice. He answered that

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[20] Hyalgon is a viscous solution that is injected into a knee to relieve pain due to osteoarthritis.

[21] A fluoroscope is an instrument with a fluorescent screen used for viewing X-ray images without taking and developing X-ray photographs.

[22] An operation to remove the synovial membrane (part of the structure that helps bones to move smoothly in the joints).

it was not his customary practice but that the patient had severe hallux limitus,[23] severe ankle arthritis, tenosynovitis,[24] and was not able to function and work. He believed she was happy and benefited from the procedures that were performed. Respondent was asked about the safety of utilization of anesthesia for elective surgery that many times, and he admitted that he wished he had been stricter and more vigilant to follow the anesthesia guidelines, which he said he knew. He also stated that he did not have Patient 1 in a prone position during surgery. He did state that Patient 1 underwent general anesthesia on at least one instance. He was asked if he felt it was safe to place a 65-year-old female under general anesthesia without any preoperative laboratory studies, and he answered that he believed the patient was not under any substantial risk. He utilized the judgment of the anesthesiologist, he said.

PATIENT 2

49. From about January 2015 to about October 2016, Respondent performed 14 elective foot surgeries on Patient 2, as described below, which presents multiple medical issues, including performing multiple surgical procedures on this patient in a relatively short time, overuse of anesthesia, operating on an at-risk patient, not documenting the dosage or the site of injectable medications, and apparent upcoding of procedures. The standard of care regarding multiple surgeries with multiple anesthesia and surgery on a medically compromised patient is that surgical interventions with general anesthesia must be minimized and upcoding of procedures is not acceptable.

50. In 2014, Patient 2 was a fifty-six (56) year-old male who developed heel spurs[25] on both feet. A magnetic resonance imaging study (MRI) revealed a cyst on left ankle, heel spurs on both heels, hammertoes, and neuroma (that is, a pinched nerve) in his left foot. Patient 2 also had

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[23] A progressive arthritic condition that limits the motion and function of the hallux, usually at the big-toe joint.

[24] Inflammation and swelling of a tendon, typically in the wrist, often caused by repetitive movements such as typing.

[25] A heel spur is a calcium deposit causing a bony protrusion on the underside of the heel bone.

a mental disability. Respondent stated that Patient 2 had excellent insurance. Respondent performed approximately sixteen (16) procedures on Patient 2's feet. The procedures were covered by insurance.

51. On January 7, 2015, Respondent performed a procedure on Patient 2. During the subject interview, Respondent was asked to explain the operative report for that date. Respondent explained that the surgery consisted of an injection to the plantar fascia of the left foot, injection and aspiration[26] of a ganglion cyst[27] in the sinus tarsi[28] of the left foot, and use of fluoroscopy. Local anesthesia with monitored anesthesia care (MAC) was used for sedation.

52. On March 21, 2015, Respondent performed a procedure on Patient 2's tendon,[29] plantar fascia release, plantar fascia repair, Unna boot, therapeutic injection, and use of fluoroscopy. Local anesthesia with IV sedation was used.

53. On April 4, 2015, Respondent performed another surgery on Patient 2. The surgery consisted of partial resection[30] of left calcaneal heel spurs, platelet-rich plasma (PRP), and amnion matrix graft[31] of the plantar fascia, trigger point injection of the left foot and application of an Unna boot. During his interview with the Board's investigators, Respondent stated that he saw no additional labs, only the history and physical examination by Dr. H.S. No podiatric history or physical examination was documented. The standard of care provides that a podiatric medical history and physical examination are indicated when surgery is performed in the hospital or outpatient surgical center.

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[26] Aspiration refers to the drawing out of fluid.

[27] A ganglion cyst is a tumor or swelling on top of a joint or the covering of a tendon (tissue that connects muscle to bone). A cyst resembles a sack of liquid.

[28] The sinus tarsi is a tube or tunnel between the talus (ankle bone) and the calcaneus (heel bone).

[29] Tendons that connect the muscles of the outer side of the calf to the foot.

[30] The excision of a significant part of an organ or structure.

[31] Viscous solutions that are rich in growth factors and contain regenerative qualities that maintain the natural healing properties of amnion used in grafting.

54. On April 18, 2015, in an outpatient surgical center, Respondent performed the following procedures on Patient 2: right plantar fascial release with amnion matrix graft injection, heel debridement right heel, intraoperative use of fluoroscopy, PRP injection of the left heel and application of bilateral Unna boots. During the subject interview, Respondent admitted that no special preoperative labs were done for this case. The standard of care provides that preoperative lab testing is indicated when surgery is performed in the hospital or outpatient surgical center. Local anesthesia with IV sedation was used.

55. On April 24, 2015, Respondent treated Patient 2. During the subject interview, Respondent was asked to read the plan word-for-word. He stated, "Um, Toradol IM injection, trigger point injection of left heel, Low-Dye strapping – uh – left – uh – extend disability until June 15." Respondent admitted that the dosage of Toradol was not documented.

56. On May 23, 2015, Respondent performed the following procedures on Patient 2: excision of calcaneal spur, left foot; PRP with amnion matrix graft injection, left foot; partial matrixectomy of ingrown left third digit bilateral border; and exostectomy of distal phalanx left third digit. No preoperative labs were documented.

57. On June 12, 2015, Patient 2 saw Respondent for an office visit. The office notes related that this was a postoperative visit and a left heel abscess with drainage was noted. When asked at the subject interview, Respondent did not know if antibiotics were given; but he said this was a wound that had split open and he planned for a primary closure the next day. Respondent was asked if he gave antibiotics for an abscessed wound, and he replied that the patient was to get antibiotics in the operating room (OR) at the time of surgery. He primarily closed this abscess. Respondent did not document any antibiotic prescription on this visit. No preoperative lab work-up or culture was documented. The standard of care provides that when an abscess is encountered, it is assumed to be infected, thus, a culture was indicated. Closure of an abscess by primary incision[32] is a departure from the standard of care.

[32] Wounds that heal by primary closure have a small, clean defect that minimizes the risk of infection and requires new blood vessels and keratinocytes to migrate only a small distance. Surgical incisions, paper cuts, and small cutaneous wounds usually heal by primary closure.

58. On June 13, 2015, Respondent documented having treated Patient 2 as follows: I&D of the left heel abscess with primary closure left heel. At the subject interview, Respondent stated that no wound cultures were done. He also stated that the patient was taking Cipro;[33] however, it was not documented. There were no preoperative laboratory studies ordered or documented. Local anesthesia was used.

59. On June 20, 2015, Respondent performed a procedure on Patient 2 documented as follows: resection of right calcaneal heel spur. There was no specific reference in the medical records about an infection of the other foot. At the subject interview, Respondent stated that Patient 2 was no longer taking Cipro. When asked to explain more about the left foot wound treatment, Respondent stated that it might have been better to call it a dehiscence[34] with a rule-out of abscess. On June 20, 2015, Respondent operated on the right foot. This was within eight days of the June 13, 2015, operation on the abscessed left foot. There was no culture taken of the left foot. To operate so soon for an elective procedure of the right foot put the patient at risk because it was not certain if the infection noted eight days earlier had resolved. The standard of care provides that when an abscess is encountered, it must be assumed to be infected, and a culture is indicated. It is not within the standard of care to perform an additional elective surgery without sufficient evidence that there is no danger to the patient, such as a culture showing the infection was resolved. Local anesthesia with IV sedation was used.

60. On July 1, 2015, Respondent performed a procedure on Patient 2's left foot. At the subject interview, Respondent read the note for that day and stated, "debridement of infected skin around the left incision site." When asked if he prescribed antibiotics, he explained that it was more of a tinea pedis, but his note did not differentiate this. There was no culture taken of the left foot or other testing to confirm that tinea pedis was present. The standard of care provides that identification of tinea pedis is done by culture or at least KOH microscopic[35] confirmation. It is

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[33] Ciprofloxacin is an antibiotic.

[34] Dehiscence refers to the splitting or bursting open of a wound.

[35] A potassium hydroxide (KOH) examination of skin scrapings may be diagnostic in tinea corporis. A KOH test is a microscopic preparation used to visualize fungal elements removed

not within the standard of care to perform debridement of skin in a postoperative site and arbitrarily identify it as tinea pedis when there could be simply some macerated[36] pedis surgical site peeling skin.

61. On July 25, 2015, Respondent performed a further procedure on Patient 2. When asked about this procedure at the subject interview, Respondent stated that the patient had a neuroma[37] and a mid-foot release. Respondent stated that he performed a cryoablation[38] and right and left foot application of Unna boots. When asked about the infection that was described on the date of July 2, 2015, he answered that it was superficial tinea and it had resolved. He stated he did not believe the patient had preoperative blood work done. The history and physical examination was signed by the anesthesiologist. No preoperative lab workup was documented, no culture was performed, and no podiatry history and physical examination was documented. There was no documentation of antibiotic dosage or duration. In closing a still infected wound, the Respondent displayed poor judgment.

62. On August 5, 2015, Respondent performed a procedure on Patient 2 who was status post cryoablation of neuromas, had physical therapy, trigger point injections left foot, intramuscular injection (IM) of Toradol and bilateral Unna boots. Respondent failed to document both the location and dosage of the trigger point injection.

63. On August 29, 2015, Respondent performed a procedure on Patient 2. The procedure was a plantar fascial repair using a Topaz wand[39] (Topaz) on the left foot, peroneal tendon repair

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from the skin.

[36] Macerated in these circumstances is a term used to describe the oversaturation of the skin due to prolonged exposure to moisture.

[37] A neuroma is a thickening of nerve tissue that may develop in various parts of the body, including in the foot.

[38] Cryoablation is a process that uses extreme cold to destroy tissue. Cryoablation is performed using hollow needles through which cooled, thermally conductive, fluids are circulated. Cryoprobes are positioned adjacent to the target in such a way that the freezing process will destroy the diseased tissue.

[39] The Topaz wand uses radiofrequency waves, referred to as coblation, to induce micro-trauma to the scar tissue of the tendon or fascia that remains unhealed. This microscopic trauma initiates blood flow to return to the diseased area to help restart the healing process.

with Topaz, neurolysis left calcaneal nerve and trigger point injection of cheloid[40] left foot were all performed. No pre-operative labs were done for this procedure.

64. On September 18, 2015, Respondent performed a procedure on Patient 2. Patient 2 returned to Respondent's office after the plantar fascia procedure, and physical therapy was performed. There was an abscess of the right hallux, I&D performed, trigger point injection of the left heel and application of an Unna boot. He confirmed that the drug and the dosage for the trigger point injection were not described. No antibiotics were given for the abscess treatment.

65. On October 24, 2015, Respondent performed procedures on Patient 2 that included a mid-foot release, second interspace neuroma left foot, excision of left Morton's neuroma, tenotomy and capsulotomy, left second hammertoe tenotomy and capsulotomy and tenotomy and capsulotomy of the left fourth hammertoe. No preoperative laboratory studies were documented. There was a history and physical examination from an outside doctor in the chart. Local anesthesia with IV sedation was used.

66. On November 6, 2015, Respondent treated an abscess of the nail area on Patient 2. Respondent failed to document if he prescribed, dispensed or administered antibiotics to the patient.

67. On November 13, 2015, Respondent performed follow up care on Patient 2 documented as neuroma, abscess right hallux. Patient 2 had physical therapy, I&D of abscess right hallux, and applications of bilateral Unna boots. During the subject interview, Respondent was asked if an antibiotic was given. The Respondent said he believed the patient had a paronychia (infection of the tissue adjacent to a nail) and the patient was on soaks, but it did not say so in the medical records. The standard of care provides that when a surgical procedure, such as I&D of an abscess is performed, documentation must be completed regarding location, description of the condition and of the procedure(s) performed. Because of the abscess, it would be appropriate to perform a culture.

[40] A cheloid, also known as keloids, is a benign tumor that usually has its origin in a scar from surgery or a burn or other injury.

68. On November 20, 2015, Respondent performed procedures on Patient 2 documented as an I&D right hallux abscess, application of an Unna boot right, Low-Dye strapping left, and physical therapy for plantar fasciitis, joint pain and neuroma. Respondent was asked at the subject interview if antibiotics were given for the abscess, and he answered, "No." He stated he believed it was an incidental chronic paronychia. He then said he did not believe it was a severe abscess. He admitted, however, that the severity of the abscess was not documented in his notes.

69. On May 7, 2016, Respondent performed procedures on Patient 2 documented to be hammertoe correction with tenotomy and capsulotomy (T&C) left two through five, right four and five digits; mid-foot release, left third interspace of 0.5 cc of dexamethasone phosphate and 0.5 cc of Marcaine plain. The preoperative history and physical examination was performed by Dr. H.S. No verification of preoperative blood work or a chest x-ray was noted. There was a corrected consent form that was presented for review. He could not speculate who corrected the consent form because it was not initialed. Respondent stated, "I can only speculate it was possibly the nurse's handwriting. Um – the label is correct, and the patient was aware of what procedures he needed to undergo." The standard of care provides that a surgery consent form is a legal document and must be appropriately signed and witnessed. Local anesthesia with IV sedation was used.

70. On August 6, 2016, Respondent performed surgery on Patient 2 documented as left partial plantar fasciotomy with the removal of bone fragments and resection of heel spur. Also, there was intraoperative fluoroscopy and therapeutic injection of the left foot. Respondent stated at the subject interview that the labs were done by the primary care physician and the history and physical examination was done by Dr. H.S. Respondent was not aware how recently the labs were ordered by the patient's primary care physician. Local anesthesia with MAC was used.

71. On October 8, 2016, Respondent performed surgery on Patient 2. The procedures were posterior tibial nerve block left, plantar heel injection, and left 3rd interspace injection. Respondent admitted at the subject interview that he was not aware of any preoperative labs. No evidence of a podiatric history and physical examination were noted. Local anesthesia with MAC was used.

72. On October 29, 2016, Respondent performed surgery on Patient 2, described as right ankle arthroscopy and right ankle synovectomy with extensive debridement of medial and lateral gutters.

73. During the subject interview, Respondent was asked if it was customary for him to perform 14 elective surgeries on a patient in one year. He answered that it was not, and he considered Patient 2 to be at a higher risk for pain management than most of his patients. He believed that step-wise pain management prevented Reflex Sympathetic Dystrophy (RSD) or complete disability, which might result in the patient not being able to work. When asked if he believed if it was safe to put a patient under anesthesia 14 times for elective foot surgery, Respondent answered that he thought it was appropriate under the circumstances. He explained that the patient received propofol and did not specifically have general anesthesia. When asked if he believed it was safe to administer propofol without doing the proper examination, such as labs, EKG, chest x-rays and blood work, he answered that he trusted the anesthesiologist's judgment. Respondent was asked to explain why this patient appeared to be undergoing surgery about every two weeks. Respondent answered that when he saw the patient originally, he was in great pain. Respondent explained that he felt it was better to perform procedures over a period of time to maximize the outcome for the patient. The standard of care provides that it is not appropriate to return the patient for repeated elective surgeries in a short period of time when it is possible to provide the services at a lesser number of operative sessions.

PATIENT 3

74. On March 28, 2016, Patient 3 was a twenty-nine (29) year-old male who worked as a truck driver. He visited Respondent and his chief complaint was toe fungus on his left big toe.

75. On May 26, 2016, Patient 3 again presented to Respondent, this time for a painful injury to his right ankle. Respondent informed Patient 3 that he had "really great insurance." He referred Patient 3 for an MRI of the ankle and treated him for toe fungus.

76. On May 25, 2016, Patient 3 had an MRI of his right ankle, which suggested a mild tenosynovitis and/or short segment instrasubstance partial-thickness tear of the peroneus brevis

tendon[41] without evidence of full-thickness tendon tear. No evidence of steochondritis dissecans[42] was seen. Mild joint effusion[43] was seen of uncertain etiology[44] and clinical significance.

77. Respondent and Patient 3 discussed the MRI results and they decided to proceed with platelet-rich plasma (PRP) injections. In the interim, Respondent tried to convince Patient 3 to undergo a tendoachilles lengthening (TAL) procedure, but Patient 3 refused. That procedure was never performed.

78. On June 4, 2016, Patient 3 arrived for the PRP injection procedure. Respondent and Patient 3 went over the informed consent form and Patient 3 noticed that Respondent was planning to perform the TAL procedure. Patient 3 informed Respondent that he never agreed to that. Respondent explained that he needed it, but Patient 3 again refused. The TAL was not performed. However, Respondent created an operative report for right Achilles tendon lengthening of bilateral hyalgan, that was not performed. D.G. overheard Respondent dictating a TAL procedure note into the Patient 3's medical chart. The operative report created by Respondent claimed that the procedures included a right Achilles tendon lengthening, bilateral hyalgan injection, and arthrocentesis, right ankle. The pre-operative documentation included exam/orders, informed consent, and anesthesia records. Local anesthesia with MAC was used.

79. On June 6, 2016, Patient 3 was seen by Respondent for an office visit and an Unna boot. The medical records noted a prescription. The records are otherwise illegible.

80. On June 9, 2016, Patient 3 was seen by Respondent for an office visit and an Unna boot. The medical records for that date included no postoperative progress notes and were largely illegible.

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[41] A tendon that inserts into the 5th metatarsal bone on the outside of the foot.

[42] A joint condition in which bone underneath the cartilage of a joint dies due to lack of blood flow. This bone and cartilage can then break loose, causing pain and possibly hindering joint motion.

[43] An escape of fluid into a body cavity.

[44] The cause, set of causes, or manner of causation of a disease or condition.

81. On about June 11, 2016, one week after the June 4, 2016 procedure, D.G. called Patient 3 to inquire how he was feeling after the procedure. Patient 3 told D.G. that he had no stitches and that he only got an injection.

82. Subsequently, Patient 3 returned to Respondent's office for additional PRP injections and laser treatments. However, after six weeks, his ankle had not improved. Patient 3 began to receive notification that his insurance company was not paying for all of the services billed. Patient 3 spoke with Respondent, who told him he would not bill him for the difference.

83. Respondent invited Patient 3 to go to an Angels baseball game and to sit in his box. Respondent told Patient 3 that if any other patients asked, to say that the PRP treatment was going well. Patient 3 did attend the game, but no other patients were there that day.

84. On June 11, 2016, Respondent performed a surgery on Patient 3. The procedure was a right ankle arthroscopy with synovectomy and right ankle therapeutic injection with Hyalgan. The surgery was performed at Valley Regional Medical Center. Respondent told Patient 3 that he wanted to do exploratory arthroscopy to see if there was damage to the articular surface because he had a history of sprains. The operative report did not mention if the surgical site was prepped. Local anesthesia with MAC was used.

85. On June 13, 2016, Patient 3 was seen by Respondent for an office visit and debridement of infected tissue. The medical records for that day contain no postoperative progress notes.

86. On June 18, 2016, Respondent again performed a surgery on Patient 3. The procedures described were a matricectomy first toe, bilateral medial border and therapeutic injections, right ankle, and left ankle. The operative report did not note a preoperative workup. The medical records did not mention if the surgical site was prepped. Local anesthesia with MAC was used.

87. On June 27, 2016, Patient 3 was seen by Respondent for an office visit. Respondent observed a postoperative hematoma or abscess in the left first lateral border. Respondent did an I&D of a perioperative drainage, but not a culture.

88. On July 1, 2016, Patient 3 was seen by Respondent for an office visit. Respondent did an I&D, applied an Unna boot, and gave an injection.

89. On July 11, 2016, Patient 3 was seen by Respondent for an office visit for examination and chart review.

90. On July 25, 2016, Patient 3 was seen by Respondent for an office visit for right ankle sprain. He was examined, and had a chart review.

91. On August 8, 2016, Patient 3 was seen by Respondent for an office visit for a complaint of right ankle pain. He was examined for the cause of the pain, had a chart review and was evaluated.

92. The insurance statement of account for Patient 3 reflects billed transactions on the following dates: March 28, 2016; May 23, 2016; May 26, 2016; June 4, 2016; June 6, 2016; June 9, 2016; June 11, 16; June 13, 2016; June 18, 2016; June 27, 2016; July 1, 2016; July 11, 2016; July 25, 2016; and August 8, 2016.

93. During the subject interview, Respondent was asked about his general practice procedures. He was asked if it was his standard to inject medications without writing down the exact dosage of what was injected and into what part of the foot it was injected. He answered that it was not his standard practice to do so. When asked why this occurred on three different patients and specifically for Patient 1 on October 25, 2016; November 1, 2016; and November 8, 2016, respondent admitted that his documentation was poor. He was then asked if he tried conservative therapy before elective surgeries. It was pointed out that consideration of conservative therapy was not documented in most of the clinical notes. Respondent admitted that this was not well documented. Then he was asked if he gave antibiotics for abscesses and infections. Respondent answered that he did so for serious infections. He did say that he thought antibiotics were given for the dehiscence on Patient 2 and it was not necessary on any other patients. He said the dehiscence procedures performed were essentially debridement of

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superficial tinea pedis[45] and chemical abscesses and somewhat normal routine postoperative complications.

FIRST CAUSE FOR DISCIPLINE

(Dishonesty)

94. By reason of the facts and circumstances alleged in paragraphs 12 through 92 above, Respondent is subject to disciplinary action under section 2234, subdivision (e), for dishonesty.

95. Respondent was dishonest in his practice of medicine as follows:

A. In respect to Patient 1, Respondent repeatedly charged for drainage of abscess after nail surgeries, when it was really a serosanguinous exudate[46] or debridement of the wound, which was part of postoperative care, including on the June 4, 2016 and June 17, 2016 visits with Patient 1.

B. In respect to Patient 1, Respondent repeatedly upcoded and performed unnecessary procedures, particularly when exostectomies were combined with nail excisions and when debridement of "infected skin" were performed in the course of normal postoperative care, including on the May 14, 2016 surgery and postoperative follow up visits with Patient 1.

C. Regarding Patient 2, Respondent unbundled and separately charged for an August 6, 2016 "therapeutic injection" when the anesthesia administered was part of the surgery fee. This was done to increase revenue.

D. In respect to Patient 3, Respondent repeatedly upcoded and performed unnecessary procedures, particularly when exostectomies were combined with nail excisions and when debridement of "infected skin" were performed in the course of normal postoperative care, including on the June 11, 2016 and June 18, 2016 surgeries and postoperative follow up visits with Patient 3.

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[45] A foot infection due to a dermatophyte fungus. It is also known as athlete's foot, although some people use the term for any kind of tinea pedis.

[46] Fluid being exuded from the body from a severe wound such as from a surgery.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

96. By reason of the facts and circumstances alleged in paragraphs 12 through 92 above, Respondent is subject to disciplinary action for gross negligence in respect to his care of Patients 1, 2, and 3, under Code sections 2234, subdivision (a), 2052, and 2264, and Title 16 California Code of Regulations sections 1366, 1366.1, 1366.2, 1366.3, 1399.521, 1399.540, 1399.541, 1399.542, 1399.543, and 1399.545.

97. Respondent was grossly negligent in his practice of medicine as follows:

A. In respect to Patient 1, he repeatedly charged for drainage of abscess after nail surgeries, when it was really a serosanguinous exudate[47] or debridement of the wound, which was part of postoperative care, including on the June 4, 2016 and June 17, 2016 visits with Patient 1.

B. Regarding the May 14, 2016 surgery on Patient 1, Respondent failed to prescribe preoperative, intraoperative, or postoperative antibiotics, and to document and submit a pre-operative podiatric medical history and physical examination.

C. Regarding procedures and follow-up regarding Patient 1, Respondent failed to document and submit a pre-operative podiatric medical history and physical examination. This occurred on October 3, 2015; October 14, 2015; October 17, 2015; June 18, 201;, April 6, 2016; May 14, 2016; and July 30, 2016.

D. Regarding Patient 1, Respondent failed to consider the possibility of infection. He also failed to prescribe antibiotics for abscess treatment. This occurred on September 18, 2015; October 7, 2015; October 14, 2015; October 17, 2015; October 28, 2015; November 6, 2015; May 14, 2016; and June 18, 2016.

E. Regarding surgeries performed on Patient 1, Respondent failed to perform and document preoperative lab work. An office procedure occurred on October 14, 2015 and a surgery on October 17, 2015.

F. Respondent performed 15 elective foot surgeries on Patient 1, a patient with risk factors including diabetes mellitus and respiratory problems. This included performing

[47] Fluid being exuded from the body from a severe wound such as from a surgery.

procedures on October 3, 2015; October 7, 2015; October 17, 201; November 7, 2015; December 12, 2015; April 6, 2016; April 16, 2016; May 7, 2016; May 14, 2016; May 21, 201; June 4, 2016; June 18, 2016 (when an infection had been observed the day before); July 9, 2016; July 30, 2016; and October 29, 2016. These 15 procedures within one year needlessly put Patient 1 at risk for overuse of anesthesia, and for operating on an at-risk patient. Respondent failed to identify adequate medical indications for the surgeries.

G. Respondent failed to document the dosage of Toradol prescribed, administered or dispensed to Patient 1 for visits on October 25, 2016; November 1, 2016; and November 8, 2016 and to Patient 2 for visits on April 24, 2015 and August 5, 2015.

H. Regarding surgeries performed on Patient 2, Respondent failed to document and submit a preoperative podiatric medical history and physical examination. These surgical procedures occurred on January 7, 2015; March 21, 2015; April 4, 2015; April 18, 2015; May 23, 2015; June 13, 2015; July 25, 2015; August 29, 2015; May 7, 2016; August 6, 2016; and October 8, 2016.

I. Regarding surgeries performed on Patient 2, Respondent failed to perform and document preoperative lab work. These procedures occurred on January 7, 2015; April 18, 2015; May 23, 2015; June 12, 2015; June 13, 2015; July 25, 2015; August 29, 2015; October 24, 2015; May 7, 2016; August 6, 2016; and October 8, 2016.

J. Regarding visits with Patient 2, Respondent repeatedly failed to take a culture when he encountered an abscess, failed to follow acceptable protocols, and used poor judgment for wound care. These visits were on June 12, 2015; June 13, 2015; June 20, 2015; July 25, 2015; and November 13, 2015.

K. Regarding Patient 2, Respondent performed debridement of skin in a post-operative site on patient's left foot, and arbitrarily identified it as tinea pedis without taking a culture or doing other testing to confirm that tinea pedis was present. This occurred on June 20, 2015; July 1, 2015; July 25, 2015; and November 13, 2015.

L. Regarding Patient 2, Respondent failed to document trigger point injection details including the location of the injection and the dosage or drug used. He also failed to

prescribe antibiotics for abscess treatment. These acts occurred on patient encounters on July 25, 2015; August 5, 2015; September 18, 2015; November 13, 2015; and November 20, 2015.

M. Regarding Patient 2, Respondent unbundled and separately charged for an August 6, 2016 "therapeutic injection" when the anesthesia administered was part of the surgery fee. This was done to increase revenue.

N. Respondent performed 16 elective surgeries on Patient 2, a patient with risk factors including diabetes mellitus and respiratory problems within a year and a half. The surgeries were performed on February 7, 2015; March 21, 2015; April 4, 2015; April 18, 2015; May 23, 2015; June 13, 2015; June 20, 2015; July 25, 2015; August 29, 2015; September 2, 2015; October 24, 2015; October 31, 2015; November 20, 2015; May 7, 2016; August 6, 2016; and October 8, 2016. This course of conduct put Patient 2 at risk for overuse of anesthesia. In addition, the Respondent failed to document adequate medical indications for the surgeries.

O. Regarding procedures and follow-up regarding Patient 3, Respondent failed to adequately document and submit a preoperative podiatric medical history and physical examination for visits on June 4, 2016 and June 11, 2016.

P. Respondent performed multiple elective surgeries on Patient 3, a patient with risk factors, within a year, on the following dates: June 4, 2016; June 11, 2016;[48] and June 18, 2016.[49] These three elective surgeries on the same extremity in 14 days, put the patient at risk for overuse of anesthesia and risk of intraoperative or post-operative complications.

Q. He failed to adequately and accurately document the medical records as follows: Regarding Patient 1, he failed to document appropriate preoperative imaging studies, especially when bone work was involved. This included chest x-rays or EKG for a procedure done on Patient 1 on June 18, 2016. This was also specifically regarding Patient 2, in follow up visits, including I&D of an abscess on November 13, 2015; November 20, 2015; and May 7,

[48] On June 11, 2016, Respondent performed an elective surgery on the right ankle, which was 7 days after a prior right ankle surgery on June 4, 2016, and the status of the prior surgery was not assessed.

[49] The June 18, 2016, event was an elective surgery on the right ankle, which was 7 days after a prior right ankle surgery on June 11, 2016.

2016. In addition, the consent form was improperly completed and needed to be corrected. It is not noted who made the corrections. This was regarding the procedure on May 7, 2016; and there was no chest x-ray for Patient 2 on May 7, 2016. Regarding Patient 3's June 18, 2016, procedure, the operative report stated that the left ankle was operated on. However, both the preoperative and the postoperative notes refer only to the right ankle. As regards to all three patients, Respondent maintained incomplete, undecipherable, and illegible medical records that provide no medical indication or basis for surgeries; he failed to adequately and accurately document the need for surgery when MRI findings demonstrated only a "mild" pathology; he charged for exostectomy of the distal phalanges when doing nail surgeries, without a recorded documentation of radiographic images to confirm the diagnosis; and he repeatedly charged for debridement of "infected skin" after surgeries, when this is a normal healing process and any simple debridement required was part of normal surgical aftercare.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

98. By reason of the facts and circumstances alleged in paragraphs 12 through 92 above, Respondent is subject to disciplinary action for repeated negligent acts in the care of patients 1, 2, and 3 acts under Code section 2234, subdivision (c).

99. Additional facts and circumstances are as follows: Regarding the May 21, 2016 surgery of Patient 1, the medical records are unclear and are confusing as to exactly what was done in the office, as opposed to what was performed in the surgery center.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Treatment)

100. By reason of the facts and circumstances alleged in paragraphs 12 through 92 above, Respondent is subject to disciplinary action for the excessive treatment of all three patients under Code section 725. This also included:

A. Treatments to Patient 1 on October 3, 2015; October 17, 2015; November 7, 2015; December 12, 2015; April 6, 2016; May 7, 2016; May 14, 2016; May 21, 2016; June 4, 2016; June 18, 2016; July 9, 2016; and October 29, 2016.

B. Treatments to Patient 2 on February 7, 2015; March 21, 2015; April 4, 2015; May 23, 2015; June 20, 2015; July 25, 2015; August 29, 2015; October 24, 2015; October 31, 2015; May 7, 2016; August 6, 2016; and October 8, 2016.

C. Treatments to Patient 3 on June 4, 2016; June 11, 2016; and June 18, 2016.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records of Patient Care)

101. By reason of the facts and circumstances alleged in Paragraphs 12 through 92, Respondent is subject to disciplinary action under Code section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to all three patients. Specifically, by creating illegible records for an April 13, 2016 follow up visit with Patient 1; by creating confusing records concerning a May 21, 2016 procedure on Patient 1; and by not documenting the severity of Patient 2's infection on November 20, 2015. The Consent form was not correct for Patient 2's procedure on May 7, 2016; by creating a June 18, 2016 operative report for Patient 3, stating that the left ankle was operated on, when both the preoperative and postoperative notes only refer to the right ankle. Respondent created illegible records for the June 9 and 13, 2016 visits with Patient 3. Respondent created illegible records for the February 3, 2017; March 10, 2017; April 21, 2017; and May 19, 2017 visits with Patient 2.

CAUSE FOR ACTION

(Physical Illness Affecting Competency)

7. On October 6, 2020, Respondent signed an application for exception of renewal fees for disabled doctors of Podiatric Medicine. This application was certified under penalty of perjury. Under the description of disabilities and explanation as to how the disability prevents the applicant from practicing Podiatric Medicine safely, Respondent stated: Bipolar disorder. Mood fluctuations, frequent bouts of depression, severe anxiety that are preventing the patient from being able to perform his work, decreased concentration, decreased energy, decreased drive.

The disability began on April 13, 2020. It was described as a permanent condition and this description was provided by his attending physican Viguen Movsesian, signed on August 20, 2020.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Podiatric Medical Board issue a decision:

1. Revoking or suspending Podiatrist License Number E 3817, issued to Charles Alexander Blaine, D.P.M.

2. Ordering Respondent to pay the Podiatric Medical Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 2497.5; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: JAN 20 2021

BRIAN NASLUND
Executive Officer
Podiatric Medical Board
Department of Consumer Affairs
State of California

Complainant

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Second Amended Accusation.docx