IN THE MATTER OF	*	**BEFORE THE MARYLAND**	
BRENNA L. STEINBERG, D.P.M.	*	**STATE BOARD OF PODIATRIC**	
Respondent	*	**MEDICAL EXAMINERS**	
License Number: 01292	*	**Case Numbers:**	**2016-006**
			2016-015
	*		**2016-030**

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CONSENT ORDER

In or around September 2015, the Maryland State Board of Podiatric Medical Examiners (the "Board") opened an investigation of **BRENNA L. STEINBERG, D.P.M.** (the "Respondent"), License Number 01292. Based on its investigation, the Board determined that it has grounds to charge the Respondent with violating the Maryland Podiatry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 16-101 *et seq.* (2014 Repl. Vol.).

The pertinent provisions of the Act provide:

Health Occ. § 16-311. Denials, reprimands, probations, suspensions, and revocations – Grounds.

(a) *In general.* – 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 $50,000 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:

(9) Promotes the sale to a patient of... devices, appliances, or goods in a manner that exploits the patient for financial gain;

(16) Grossly overutilizes health care services; [and]

(17) Behaves… unprofessionally in the practice of podiatry[.]

Prior to the Board issuing disciplinary charges, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. LICENSING BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice podiatry in the State of Maryland. The Respondent was originally licensed to practice podiatry in Maryland on July 20, 1999, under License Number 01292. The Respondent's license is current through December 31, 2021.

2. At all times relevant, the Respondent was a part owner/operator of Frederick Foot and Ankle ("FFA") located at 141 Thomas Johnson Drive, Suite 170, Frederick, Maryland 21702.

II. COMPLAINTS

3. On or about September 17, 2015, the Board received a complaint from a patient ("Patient F"),[1] who alleged that between June 11, 2015 and July 27, 2015, she had five appointments with the Respondent during which the Respondent made multiple misdiagnoses and administered injections that may have caused nerve damage. After

[1] To ensure confidentiality and privacy, the names of individuals and facilities, other than the Respondent's, involved in this case are not disclosed in this document.

receiving the complaint, the Board initiated an investigation of the Respondent under Case Number 2016-006.

4. On or about December 3, 2015, the Board received a second complaint against the Respondent from a former employee ("Employee A"). Employee A alleged that while working as a medical assistant at FFA, she was often instructed by the Respondent to perform medical procedures such as administering cortisone injections and taking radiographs without supervision. Employee A further alleged that the Respondent routinely ordered Durable Medical Equipment ("DME") for patients based on insurance coverage and irrespective of the patient complaints. After receiving the complaint, the Board opened a second investigation of the Respondent under Case Number 2016-015.

5. On or about March 17, 2016, the Board received a third complaint against the Respondent from a podiatrist ("Podiatrist A") licensed in Maryland alleging overutilization of health care services and inappropriate care. After receiving the complaint, the Board opened a third investigation of the Respondent under Case Number 2016-030.

III. BOARD INVESTIGATION

6. In the course of investigating the three complaints against the Respondent, the Board interviewed witnesses, solicited written responses from the Respondent and subpoenaed twelve patient records from the Respondent. The Board submitted the twelve patient records to a podiatrist (the "Board Expert") licensed in Maryland for a practice review. After reviewing the twelve patient records, the Board Expert concluded that the Respondent: dispensed DME in a manner that exploited patients for financial

gains; grossly overutilized heath care services; and behaved unprofessionally in the practice of podiatry.

IV. PATIENT-SPECIFIC SUMMARIES

Patient A

7. Patient A, a female born in the 1940s, initially saw the Respondent on or about May 13, 2014, with complaints of medial left foot pain for the past seven to twelve months. After physical examination and diagnostic ultrasound, the Respondent diagnosed Patient A with pain in her limb, tenosynovitis and edema. The Respondent administered a cortisone injection with a low dye strapping and dispensed an air sport ankle brace.

8. On or about June 19, 2014, Patient A complained of left anterior ankle pain. The Respondent diagnosed Patient A with plantar fibromatosis after a diagnostic ultrasound. The Respondent dispensed custom orthotics, applied cortisone iontophoresis, performed therapeutic ultrasound and ordered magnetic resonance imaging ("MRI") of foot and ankle. The Respondent also applied Low Dye strapping despite having dispensed orthotics. The Board Expert concluded that the Respondent overutilized expensive imaging studies when proper physical examination would have been adequate. The MRI results found lack of evidence of posterior tibial tendon dysfunction ("PTTD") and suggested joint involvement of the first cuneiform navicular joint.

9. On or about July 3, 2014, the Respondent noted that she discussed MRI results with Patient A. In her written summary of care to the Board, dated December 1,

2016, the Respondent stated that she discussed the probability of neuritis with Patient A; however, the Board expert determined that she failed to document the subjective complaints or objective findings to support that diagnosis or rationale as to the etiology of the neuritis. The Respondent noted this was due to an electronic medical record error. The Respondent dispensed a transcutaneous electrical nerve stimulation ("TENS") unit to Patient A in response to her pain complaint.

10. Patient A returned on or about July 29, 2014 and reported improvement. The Respondent treated Patient A with therapeutic ultrasound, cortisone iontophoresis and strapping, and dispensed an accord ankle brace to support the posterior tendon. The Board's Expert concluded that the strapping and ankle brace were unnecessary given that Patient A was dispensed orthotics and the MRI showed no evidence of PTTD, although the MRI did show evidence of degenerative changes at the joint.

11. By September 9, 2014, Patient A reported much improvement and was able to walk with minimal pain. She returned the brace because she did not like it and continued using the TENS unit.

12. Patient A returned on or about September 10, 2015, with complaints of new pain on her bilateral tailor's bunions and right lateral ankle. Patient A stated that she injured her ankle in June and went to urgent care where a brace was ordered for her. She reported her pain as 6 out of 10. The Respondent administered cortisone injections to the tailor's bunions and dispensed a walking boot, even though Patient A had already received a brace previously. Patient A reported that the brace from urgent care was not helpful. The Respondent also took a radiograph and ordered an MRI.

13. Patient A returned on or about October 1, 2015, for a follow-up on the MRI results. The Respondent administered a cortisone injection to the right lateral ankle. The Board Expert determined that the Respondent unnecessarily dispensed a Game Day brace as Patient A already had received an ankle brace and a walking boot for the same complaint.

14. From on or about May 13, 2014, to October 29, 2015, Patient A saw the Respondent on twelve visits, during which she received diagnostic or therapeutic ultrasound during eleven of the visits, six cortisone injections, seven Low Dye straps and eight DMEs.

Patient B

15. Patient B, a female born in the 1940s, began seeing the Respondent on or about July 8, 2014, for ankle pain and diabetic foot care.

16. At the initial visit on or about July 8, 2014, Patient B presented with complaints of right ankle pain. The Respondent diagnosed Patient B with peroneal tendonitis, edema, hammertoes and callouses. The Respondent administered therapeutic ultrasound, applied Low Dye strapping and dispensed an ankle brace and diabetic shoes. The Board Expert determined that a peripheral arterial disease testing ("PAD Net") that the Respondent ordered was not generally used in podiatry and constituted overutilization of health care services.

17. An MRI on July 28, 2014, revealed a split tear of the peroneous brevis tendon as well as a calcaneal spur.

18. On or about August 22, 2014, the Respondent documented performing right peroneal brevis tendon repair and exostectomy of the cuboid bone. The exostosis of the cuboid was an incidental finding made intraoperatively and documented in the operative report.

19. The Board expert determined that, throughout Patient B's treatment, the Respondent billed under Current Procedural Terminology ("CPT") Code 99213 (Established Patient Office or Other Outpatient Services) when no charge visit was indicated because the visit occurred during a global period or was in combination with routine diabetic foot care.

Patient C

20. Patient C, a male born in the 2000s, saw the Respondent from 2004 to 2016 for issues concerning flat feet and ankle instability. The patient first presented at 3 years old for concerns of his parents related to flexible flat feet, right ankle turning in and frequently falling after running.

21. On April 2, 2015, the Respondent documented that Patient C presented with complaints of bilateral, lateral ankle pain. The Respondent dispensed bilateral Game Day braces and custom fitted Patient C for orthotics. The Respondent diagnosed Patient C with tibialis tendonitis and plantar fasciitis but the Board Expert determined that the Respondent failed to maintain detailed documentation of her findings and rationale.

22. Patient C saw the Respondent on or about December 3, 2015, with complaints of right lateral ankle pain after paying basketball. The Respondent diagnosed

Patient C with plantar fibromatosis, which the Board Expert determined to be inadequately supported by documentation. After examination, the Respondent dispensed a CAM walker and referred Patient C for physical therapy. The physical therapy notes support that imaging showed growth plate damage.

23. Patient C returned on or about December 23, 2015, for a follow-up visit. He reported improvement with physical therapy. The Respondent ordered therapeutic ultrasound and applied Low Dye strapping. The Respondent dispensed an accord ankle brace but the Board expert determined that she failed to document the necessity for dispensing another type of ankle brace. By January 26, 2016, the patient reported no pain and was discharged from physical therapy.

Patient D

24. Patient D, a female born in the 1950s, saw the Respondent from 2007 to 2016 for general diabetic foot and various conditions including but not limited to PTTD left, DM, ulcer hallux left, neuroma 2nd IS right and left, ingrown nail 3rd and 2nd left, neuroma 3rd IS right and left, ulcer hallux 3rd toe left, hammer toe, bilateral ankle pain, edema, RSD, plantar fasciitis, partial tear of the posterior tibial tendon, partial tear of Achilles' tendon, fractured 2nd metatarsal, arthritis in the tarsal, cellulitis, ingrown nail 3rd left, medial hallux right and sinus tarsi neuritis. The Respondent initially saw Patient D on or about January 16, 2007, for diabetic foot care, left ankle pain and heel spurs. She reported a history of reflex sympathetic dystrophy on the right side of her body and left leg. Pulses were noted as 1+/4, bilaterally with edema present. She was provided diabetic shoes and educated on diabetes.

25. On September 16, 2010, the Respondent treated Patient D for diabetic foot care, ulcer debridement and dressing to the left hallux and ingrown toenail excision to the left third digit. The Board Expert determined that the PAD Net the Respondent provided on this visit was not generally used in podiatry and constituted overutilization of health care services.

26. On or about September 30, 2010, Patient D returned to the Respondent for a follow up visit. The Respondent administered a nerve block to address neuromas and casted Patient D for a Richie type brace for her ankle pain.

27. On or about October 7, 2010, the Respondent treated Patient D's 2nd interspace bilateral neuroma with sclerotherapy. The Respondent provided Patient D with Low Dye strapping under the diagnosis of fasciitis.

28. Over the approximately five- and one-half-year period, from September 16, 2010 until February 18, 2016, the Respondent ordered for Patient D the following:

Date	Location
9/16/10	Padnet
10/7/10	Ritchie Brace
12/20/10	DM shoes
2/8/11	Casted for Ritchie Brace Right Ankle, Ankle foot orthosis (L1920) and addition to lower extremity orthosis (L2820)
8/8/11	Cam walker R and Even up L
11/21/11	Static ankle foot orthosis L4396 night splint
1/25/12	DM shoes 3 inserts
3/12/12	Nerve biopsy
6/14/12	Cast for Arizona Brace bilaterally
7/5/12	PO shoe
4/2/13	DM shoes 3 inserts
5/14/13	PO shoe for IN surgery
12/16/13	Cast for Moore Balance Brace
9/10/15	podus boot

2/18/16	DM shoe and inserts

29. The Board Expert determined that the Respondent inappropriately administered cortisone injections to Patient D. The Board Expert determined that repeated injections facilitated the breakdown of cross-links between collagen fibers increasing the risk for ligamentous, tendinous and capsular rupture. The MRI report for Patient D confirmed a "tear of the anterior talo-fibula ligament." Dr. Steinberg noted she did not administer more than 4 injections to any area in any given year. On or about July 5, 2012, the Respondent appropriately prescribed Bactrim for a MRSA infection of a diabetic foot ulcer.

Patient E

30. Patient E, a male born in the 1970s, initially saw the Respondent on or about February 3, 2016, with complaints of a swollen left foot and left posterior heel pain after a plane ride. The Respondent took bilateral radiographs despite Patient E complaining of left foot pain. The Board Expert determined that Respondent diagnosed Patient E with posterior calcaneal bursitis and Achilles tendonitis but billed Patient E under the diagnosis of plantar fasciitis. The Respondent administered a cortisone injection to the left posterior calcaneal bursa, along with therapeutic ultrasound and Low Dye strapping. The Respondent recommended bilateral air heel and night splint, which Patient E initially declined.

31. Patient E returned on or about February 17, 2016, for a follow up visit. The Respondent noted that Patient E reported reduced pain with the air heel and night splint.

The Respondent took a diagnostic ultrasound, which showed decreased inflammation. The Respondent administered iontophoresis, cortisone patch and therapeutic ultrasound, applied strapping and scanned Patient E for custom orthotics. Patient E received the orthotics on or about March 24, 2016, which were billed under the diagnostic code for plantar fibromatosis, documented by physical exam findings on February 17, 2016.

Patient F

32. Patient F, a female born in the 1970s, saw the Respondent on three occasions on or about June 11, 2015, June 15, 2015, and June 29, 2015, with complaints of pain to her "right big toe."

33. Patient F returned on or about June 15, 2015, for a follow-up visit with the Respondent. The Respondent added other diagnoses such as joint ankle pain and plantar fibromatosis, which the Board Expert determined were unrelated to Patient F's chief complaint and not supported by clinical findings. The Respondent dispensed bilateral air heel, which the Board Expert determined was not indicated. The Respondent also ordered an MRI and DEXA scan, which according to the Board Expert was excessive, unnecessary and did not support the Respondent's documented diagnoses. The MRI revealed bone bruise.

34. Patient F saw the Respondent again on or about June 29, 2015. The Respondent took radiographs and documented a stress fracture of the right foot with no mention of which bone. The Board expert determined a review of the radiographs failed to exhibit any sign of stress fracture.

Patient G

35. Patient G, a female born in the 1980s, saw the Respondent on or about March 23, 2016 with complaints of pain to her left heel and possible flare up of previous left Lisfranc injury and new plantar fasciitis. At this initial visit, Patient G described the symptoms as pain of six out of ten to the left midfoot dorsal and plantar areas. On physical examination, the Respondent noted pain on palpation to the left heel and dorsal midfoot as well as the medial tubercle of the calcaneus and along the fascial band on the left. The Respondent performed a diagnostic ultrasound, took bilateral radiographs, administered a cortisone injection, applied Low Dye strapping, dispensed a CAM foot walker and ordered an MRI.

36. The Board Expert determined that the Respondent unnecessarily ordered bilateral radiographs when Patient G only complained of left foot pain. The Respondent utilized ultrasound guidance to administer the cortisone injection but there was no needle displayed in the ultrasound image. However, the Respondent did include a description of the needle in her notes.

Patient H

37. Patient H, a female born in the 1940s, saw the Respondent five times between on or about June 15, 2015 and August 20, 2015, for a fractured right toe. At her initial visit, on or about June 15, 2015, Patient H reported being seen at a local emergency department after dropping a table on her right hallux. The Respondent took radiographs, which she documented as showing a fracture. On physical examination, the

Respondent found Patient H's right first nail plate as partially attached. The Respondent removed the right toenail and dispensed a CAM walker.

38. Patient H returned on or about June 18, 25 and 29, 2015, and August 20, 2015, for monitoring of bone healing. For four of the five total visits, the Respondent ordered repeat radiographs, which the Board Expert determined were excessive and unnecessary. Moreover, the Board Expert determined that none of the sets of x-rays demonstrated the fracture.

Patient I

39. Patient I, a female born in the 1960s, saw the Respondent three times between September 24, 2015 and November 12, 2015, for bilateral heel pain. At the initial visit on September 24, 2015, Patient I reported bilateral heel pain for the past eight months. The Respondent performed a physical examination and diagnostic ultrasound. The Respondent diagnosed Patient I with plantar fasciitis and possible neuroma, even though the Board Expert determined there were no subjective or objective findings for neuroma and under the Review of Symptoms neuroma was documented as "denied." The Respondent recommended cortisone injection, which Patient I declined. Instead, the Respondent prescribed Lidoderm patches. The Respondent ordered bilateral foot and ankle MRIs to evaluate plantar fasciitis, tarsal tunnel and neuroma. An MRI on October 6, 2015, revealed plantar fasciitis and a neuroma at the second interspace.

40. Patient I returned on October 8, 2015, for a follow up visit and reported a pain level on that date of two out of ten. Despite the improvement on that date, the Board Expert determined that the Respondent excessively and unnecessarily dispensed the

following DMEs: heel cups, right CAM walker, right CAM walker socks and right surgical shoe.

41. Patient I returned on November 12, 2015 and reported bilateral heel and continued neuroma pain. The Respondent noted that there was a neuroma finding on the MRI and administered a cortisone injection to the right 2nd interspace. The Respondent also performed therapeutic ultrasound, Low Dye strapping and dispensed bilateral night splints.

Patient J

42. Patient J, a male born in the 1960s, initially saw the Respondent in June 2014. The Respondent billed Patient J for an orthotic device and an initial office visit with a date of June 5, 2014. However, the first patient record for Patient J received from the Respondent is dated June 23, 2014.[2]

43. On or about June 23, 2014, Patient J returned to the Respondent with complaints of a possible ingrown toenail to the right great toe. The Respondent performed a purported nail unit biopsy from the left third toe with "sharp, sterile clippers," and sent a sample of the nail to the laboratory for KOH testing. The Respondent also performed a permanent partial nail removal to the medial border of the right first toenail. The Respondent billed Patient J for "Nail Unit Biopsy," a surgical procedure, when she performed a clipping of nail for KOH testing.

[2] In her written summary of care to the Board, dated November 22, 2016, the Respondent also noted that the first date of service was June 23, 2014, not June 5, 2014.

44. On July 3, 2014, the patient presented with infection of the nail and Keflex was appropriately prescribed.

45. Patient J returned on July 17, 2014, for an ingrown toenail recheck of the right hallux. As part of the care plan the Respondent documented that she 1) discussed that the nail can be trimmed back or it can be removed along one side, or the total nail can be removed permanently or temporarily and 2) discussed with Patient J the benefits of custom orthotics as functional control devices.

46. On or about June 2, 2015, Patient J complained of an ingrown toenail on his left big toe and right heel pain. After a physical examination, the Respondent diagnosed Patient J with hypertrophic nails, an abscess on the left first toe, and plantar fasciitis. The Respondent billed Patient J for an office visit (99213)[3], low dye strapping and a cortisone injection. The Respondent also billed Patient J for drainage of skin abscess. The treatment is documented as an incision and drainage of multiple abscesses or complicated; however, only the great toenail of the right foot is described as being addressed in the medical record. The Board Expert determined that the Respondent inappropriately billed under CPT 10061 when she should have billed under CPT 10060. The Respondent further billed Patient J for an airheel and a night splint, which according to the Board Expert was unnecessary overutilization given that it was an initial visit for heel pain and the symptoms had only been present for seven to ten days. The Board Expert also determined that the Respondent overutilized expensive unnecessary

[3] The Board Expert determined that the Respondent should have billed for 99212 instead of 99213. Patient J was also seen by the Respondent on or about January 26, 2016, at which time, the Respondent billed Patient J for 99213 instead of 99212.

procedures including, but not limited to: ultrasound guided injection and ultrasound therapy.

47. Patient J returned on or about June 23, 2015, for a "check-up." Patient J reported a pain level of four out of ten for his right heel and one out of ten for his left total nail removal. The Respondent diagnosed Patient J with acute plantar fibromatosis, tenosynovitis foot and ankle and edema. The treatment provided included ultrasound, strapping of the right ankle, electric current therapy and ultrasound therapy.

48. Patient J returned on or about September 29, 2015, for a follow-up after his "PRP to [his] right heel." Patient J described a 70% improvement and less constant pain. Patient J reported that he had been wearing his cam walker and heel cups. The Respondent diagnosed Patient J with acute plantar fasciitis and administered strapping of the right ankle, ultrasound non-vascular, electric current therapy and ultrasound therapy.

49. Patient J returned on or about October 14, 2015, with complaints that his right heel did not "feel much better." Patient J reported a pain level of three out of ten. The treatment the Respondent provided included strapping of the right ankle, electric current therapy, ultrasound therapy, AFO ankle gauntlet and a second airheel. The Board Expert determined that Patient J was already dispensed a cam walker on September 18, 2015, and an airheel on June 2, 2015.

50. On or about November 11, 2015 and December 23, 2015, Patient J reported a pain level of two out of ten for his right heel. The treatment the Respondent administered included strapping of the ankle, ultrasound, electric current therapy and ultrasound therapy.

51. On or about January 14, 2016, Patient J complained of excruciating right medial heel pain. His pain was so severe he could not eat. Patient J reported experiencing burning, but denied experiencing numbness, tingling, and tremors. A physical exam of Patient J revealed there was "no evidence of posterior tibial, superficial peroneal, or sural nerve pathology." The Respondent appropriately did not test for percussion of the tibial nerve due to the severity of the patient's pain. The Respondent diagnosed Patient J with other specified mononeuropathies of right lower limb and appropriately referred the patient for a neurology consult. The consult revealed possible right tarsal tunnel syndrome.

Patient K

52. Patient K, a female born in the 1950s, initially saw the Respondent on or about January 16, 2009, with complaints of bilateral foot pain. She was an obese patient with multiple complaints. Throughout the Respondent's seven-year treatment of Patient K, the Respondent diagnosed Patient K with midfoot pain, ankle pain, medial ankle pain, lateral ankle pain, plantar fasciitis, first MTP joint pain, sinus tarsi pain, and tenosynovitis.

53. Over the seven-year period, from August 5, 2009 until October 26, 2016, the Respondent administered multiple cortisone injections to Patient K on at least twenty-five (25) occasions of which twenty-three (23) injections were to the ankle/sinus tarsi:

Date	Location
8/5/2009	right ankle
3/25/2010	lateral right ankle
4/13/2010	bilateral ankles on the lateral sides
9/2/2015	bilateral sinus tarsi with ultrasound guidance

9/17/2015	medial right ankle joint and the sinus tarsi in the right foot with ultrasound guidance[4]
9/23/2015	medial ankle bilaterally
9/30/2015	Right medial ankle with ultrasound guidance
10/7/2015	bilateral lateral ankles with ultrasound guidance
10/14/2015	right medial ankle with ultrasound guidance
2/3/2016	left heel with ultrasound guidance
2/17/2016	right first MPJ
2/24/2016	first right MTP
3/2/2016	left heel
3/9/2016	first right MTP joint
3/23/2016	right MTP joint
4/20/2016	Right lateral ankle with ultrasound guidance
5/4/2016	lateral right ankle
5/18/2016	Right anterior CF ligament
6/1/2016	left sinus tarsi joint[5]
6/29/2016	left lateral ankle
8/15/2016	right sinus tarsi
8/31/2016	sinus tarsi bilaterally
9/14/2016	sinus tarsi bilaterally and right first MPJ
10/13/2016	Right lateral ankle
10/26/2016	Right lateral ankle

54. During the seven-year period from January 16, 2009 until June 1, 2016, the Respondent dispensed at least fourteen (14) different DME products to Patient K, including but not limited to the following:

[4] In her written summary of care to the Board, dated December 5, 2016, the Respondent noted that during this visit she discussed the MRI results with Patient K which "revealed a tear of the ATFL, a calcaneal spur, edema around the lateral malleolus and a cyst of the anterior aspect of the navicular." A review of the MRI Final Report also revealed that all of the tendons were normal as well as the sinus tarsi and deltoid ligament, and there was "no significant joint effusion." The Board Expert determined that the Respondent, despite noting the tear to the ATFL, continued to inject cortisone to this area. The Respondent also injected cortisone to the sinus tarsi despite the MRI noting the sinus tarsi was normal. The Board Expert determined that the Respondent failed to provide a rationale in the chart to address this.

[5] The Respondent documented in the office procedure's section of Patient K's chart that cortisone injections were administered to the bilateral sinus tarsi joints. The ultrasound images however only reveal cortisone was injected to the left sinus tarsi joint.

Date	DME Product
1/16/2009	Removable foot inserts (L3000)[6]
3/25/2010	over the counter AFO (L1906)
4/13/2010	orthotic (L3000), fiberglass casting material (A4590), unlisted casting procedure (29799)
4/29/2010	bilateral braces (L1906x2)
5/27/2010	over the counter arches (S003)
6/11/2010	custom orthotics
10/18/2011	custom orthotics
7/29/2013	custom orthotics
7/30/2013	Richie braces (L1970, L2340, L2820)
9/2/2015	bilateral prefabricated PTTD braces (L1906)
10/7/2015	Bilateral Moore Balance Braces (L1940, L2330, L2820)
2/3/2016	Left CAM walker[7] (L4361)
3/23/2016	carbon fiber inserts (L2360)
6/1/2016	TENS unit dispensed

55. On or about March 25, 2010, and April 29, 2010, the Respondent documented dispensing the exact same appliances (L1906) to the same side 16 days apart.

56. The Board Expert determined that the Respondent unnecessarily ordered and billed for at least three DMEs in a row (9/2/15, 10/7/15 and 2/3/16) that had similar function, and Patient K was not able to wear any of them.

57. On or about September 2, 2015, the Respondent ordered an MRI of the right ankle to check for a "tendon, ligament tears or other bony pathology not seen on radiography or ultrasound." The resulting report showed normal sinus tarsi with marked thickening of the plantar fascia. All tendons and deltoid ligaments were normal. The

[6] In her written summary of care to the Board, dated December 5, 2016, the Respondent noted that Patient K "self-reported success in the past with custom orthotics but was not ready to try them again." The Respondent, however, billed Patient K for removable foot inserts (L3000).

[7] The Respondent noted that Patient K reported that she was not using her Moore Balance Braces.

Respondent proceeded to subsequently administer injection to the medial ankle and sinus tarsi, despite a normal finding on the MRI. The Board Expert determined that the Respondent also failed to consider and document the finding of partial tear of the ATF ligament and proceeded to administer injection to the calcaneofibular ligament, which according to the Board Expert increased the probability of rupture to that ligament and lateral instability. Patient K had previously had eleven cortisone injections to the "lateral right ankle" over a period of seven years.

58. The Board Expert determined that on or about May 4, 2016, and September 14, 2016, the Respondent unnecessarily ordered two additional MRI studies, which were performed on May 10, 2016, and September 26, 2016.

Patient L

59. Patient L, a male born in the 1940s, sought treatment from November 2014 to August 2016. Patient L initially saw the Respondent on August 12, 2015, with complaints of right ankle pain. For approximately the next year, from August 2015 to August 2016, Patient L saw the Respondent on multiple visits per month for conditions including but not limited to, right and left ankle pain, ingrown toenails and Achilles pain.

60. The Board Expert determined that during Patient L's treatment period, the Respondent overutilized dispensing of DMEs that were excessive and unnecessary. For example, on September 9, 2015, the Respondent dispensed bilateral Moore balance brace to Patient L. Moreover, the Respondent's rationale for dispensing the brace was based on her assessment that Patient L tested high on the Fall Risk Assessment, even though Patient L denied unsteady gait in the review of system. The Board Expert determined

that, instead of fabricating expensive custom braces, inexpensive over-the-counter devices would have sufficed. Throughout the one-year treatment period, taken collectively, the Respondent dispensed the following DMEs that, on the whole, was determined by the Board Expert to be excessive: TENS (8/12/15), left night splint (10/29/15), CAM walker (12/1/15), left Air Heel (2/3/16), Tall CAM walker (2/23/16), left CAM walker sock (3/1/16), bilateral heel cups (5/10/16) and PTTD brace (6/22/16).

61. The Board Expert determined that, over the span of approximately one year, the Respondent overutilized diagnostic services. During this treatment period, the Respondent routinely took radiographs and performed ultrasound for diagnostic purposes. Despite these diagnostic tools, the Respondent ordered three MRIs of the left ankle, on December 1, 2015; March 1, 2016; and, May 10, 2016, which the Board Expert determined were excessive and unnecessary.

62. Additionally, the Respondent also ordered PAD Net on September 17, 2015, which the Board Expert determined was not indicated and unnecessary.

63. Finally, the Board Expert determined that the Respondent overutilized cortisone injections. The Respondent administered the following injections, which the Board Expert determined, on the whole, were excessive: right lateral ankle (8/12/15), right sinus tarsi (9/2/15), bilateral sinus tarsi (9/17/15), bilateral sinus tarsi (10/1/15), left medial ankle (12/1/15), left lateral ankle and Achilles (2/23/16).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's conduct, as described above, constitutes violations of the Act as cited above, specifically:

> The Respondent's actions, as described above, constitute: promoting the sale to a patient of devices, appliances, or goods in a manner that exploits the patient for financial gains, in violation of Health Occ. § 16-311(a)(9); grossly overutilizing health care services, in violation of Health Occ. § 16-311(a)(16); and behaving unprofessionally in the practice of podiatry, in violation of Health Occ. § 16-311(a)(17).

ORDER

It is, on the affirmative vote of a majority of the Board, hereby:

ORDERED that the Respondent is placed on **PROBATION** for **ONE (1) YEAR** to commence on the date of this Consent Order. The Respondent shall comply with the following terms and conditions:

A. Within three years of the date of this Consent Order, the Respondent shall make an anonymous donation in the amount of **$50,000 (FIFTY-THOUSAND DOLLARS)** to the American Podiatric Medical Association (APMA) Foundation Scholarship Fund;

B. Within thirty (30) calendar days from the date of this Consent Order, the Respondent shall submit the name and professional credentials of a podiatrist licensed in Maryland for Board approval to serve as Supervisor for her practice of podiatry. The Supervisor shall not be associated with the Respondent through any current or past personal, collegial, professional or academic affiliation. The Respondent shall provide the Supervisor with a copy of this Consent Order, and any other document the Board deems relevant to her case. The Respondent understands and agrees that the Board may terminate any Supervisor and require that another Supervisor be designated. In the event that the

Board requires another Supervisor be designated, the Respondent will have 30 days to submit the name and credentials of a new Supervisor to the Board;

C. The Respondent shall ensure that the Supervisor notifies the Board (in writing, within ten (10) days of the Board's approval) of his/her acceptance of the supervisory role;

D. The Supervisor shall meet with the Respondent in person at least once a month for a period of three years for random chart review and discussion. At these meetings, the Supervisor shall choose a random sample of podiatric charts of at least ten (10) active cases to review. The Supervisor shall review the charts to determine the Respondent's compliance with quality of care, appropriate utilization of health care services and record keeping standards. In addition, the Supervisor shall discuss the cases with the Respondent to evaluate the Respondent's understanding of the conditions she is treating and her compliance with quality of care, appropriate utilization of health care services and record keeping standards;

E. The Supervisor shall submit quarterly written reports to the Board, which shall include but not be limited to the number and type of cases reviewed, podiatric issues discussed and his/her assessment of the Respondent's understanding of the conditions she is treating and her compliance with standards of care, appropriate utilization of health care services and record keeping standards. The Board and the Respondent will use the agreed upon format for the written reports submitted by the Supervisor;

F. The Respondent is solely responsible for ensuring that the Supervisor submits the required quarterly reports to the Board in a timely manner;

G. The Board has sole authority to implement any changes in the supervision and retains all authority to approve any changes in the supervision;

H. In the event that the Supervisor discontinues supervising the Respondent for any reason, the Respondent shall immediately notify the Board and submit a replacement candidate to serve as her Supervisor under the terms specified above, including that

the Respondent will submit the name of a new Supervisor within 30 days;

I. For a period of three years from the date of the Consent Order, the Board may, in its sole discretion, conduct random chart reviews and billing audits. The chart reviews and billing audits must be for dates of service **after** the date of this Consent Order;

J. Within sixty (60) days of the date of this Consent Order, the Respondent shall submit a course syllabus for in-person or online tutorial courses on the following topics: four (4) credit hours on podiatric billing practices and four (4) credit hours on professional ethics, for Board approval. Within six (6) months of the date of this Consent Order, the Respondent shall enroll in and successfully complete the Board-approved courses. The Respondent is solely responsible for promptly providing to the Board verification of her successful completion of the courses upon their completion. Credit received from these mandated courses under this provision may not be applied toward the continuing education requirements of license renewal;

K. For a period of three years from the date of the Consent Order, the Respondent shall promptly notify the Board of any changes in employment or professional affiliations;

L. The Respondent shall provide a copy of this Consent Order to any of her employers and professional affiliations[8]; and

M. The Respondent shall comply with the Maryland Podiatry Act and all laws, statutes and regulations pertaining to the practice of podiatry in Maryland.

AND IT IS FURTHER ORDERED that, after the conclusion of the **ONE (1) YEAR** probationary period, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation

[8] In this order, "professional affiliations" means any employer, organization, association, or other entity that provides podiatric medical services where the Respondent serves in a professional capacity, whether paid or unpaid, such as entities where the Respondent holds hospital or ASC privileges.

may be terminated through an order of the Board. The Respondent may be required to appear before the Board or a committee of the Board to discuss her petition for termination. The Board shall grant the petition to terminate the probation if the Respondent has complied with all of the terms and conditions and there are no pending complaints of similar violation; and it is further

ORDERED that if the Board determines, after notice and an opportunity for an evidentiary hearing before the Board that there is a genuine dispute as to a material fact, or a show cause hearing before the Board if there is no genuine dispute as to a material fact, that the Respondent has failed to comply with any terms or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, impose a civil monetary fine upon the Respondent, or suspend or revoke the Respondent's license to practice podiatry in Maryland; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that, unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board Chair; and is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

Jan 17/2020
Date

Yvonne U. Umezurike, D.P.M.
Board President
Maryland State Board of Podiatric Medical Examiners

CONSENT

I, Brenna Steinberg, D.P.M., acknowledge that I had the opportunity to be represented by and consult with counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

1/16/2020
Date

Brenna Steinberg, D.P.M.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF FREDERICK

I HEREBY CERTIFY that on this 16 day of JANUARY _____, 2020, before me, a Notary Public of the foregoing State and City/County personally appeared Brenna Steinberg, D.P.M., and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: December 28. 2021