IN THE MATTER OF	*	**BEFORE THE**
LARRY BERNHARD, D.P.M.	*	**MARYLAND STATE BOARD OF**
	*	**PODIATRIC**
	*	**MEDICAL EXAMINERS**
License Number: 00591	*	**Case Number: 2004-057**
RESPONDENT	*	

* * * * * * * * * * * * *

ORDER FOR TERMINATION OF PROBATION AND REINSTATEMENT WITHOUT CONDITIONS

BACKGROUND

On December 20, 2005, the Maryland State Board of Podiatric Examiners (the "Board") and Larry Bernhard, D.P.M., Respondent") entered into a Final Consent Order (the "Order") which is incorporated by reference as if fully set forth herein. This Order resulted from Respondent having violated a prior Consent Order dated January 8, 2004, which is incorporated by reference as if fully set forth herein.

The pertinent terms and conditions of the Order dated December 20, 2005, were that the Respondent was to serve an additional one (1) year period of probation ending January 8, 2007; that mentoring requirements be extended for an additional year ending January 8, 2007; that the Respondent was to submit 10 patient charts to the Board on a monthly basis; and that Respondent was to come before the Board six (6) months from the date of the Order to review his progress.

FINDINGS OF FACT

1. On December 20, 2005, the Respondent entered into a Final Consent Order with the Board.

2. The Respondent has successfully completed the past six (6) months of extended probation.

3. The Respondent has petitioned the Board to terminate probation and to reinstate his license to practice podiatry in this State without any conditions whatsoever.

5. On June 8, 2006, a full quorum of the Board voted to grant Respondent's petition.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Maryland State Board of Podiatric Examiners concludes, as a matter of law, that the Respondent has met the conditions attached to his probation.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, this 12th day of June, 2006, by the Maryland State Board of Podiatric Medical Examiners hereby:

ORDERED that the Respondent's Maryland podiatry license be and is hereby reinstated without conditions; and it is further

ORDERED that this document is a public document pursuant to Md. Code Ann., State Gov't Article, § 10-611 *et seq.*

6/12/06
Date

Ira Deming, D.P.M., PRESIDENT

IN THE MATTER OF	*	**BEFORE THE STATE**
LARRY BERNHARD, D.P.M.	*	**BOARD OF PODIATRIC**
License No. 00591	*	**MEDICAL EXAMINERS**
Respondent	*	**CASE NUMBER: 2004-057**

* * * * * * * * * * * * *

FINAL CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Podiatric Medical Examiners (the "Board"), and subject to Md. Health Occ. Ann. § 16-101, et seq., (2000 Repl. Vol. and 2004 Supp.) (the "Act"), the Board charged Larry Bernhard, D.P.M., (the "Respondent"), with violations of the Consent Order of January 8, 2004, as well as violations of its Act.

The Respondent was given notice of the Violation and Charges by letter dated October 14, 2005. Accordingly, a Case Resolution Conference was held on November 4, 2005, and was attended by Ira M. Demming, D.P.M., President of the Board, and David J. Freedman, D.P.M., Board member, Eva Schwartz, Executive Director of the Board, Elaine Hanratty, Administrative Officer of the Board, and Richard Bloom, Assistant Attorney General, Board Counsel. Also in attendance were the Respondent and his attorney, William M. Ferris, and Roberta Gill, Assistant Attorney General, Administrative Prosecutor.

Following the Case Resolution Conference, the parties and the Board agreed to resolve the matter by way of settlement. The parties and the Board agreed to the following:

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice podiatry in Maryland. The Respondent was first licensed on June 10, 1981. The Respondent's license expires on December 31, 2005.

2. Prior to the time that the Board entered into the aforesaid Consent Order of January 8, 2004, the Respondent maintained a private practice of podiatric medicine in Pasadena, Maryland.

3. Based upon a complaint filed with the Board, on or about August 13, 2002, the Board began an investigation of the Respondent's prescribing practices. A pharmacy survey was conducted, which showed that the Respondent prescribed excessive amounts of Controlled Dangerous Substances (CDS) to numerous patients.

4. After reviewing the drug screen, the Board subpoenaed several patient records. For those records that the Board's investigator was able to go and pick up the originals upon presentation of the subpoena, the records were not in the SOAP[1] format. In some instances, billing failed to match treatment dates and the billing was often done in codes that were inconsistent with the recorded procedure. For the records that the Respondent could not find at the time of presentation of the subpoena, but which were brought to the Board or picked up from his attorney's office at a later date, those records were in the SOAP format.

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1 SOAP is an acronym for Subjective, which describes the patient's complaint/symptoms; Objective, which deals with the examination findings, such as temperature, blood pressure, etc; Assessment, which deals with the diagnoses resulting from the examination; and, Plan, which is the treatment plan.

5. Based on the Respondent's excessive prescribing practice of CDS, the Board summarily suspended the Respondent's license on September 9, 2002. Following a hearing on the merits of the summary suspension, at which several of the Respondent's patients testified, as well as the Respondent, the Board issued a subsequent Order, effective October 21, 2002, which forbade the Respondent from prescribing any CDS. Subsequently, the Respondent closed his office and informed the Board that he was engaging in nursing home practice only.

6. On October 9, 2003, charges were issued against the Respondent which alleged that the Respondent violated the Act and regulations in numerous ways. For all of the records reviewed, the Respondent: often failed to update the patients' health histories; failed to document objective findings; prescribed CDS in excessive amounts; failed to record operative reports; wrote illegibly; prescribed for and treated for conditions outside the practice of podiatry.

7. As a settlement of the charges, a Consent Order was entered into, dated January 8, 2004.

8. The Consent Order required, *inter alia*, that the Respondent's license to practice podiatry was **SUSPENDED** for one year, and that that Suspension was immediately **STAYED**, and the Respondent be placed on Probation for three years, subject to the following conditions:

A. The Respondent may prescribe Controlled Dangerous Substances (scheduled drugs) only if the prescriptions are co-signed by the patient's primary care physician, and a notation of such co-review is made into the patient's chart;

B. The Respondent shall take and pass, during the first year of Probation, the PMLexis examination, and cause documentation of that passage to be sent to the Board;

C. During the first year of Probation, the Respondent must take a Board-pre-approved mini-course in the management of diabetes, with documentation of the successful completion thereof sent to the Board;

D. During the first year of Probation, the Respondent shall take a records-keeping course pre-approved by the Board, with documentation of its successful completion sent to the Board;

E. During the first year of Probation, the Respondent shall take an ethics course, pre-approved by the Board, with the documentation of the successful completion thereof sent to the Board;

F. During the first year of Probation, the Respondent shall take a course on prescribing controlled substances, pre-approved by the Board, with the documentation of its successful completion thereof sent to the Board;

G. During the first year of Probation, the Respondent's practice shall be mentored on a monthly basis for the first three months of the Probation and then quarterly thereafter, with reports being sent to the Board by the Mentor on a timely basis. The Respondent shall pay the Mentor, who shall be pre-approved by the Board, Two Hundred Dollars ($200) per hour for a minimum of four (4) hours per visit, at the conclusion of each mentoring session. The Respondent shall also pay the Mentor $200 per hour for travel

and report-writing. Further mentoring is at the discretion of the Board, following the conclusion of the first year of Probation;

H. The Respondent shall implement certain corrective procedures, as submitted to the Board.

I. The Respondent shall notify all nursing homes, hospitals, medical clinics and outpatient surgery centers regarding this Order, with a copy of such notification sent to the Board within 30 days of effective date of this Order;

J. The Board may review the Respondent's charts/treatments files/medical records at any time.

9. The Order further contained the following provisions:

> Should the Board receive in good faith information that the Respondent has substantially violated the Act or if the Respondent violates any conditions of this Order or of Probation, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further disciplinary action against the Respondent, including lifting the Stay of Suspension, or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it

ORDERED that the Respondent shall practice competently and in accordance with the laws and regulations governing the practice of podiatry in Maryland.

FINDINGS SPECIFIC TO THE VIOLATION OF THE CONSENT ORDER

10. The Board charged the Respondent with violation of the Consent Order of January 8, 2004, in the following ways:

A. The Respondent shall take and pass, during the first year of Probation, the PMLexis examination, and cause documentation of that passage to be sent to the Board: the Respondent failed to take the examination in a timely fashion.[2]

B. The Respondent shall notify all nursing homes, hospitals, medical clinics and outpatient surgery centers regarding this Order, with a copy of such notification sent to the Board within 30 days of effective date of this Order; the Respondent failed to copy the Board with any such notice.

C. The Board may review the Respondent's charts/treatments files/medical records at any time. Accordingly, the Board attempted to review the Respondent's patient charts and, on April 28, 2004 and May 10, 2004, the Board issued subpoenas to the Respondent for a total of eleven patients' records. The Respondent refused to supply his records, claiming that he had "shred" them. As a result of the Respondent's failure to supply patient records as per the Consent Order, the Board had to obtain many of the records from the nursing homes that the Respondent practiced in, as well as obtaining invoices from Medicare. Those records were analyzed, as set forth below.

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2 The Respondent took the examination on June 8, 2005, and passed it.

FINDINGS WITH REGARD TO VIOLATIONS OF THE ACT

As a result of the aforementioned, the Board charged the Respondent with additional violations of its Act.[3]

Thus in addition to the Violation of Probation and of the Consent Order, set forth above, the Board charged that the Respondent violated the following provisions of the Act.

Specifically, the Board charged the Respondent with violation of the following provisions of § 16-311:

> (a) Subject to the hearing provisions of § 16-313 of this subtitle, the Board, on the affirmative vote of a majority of its members then serving, may deny a license or a limited license to any applicant, reprimand any licensee or holder of a limited license, impose an administrative monetary penalty not exceeding $5,000 on any licensee or holder of a limited license, place any licensee or holder of a limited license on probation, or suspend or revoke a license or a limited license if the applicant, licensee or holder:
>
> (10) Willfully makes or files a false report or record of podiatric services rendered;
>
> (11) Willfully fails to file or record any report as required by law, willfully impedes or obstructs the filing or recording of the report, or induces another to fail to file or record the report;
>
> (12) Submits a false statement to collect a fee;
>
> (17) Behaves fraudulently, immorally, or unprofessionally in the practice of podiatry;
>
> (18) Is....professionally incompetent;

3 In addition, the Consent Order contained the following provision: "ORDERED that the Respondent shall practice competently and in accordance with the always and regulations governing the practice of podiatry in Maryland."

(27) Fails to cooperate with a lawful investigation conducted by the Board.

In addition, the Respondent violated the following provisions of Md. Health Gen. Code Ann. §4-403.

> (b) *5 year period absent notification* – Except for a minor patient, unless a patient is notified, a health care provider may not destroy a medical record or laboratory or X-ray report about a patient for 5 years after the record or report is made.[4]

FINDINGS OF FACT

The Board based its charges on the following facts that the Board has cause to believe are true:

11. A review of the Respondent's records disclosed the following overall deficiencies:

A. The Respondent billed almost every nursing home visit as a code 99312 or 99313 and, rarely, 99311, which the documentation does not support for this higher level of billing.[5]

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4 In addition, Medicare regulations require a Medicare provider to maintain records for 6 years. (CMS Medicare Manual Pub 100-6) http://ww.cms.hhs.gov/manuals/pm_trans/R14FM.pdf

5 Code 99311 is defined as: Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

a problem focused interval history;
a problem focused examination;
Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

Code 99312 is defined as: Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

an expanded problem focused interval history;

B. Documentation is hard to read and doesn't appear to mandate an Evaluation and Management ("E&M") visit, because it clearly indicates "routine foot care" was provided in many instances.[6]

12. The Board found with regard to several specific patients, as follows:

A. Patient A[7] at HCR Manor Care:[8]

1) Date of Service: 1/15/04, billed 99313, the Respondent failed to document chief complaint and failed to mention Diabetes Type 1 as a diagnosis. The Respondent recorded that he provided related treatment to "sacral" and foot ulcers. The Respondent billed 99313; however, based on the poor documentation, the Respondent should have billed this as code 99311;

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an expanded problem focused examination;
Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

Code 99313 is defined as: Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:
a detailed interval history;
a detailed examination;
Medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

6 On an initial visit, to bill as an E&M visit is permissible under Medicare.
7 Patients' names are confidential, but may be disclosed to the Respondent by contacting the Administrative Prosecutor.
8 This patient's primary diagnosis was Diabetes Mellitus, Type 1.

2) Date of Service: 1/22/04, billed 99313. Although the Respondent billed for the highest level of service for a nursing home visit on this date, he failed to document that he provided any;

3) Date of Service: 1/29/04, billed 99313. The Respondent failed to record a chief complaint, and failed to mention Diabetes Type 1 as a diagnosis. Based on the documentation, or lack thereof, the Respondent should have billed CPT Code 99311;

4) Date of Service: 2/5/04, billed 99313. The Respondent failed to document a chief complaint, and failed to mention Diabetes Type 1 as a diagnosis. Based on the documentation, or lack thereof, the Respondent should have billed CPT Code 99311.

B. Patient B at Mariner Glen Burnie:[9]

1) Date of Service: 2/11/04, billed 99312. The Respondent billed for treatment not substantiated by any documentation that he rendered same;

2) Date of Service: 2/18/04, billed 99312. The Respondent billed for treatment not substantiated by any documentation that he rendered same;

9 The primary diagnosis was ulcer heel/midfoot.

3) Date of Service: 2/25/04, billed 99312. Based on the documentation, or lack thereof, the Respondent billed for treatment not substantiated by any documentation that he rendered same;

4) Date of Service: 3/3/04, billed 99312. The Respondent billed for treatment not substantiated by any documentation that he rendered same;

5) Date of Service: 3/10/04, billed 99312. Based on the documentation, or lack thereof, the Respondent should have billed 99311;

6) Date of Service: 3/17/04, billed 99312. The Respondent billed for treatment not substantiated by any documentation;

7) Date of Service: 3/24/04, billed 99312. Based upon the documentation, or lack thereof, the Respondent should have billed 99311.

C. Patient C at HCA Manor Care[10]

1) Date of Service: 3/26/04, billed 99313. The Respondent billed for treatment not substantiated by any documentation;

2) Date of Service: 4/2/04, billed 99312. The Respondent recorded that the patient's chief complaint was "heel pain." The Respondent failed to mention Diabetes Type 1 as a diagnosis. Based

10 The patient's primary diagnosis was diabetes mellitus, Type 1.

upon documentation, or lack thereof, the Respondent should have billed this as CPT code 99311;

3) Date of Service: 4/28/04, billed 99313. The Respondent recorded that the patient's chief complaint was for "heel pain". The Respondent failed to mention Diabetes Type 1 as a diagnosis. Based upon documentation, or lack thereof, the Respondent should have billed CPT Code 99311;

4) Date of Service 5/6/04; billed 99312-25 and 20050[11]. The Respondent should have billed a code 99311. Based upon documentation of lack thereof the Respondent should not have billed for an E&M visit of Code 99312-25, as he had made his diagnosis of heel pain on the previous visit.

D. Patient D at Mariner Glen Burnie[12]

1) Date of Service: 1/2/04, billed 99313[13]. Although the Respondent billed Medicare for service, documentation failed to mandate such a high level of billing;

2) Date of Service: 1/9/04, billed 99313. Although the Respondent billed Medicare, there is no documentation that he provided the service billed for;

11 20550- is an injection(s); single tendon sheath, or ligament, aponeurosis (eg. plantar fascia).
12 This patient's primary diagnosis was diabetes mellitus, Type 1, uncontrolled, with other manifestations.
13 The patient was also diagnosed with a decubitus ulcer, which is a bed sore or pressure sore.

3) Date of Service: 1/16/04, billed 99312. The Respondent failed to record a chief complaint and failed to note Diabetes Type 1 as a primary diagnosis. Based upon the documentation, or lack thereof, the Respondent should have billed CPT code 99311;

4) Date of Service: 1/23/04, billed 99312. The Respondent billed Medicare for service, but he failed to document that he provided any services;

5) Date of Service: 1/2/04, billed 99312. The Respondent billed Medicare for service, but he failed to document that he provided any services.

E. Patient E at Larkin Chase Nursing Home[14]

1) Date of Service: 1/7/04, billed 99313. Although the Respondent billed Medicare for service, he failed to document that he provided any services;

2) Date of Service: 1/14/04, billed 99313.[15] Although the Respondent billed Medicare for service, he failed to document that he provided any services;

3) Date of Service: 1/21/04, billed 99312. Although the Respondent billed Medicare for service, he failed to document that he provided any services;

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14 The patient's primary diagnosis was a decubitus ulcer.
15 The patient was also diagnosed with peripheral vascular disease (or PVD).

4) Date of Service: 1/28/04, billed 99313. The Respondent's notes lack an impression and plan. Based upon the documentation, or lack thereof, the Respondent should have billed CPT code 99311;

5) Date of Service: 2/4/04, billed 99312. The Respondent failed to record a chief complaint and his notes are illegible. The Respondent should have billed CPT code 99311;

6) Date of Service: 2/11/04, billed 99312. Although the Respondent billed Medicare for services rendered, no documentation was provided;

7) Date of Service: 3/12/04. The Respondent did not bill Medicare, but he failed to note a chief complaint, his writing was illegible, and the treatment plan was minimal.

F. Patient F at Larkin Chase[16]

1) Date of Service: 1/7/04, billed 99312. The Respondent billed Medicare for service, but failed to document that he provided that level of service;

2) Date of Service: 1/14/04, billed 99312. The Respondent billed Medicare for service, but failed to document that he provided that level of service;

16 The patient's primary diagnosis was decubitis ulcer.

3) Date of Service: 1/21/04, billed 99312. The Respondent billed Medicare for service, but failed to document that he provided that level of service;

4) Date of Service: 1/28/04, billed 99311. The Respondent billed Medicare for services for which he failed to document that he provided that level of service.

13. As set forth above, the Respondent violated the Consent Order, the terms of Probation, and the Act.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board finds that Respondent violated § 16-311 (10), (11), (12), (17), (18) and (27). The Respondent also violated Md. Health Gen. Code Ann. § 4-403 (b).

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 20 day of December, 2005, by a majority of a quorum of the Board,

ORDERED that, in addition to any requirements hereafter, the Consent Order of January 8, 2004 is incorporated herein and made a part hereof, especially the notification to and documentation to the Board of nursing homes where the Respondent provides services;

ORDERED that the Respondent's Probation is extended until January 8, 2007, subject to the following conditions:

1. The Respondent's mentoring requirement, including quarterly reports, shall be continued for one year, ending January 8, 2007;
2. Within nine months of this Consent Order, the Respondent shall provide documentation to the Board that he has taken and passed a Board-pre-approved course in Medicare billing, such as provided on trailblazers.com. Any problems in achieving this requirement in a timely fashion shall be directed immediately to the Board in writing;
3. Beginning 60 days from the date of this Consent Order, and for the duration of the Probationary period, the Respondent shall, on a monthly basis, submit to the Board 10 patient charts from one given week out of each month to include treatment notes, CMS/1500 claim forms, and the explanation of benefits returned by the insurance carrier;
4. Six months from the date of this Consent Order, the Respondent shall appear before the full Board to discuss the changes that he has initiated and incorporated into his practice in order to meet the Board's requirements for acceptable and accurate record-keeping and coding, as part of the Respondent' s action plan;
5. The Respondent shall be subject to re-audit;
6. The Respondent shall take and pass the Board's jurisprudence examination in January 2006.

ORDERED that the Consent Order is effective as of the date of its signing by the Board; and be it

ORDERED that, should the Board receive an unfavorable report regarding the Respondent for any violation of this Consent Order or of Probation, the Board may take immediate action against the Respondent, including automatic revocation of the Respondent's license, providing notice and an opportunity to be heard are provided to the Respondent in a reasonable time thereafter. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it

ORDERED that the Respondent shall practice in accordance with the laws and regulations governing the practice of podiatry in Maryland; and be it further

ORDERED that the Respondent may not petition for termination of his probationary status prior to six (6) months from the date of the Consent Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions of Probation, as it deems necessary;

ORDERED that for purposes of public disclosure, as permitted by Md. State Govt. Code Ann. §10-617(h) (2004 Repl. Vol.), this document consists of the contents of the

foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank that it is mandated to report to.

12/20/05

Ira M. Deming, D.P.M., President
State Board of Podiatric Medical Examiners

CONSENT OF LARRY BERNHARD, D.P.M.

I, Larry Bernhard, D.P.M., by affixing my signature hereto, acknowledge that:

1. I am represented by an attorney, William M. Ferris, and have been advised by him of the legal implication of signing this Consent Order.

2. I am aware that without my consent, my license to practice podiatry in this State cannot be limited except pursuant to the provisions of § 16-312 of the Act and the Administrative Procedure Act (APA) Md. State Govt. Code Ann. §10-201, et seq., (2004 Repl. Vol.).

3. I am aware that I am entitled to a formal evidentiary hearing before the Board.

By this Consent Order, I hereby consent and admit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in its entirety. By doing so, I waive my right to a formal hearing as set forth in § 16-313 of the Act and §10-201, et seq., of the APA, and any right to appeal as set forth in § 16-315 of the Act and §10-201, et seq., of the APA. I acknowledge that my failure to abide by the conditions set forth in this Order and following proper procedures, I may suffer disciplinary action, possibly including revocation, against my license to practice podiatry in the State of Maryland.

12/13/05
Date

Larry Bernhard, D.P.M.

STATE OF MARYLAND :

CITY/COUNTY OF QUEEN ANNE'S :

I HEREBY CERTIFY that on this 13th day of December, 2005, before me, William M. Ferris (Print Name) a Notary Public of the foregoing State and (City/County), personally appeared Larry Bernhard, D.P.M., License No. 00591, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Notary Public

My Commission Expires: 8/1/2008