BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MARIA S. POSADAS, M.D.** Holder of License No. 35890 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-19-0241A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 3, 2020. Maria S. Posadas, M.D. ("Respondent"), appeared with legal counsel, Andrew Barbour, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 35890 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-19-0241A after receiving notification from a Clinic where Respondent was employed, alleging that Respondent failed to maintain adequate records, and failed to timely complete records. Board staff selected eight of Respondent's patients for quality of care review, and deficiencies were identified in six of the charts reviewed relating to the Respondent's documentation.

Patient MG

4. A review of Respondent care and treatment for Patient MG identified deficiencies as follows: MG provided a pre-visit blood draw on January 28, 2019 and Respondent saw the patient on January 31, 2019. Respondent's note does not include

documentation of a discussion regarding MG's lab work. A result letter was sent to the patient dated for January 30, 2019 with results. The letter states "discuss at f/u" without any further explanation of the test results provided.

Patient RK

5. A review of Respondent's records for Patient RK identified deficiencies such as the following: Respondent saw RK on August 3, 2017 for a follow-up visit regarding his diabetes. A letter titled "Result Letter to Patient" dated for August 4 2017 contains no explanation of the results to the patient other than "a1c 6.8".

Patient GF

6. A review of Respondent's records for patient GF identified deficiencies such as duplicated review of systems, and a lack of documented conversation and/or plan of care.

Patient KP

7. A review of Respondent's records for Patient KP identified deficiencies such as the following: A record for a visit dated January 29, 2018 lacks information identifying a plan of care or discussion with a patient regarding the plan of care. A record for a visit on February 14, 2018 also lacks documentation for a plan of care or discussion with a patient for a plan of care. Additionally, the record has two electronic signatures for February 16 and February 21, 2018 without documentation of amendments to the medical record. The documentation of history and review of symptoms is identical between the records dated for January 29, 2018 and February 14, 2018.

Patient HS

8. A review of Respondent's records for Patient HS identified deficiencies such as the following: The record for a visit dated December 20, 2017 does not have

documentation of conversation of plan with patient or results of previous testing from September 2017. Respondent's record for a visit dated July 24, 2018, contains a line through the assessment portion of the record and date stamps for July 25, 2018, July 26, 2018 and July 31, 2018 indicating several changes in the record. Records dated for January 29, 2019, identifies a plan of care, but does not include discussion regarding that plan with the patient. In the same record, there are lines through duplicate documentation and the systolic portion of blood pressure is not recorded. Additionally, the same record has two signatures by Respondent for January 29, 2019 at 2:14 PM and again on January 31, 2019 at 1:31 PM.

Patient PB

9. A review of Respondent's records for Patient PB identified deficiencies such as the following: The records dated for January 5, 2015, August 6, 2015, February 6, 2016, and February 9, 2016 contain identical wording for the review of symptoms and patient information as follows: "I have noted the review of systems as filled out on the patient's questionnaire and have discussed this with the patient and found as negative except those that are mentioned in the History of Present Illness." Additionally, most of Respondent's documentation regarding PB lacks documentation of any discussion with the patient regarding the plan of care.

10. During the course of the Board's investigation, Respondent failed to timely respond to Board staff's requests and failed to timely update her contact information with the Board, resulting in delay to the Board's investigation.

11. During a Formal Interview on this matter, Respondent testified her recordkeeping for the above referenced patients. With regard to Patient GF, a Board member asked Respondent about what appeared to be duplicated review of symptoms information in multiple visits. Respondent testified that patients came to the clinic and

filled out a questionnaire, and that as long as it was noted that the questionnaire was reviewed, the duplicated information would be considered appropriate. Respondent acknowledged that some notes were missing documentation indicating that she discussed plans of care with patients, and stated that she planned on incorporating this information into future notes.

12. Additionally during the Formal Interview, Respondent testified regarding strike through notes in Patient HS's record. She stated that those were the result of third parties such as Clinic coders or compliance staff recommending changes. However, a Board member noted that there is no indication regarding the basis for these changes. A Board member asked Respondent about a written statement she provided during the investigation indicating that her notes did not do justice to the intensive discussions that occurred with patients during visits. Respondent stated that she would not be able to completely document her visits and maintain patient volume, and discussed changes to her practice such as retaining a scribe for future visits.

13. Respondent also testified regarding records from the Clinic indicating that Respondent had repeated instances of unsigned notes, as well as late or incomplete documentation. Respondent testified that she lacked support from the Clinic for efforts to improve processes that would assist her in more timely completing patient charts. Respondent testified regarding corrective action plans for Respondent that were in her Clinic file. Respondent testified that she had difficulty reaching the Board investigator and she could not adequately explain the reason for delay in updating her address. Board staff noted information in the file regarding the investigator's attempts to contact her and request an address update.

14. During that same Formal Interview, Board members commented that the record contained evidence that Respondent was offered assistance by the Clinic on

multiple occasions to improve timeliness and completeness of her documentation. Additionally, Board members commented that it appeared that Respondent did not take adequate responsibility for the pattern of recordkeeping deficiencies.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(a) ("Violating any federal or state laws or rules and regulations applicable to the practice of medicine."). Specifically, Respondent's conduct violated A.R.S. § 32-1435(A) ("Each active licensee shall promptly and in writing inform the board of the licensee's current residence address, office address and telephone number and of each change in residence address, office address or telephone number that may later occur.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(ee) ("Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.
2. Respondent is placed on Probation for a period of six months with the following terms and conditions:

a. **<u>Continuing Medical Education ("CME")</u>**

Respondent shall within six months of the effective date of this Order obtain no less than 10 hours of Board staff pre-approved Category I CME in an intensive, in-person course regarding medical recordkeeping. Respondent shall within thirty days of the effective date of this Order submit her request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for license renewal. The Probation shall terminate upon Respondent's proof of successful completion of the CME coursework.

b. **<u>Obey All Laws</u>**

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s).

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 6th day of August, 2020.

ARIZONA MEDICAL BOARD

By [signature]
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 6th day of August, 2020 to:

Maria S. Posadas, M.D.
Address of Record

Andrew Barbour, Esq.
Munger Chadwick, PLC
333 North Wilmont, Suite 300
Tucson, Arizona 85711
Attorney for Respondent

ORIGINAL of the foregoing filed
this 6th day of August, 2020 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Robles
Board staff