

**STATE OF CONNECTICUT
CONNECTICUT BOARD OF EXAMINERS IN PODIATRY**

Richard J. Grayson, D.P.M.

Petition No. 2003-0715-019-005

MEMORANDUM OF DECISION

Procedural Background

On December 9, 2004, the Department of Public Health ("the Department") presented the Connecticut Board of Examiners in Podiatry ("the Board") with a Statement of Charges, against Richard J. Grayson, D.P.M. ("respondent"). The Statement of Charges and the Notice of Hearing were sent to respondent by certified mail, return receipt requested, and by first class mail on December 23, 2004. The Notice of Hearing scheduled a hearing for March 9, 2005, and notified the parties that the hearing would be held before the Board. Dept. Exh. 1.

On January 3, 2005, the respondent filed a motion for more particular statement. Bd. Exh. 3. On January 11, 2005, the Department filed a response to respondent's motion for more particular statement and moved to modify the charges. Bd. Exh. 3. A Ruling on respondent's motion for particular statement was issued by the Board on January 25, 2005, granting the respondent's motion absent objection from the Department, and ordering the Department to amend its Statement of Charges on or before February 1, 2005. Bd. Exh. 3. The Department filed its amended Statement of Charges ("Charges") on February 3, 2005. Bd. Exh. 4. On February 14, 2005, respondent filed an answer. Bd. Exh. 5. On February 18, 2005, respondent filed an amended answer. Bd. Exh. 6. On March 1, 2005, the Department filed an answer to affirmative defenses of respondent. Bd. Exh. 7.

On March 9, 2005, the Board held an administrative hearing to adjudicate respondent's case. Respondent was represented by Attorney Kerry Wisser; the Department was represented by Attorney Ellen Shanley.

The Board conducted the hearing in accordance with Chapter 54 of the Connecticut General Statutes and Regulations of Connecticut State Agencies § 19a-9-1 *et seq.* All Board members involved in this decision received copies of the entire record

and attest that they have either heard the case or read the record in its entirety. This decision is based entirely on the record.

Allegations

1. In the first numbered paragraph 1 of the Charges, the Department alleges that respondent, of Avon Connecticut, is and has been at all times referenced in the Charges, the holder of Connecticut podiatric license number 00313.
2. In the second numbered paragraph 1 of the Charges, the Department alleges that Mr. R. was a patient of respondent.
3. In numbered paragraph 2 of the Charges, the Department alleges that Mr. S was also a patient of respondent.
4. In numbered paragraph 3 of the Charges, the Department alleges that the medical histories of Mr. R and Mr. S differ.
5. In numbered paragraph 4 of the Charges, the Department alleges that on or about July 10, 2002, Mr. S sought treatment by respondent.¹
6. In numbered paragraph 5 of the Charges, the Department alleges that on or about July 10, 2002, respondent examined and treated Mr. S, while under the assumption that Mr. S was Mr. R.
7. In numbered paragraph 6 of the Charges, the Department alleges that respondent documented said treatment of Mr. S in Mr. R's medical records.
8. In numbered paragraph 7 of the Charges, the Department alleges that respondent billed for payment for treatment of Mr. R on July 10, 2002.
9. In numbered paragraph 8 of the Charges, the Department alleges that Mr. R was not treated by respondent on July 10, 2002.
10. In numbered paragraph 9 of the Charges, the Department alleges that respondent failed to document, timely, his July 10, 2002 treatment of Mr. S in the medical records he maintained for Mr. S.
11. In numbered paragraph 10 of the Charges, the Department alleges that respondent failed to maintain medical records, timely, for his treatment of Mr. S, in violation of Section 19a-14-40 of the Connecticut Public Health Code.

¹ While the Charges state that the date of the treatment was July 20, 2002, the Department, at the administrative hearing on March 9, 2005, orally amended the Charges to change the date of treatment to July 10, 2002. (Tr. 3/9/05, pp. 4-5.)

12. In numbered paragraph 11 of the Charges, the Department alleges that respondent failed to have an adequate mechanism in place to ensure that each patient's identity could accurately be determined prior to the patient's examination and/or treatment.
13. In numbered paragraph 12 of the Charges, the Department alleges that the above facts constitute grounds for disciplinary action pursuant to the Connecticut General Statutes § 20-59:
 - a. § 20-59(4), and/or,
 - b. § 20-59(11).

Findings of Fact

1. Respondent, of Avon, Connecticut is, and has been at all times referenced herein, the holder of Connecticut podiatric license number 000313. Bd. Exh. 6.
2. Mr. R began seeing respondent as a patient in December of 1998. On July 10, 2002, Mr. R was 77 years old, 6 feet 2 inches tall with a size 13 foot. Mr. R was not treated by respondent on July 10, 2002. Bd. Exh. 6; Dept. Exh. A; Tr., pp. 23, 25-27, 51, 70, 86.
3. On July 10, 2002, Mr. S was also a patient of respondent. Mr. S was also 77 years old on July 10, 2002, of similar stature to Mr. R, with a size 13 foot. Mr. S was hearing impaired. Bd. Exh. 6; Tr., pp. 86, 90, 105, 11-13, 118.
4. On July 10, 2002, Mr. S sought treatment from respondent as a walk-in patient, without a prior appointment, for an acute foot problem. Respondent treated and took x-rays of Mr. S's foot. Bd. Exh. 6; Tr., pp. 11-12, 109-111.
5. On July 10, 2002, respondent examined and treated Mr. S, while under the assumption that Mr. S was Mr. R. Respondent and staff referred to Mr. S as Mr. R several times during Mr. S's July 10, 2002 visit, but because Mr. S did not hear clearly, he did not correct them. Bd. Exh. 6; Tr., pp. 86, 87, 102-03, 105, 109-111.
6. Respondent documented said treatment of Mr. S in Mr. R's medical records. Bd. Exh. 6; Tr., pp. 111-12.
7. Respondent billed for payment through Medicare for treatment of Mr. R on July 10, 2002. Rec. Exh. 6; Tr., pp. 24-26, 111.
8. Sometime in August 2002, Mr. R received notice from Medicare regarding treatment by respondent on his foot on July 10, 2002. Tr., pp. 24-25, 45-46, 66-67.

9. In August 2002, Mr. R called Medicare and respondent and informed both of them that he did not receive treatment from respondent on July 10, 2002. Respondent and his receptionist informed Mr. R that according to their records, Mr. R did receive treatment from respondent on July 10, 2002. Tr., pp. 26-31, 47-50, 67, 69, 75, 85, 86, 88, 89, 111; Dept. Exh. A.
10. Medicare made payment to respondent for treatment of Mr. R. Tr. pp. 33, 81.
11. On January 18, 2004, respondent and staff realized an error had been made and that Mr. S's x-rays and treatment were billed to and placed in Mr. R's medical records. Respondent then corrected Mr. S's and Mr. R's medical records to appropriately reflect that respondent had provided care to Mr. S on July 10, 2002. Tr., pp. 81, 91-93, 116, 117.
12. Since January of 2004, respondent has instituted an office policy in which all patients must sign-in when they arrive on a self-adhesive label that is transferred to the patient's paperwork. Respondent also instituted a policy to record the time a patient is seen and the entry is highlighted if the appointment was made the same day or was a walk-in patient. Tr., pp. 91-93, 96.
13. Respondent retracted the bill issued to Mr. R when respondent realized that an error had been made, and reimbursed Medicare accordingly. Bd. Exh. 6; Tr., p. 81.

Discussion and Conclusions of Law

The Department bears the burden of proving the allegations by a preponderance of the evidence. *Steadman v. Securities and Exchange Commission*, 450 U.S. 91, 67 L. Ed. 2d 69, 101 S. Ct. 999, *reh'g denied*, 451 U.S. 933, 68 L. Ed. 2d 318, 101 S. Ct. 2008 (1981); *Swiller v. Commissioner of Public Health and Addiction Services*, Superior Court, judicial district of Hartford-New Britain at Hartford, Docket No. 705601 (October 5, 1995, Hodgson, J.).

The Board relied on the training and experience of its members in making its findings of facts and conclusions of law. *Pet v. Department of Health Services*, 228 Conn. 651, 667 (1994).

The Board finds that the Department met its burden of proof with regard to allegations 1 through 11 and 12(a) of the Charges, but failed to meet its burden of proof with regard to allegation 12(b) of the Charges.

In allegations numbered 9, 10 and 11 of the Charges, the Department alleges that respondent failed to: (1) timely document his July 10, 2002 treatment of Mr. S in the

medical records he maintained for Mr. S; (2) timely maintain medical records for his treatment of Mr. S; and, (3) have an adequate mechanism in place to ensure that each patient's identity could accurately be determined prior to the patient's examination and/or treatment. The Department contends that the above conduct by respondent violates subsections (4) and (11) of Conn. Gen. Stat. § 20-59.

Sections 20-59(4) and (11) of the General Statutes provide:

The board may take any of the actions set forth in section 19a-17 for any of the following reasons: . . . (4) illegal or incompetent or negligent conduct in the practice of podiatry; . . . (11) violation of any provision of this chapter or any regulation adopted hereunder.

A preponderance of the evidence establishes that the Department met its burden with respect to allegations 9, 10, and 11 of the Charges by virtue of respondent documenting and maintaining the July 10, 2002 treatment records and x-rays of Mr. S in Mr. R's medical file until on or about January 18, 2004, and failing to have an adequate mechanism in place to ensure that each patient's identity could accurately be determined prior to the patient's examination and/or treatment. Respondent does not dispute that on July 10, 2002 that Mr. S was misidentified by him and his staff as Mr. R., or that the treatment record of Mr. S's July 10, 2002 visit was placed in Mr. R's medical record.

The Board concludes that the above conduct by respondent constitutes a violation of Conn. Gen. Stat. § 20-59(4), but does not violate Conn. Gen. Stat. § 20-59(11).² The board finds that such a violation, in this instance, does not warrant the imposition of a penalty against the respondent's podiatric license.

As detailed below, the Board notes that several factors contributed in creating this unique coincidental scenario and recognizes that respondent took immediate action, upon his discovery of the error, to correct the medical records of Mr. R and Mr. S and to implement new office policies designed to prevent similar incidents in the future. (Finding of Facts ("FF"), ¶¶ 1-13.)

² Conn. Gen. Stat. § 20-59(11) authorizes the Board to impose disciplinary action against respondent's license for a violation of any provision of Chapter 375 or any regulation adopted hereunder. The Department alleges that respondent violated Conn. Gen. Stat. § 20-59(11) in that the respondent failed to timely maintain medical records for his treatment of Mr. S in violation of Section 19a-14-40 of the Regulations of Connecticut State Agencies. That regulation, however, was not adopted under the provisions of Chapter 375 and accordingly cannot constitute a violation of Conn. Gen. Stat. § 20-59(11).

As of July 10, 2002, both Mr. S and Mr. R were described as large in stature, 77 years old, with a size 13 foot. (FF, ¶¶ 2-3.) The apparently similar characteristics of Mr. S and Mr. R spawned a series of interactions between Mr. S, respondent, and respondent's staff in which Mr. S was referred to and misidentified continuously on July 10, 2002 as Mr. R. When Mr. S entered respondent's office as a walk-in patient, respondent's receptionist, Donna Walker, referred to him as Mr. R, and Mr. S, being hard of hearing, never corrected Ms. Walker. As a result, the treatment provided to Mr. S was documented in Mr. R's medical record. (FF, ¶¶ 4-7.) As testified by Ms. Walker, Mr. R's medical record, the x-ray and the appointment book all reflected that Mr. R, not Mr. S, was treated in respondent's office on July 10, 2002. Having gone uncorrected by Mr. S for the full duration of his visit, respondent and his staff believed Mr. S to be Mr. R.

Mr. R's insistence that he did not visit respondent's office on July 10, 2002, and his persistence in having his medical record corrected, including filing a claim with the Department, prompted respondent and his staff to reevaluate the possibility that an error was made by his office. Finally, in January 2004, respondent and his staff discovered that Mr. S, not Mr. R, made the July 10, 2002 visit to respondent's office. (FF, ¶ 11.) As a result of this discovery, respondent took immediate action to rectify the situation by: (1) instituting new office recordkeeping policies; (2) reimbursing Medicare for payments made on behalf of Mr. R; (3) correcting Mr. R and Mr. S's medical records; and, (4) retracted the bill issued to Mr. R for treatment rendered on July 10, 2002. (FF, ¶¶ 11-13.)

Based on the foregoing, the Board finds that while respondent's conduct constituted a violation of Conn. Gen. Stat. § 20-59(4), there is no good cause to impose a penalty in this instance.

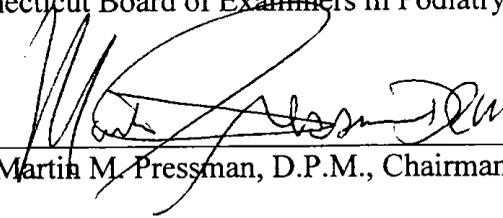
Order

Based upon the record in this case, the above findings of fact and conclusions of law, and pursuant to the authority vested in it by Conn. Gen. Stat. §§ 19a-17(a) and 20-202, the Board does not order any disciplinary action in the case of Richard Grayson, D.P.M., Petition number 2003-0715-019-005, podiatric license number 000313, and orders that this case be DISMISSED.

This Decision shall become effective upon the signature of the Board Chairperson.

Connecticut Board of Examiners in Podiatry

12/17/05
Date


by: Martin M. Pressman, D.P.M., Chairman CHAIR