VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: ZELDA WEST-JOHNSON, M.D.
License No.: 0101-057120

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Zelda West-Johnson, M.D., on May 14, 2014, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Kevin O'Connor, M.D., Chair; Lorri Kleine, Esq.; and Ray Tuck, Jr., D.C. Dr. West-Johnson appeared personally and was represented by legal counsel, Gerald Canaan, Esquire, and Meredith Brebner, Esquire. Julia Bennett, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions. The purpose of the informal conference was to inquire into allegations that Dr. West-Johnson may have violated certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated February 26, 2014.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law:

1. Zelda West-Johnson, M.D., was issued license number 0101-057120 by the Board to practice medicine and surgery in the Commonwealth of Virginia on January 28, 1998. Said license is currently active and will expire on July 31, 2014, unless renewed or restricted.
2. Dr. West-Johnson violated Section 54.1-2915.A(3), (12), (16), and (18) of the Code, and 18 VAC 85-20-26.C of the Board’s General Regulations, in that, from approximately 2006 to November 2013, she maintained and operated her Richmond, Virginia office in such an unsanitary, chaotic, and disorganized state, including (without limitation) her filing system for patient records and documentation within such records, that her practice constituted a danger to the health and welfare of patients and the public. Specifically:

a. Dr. West-Johnson maintained her office in an unsafe and non-hygienic manner, as evidenced by information provided by her former office manager, Patient A, and investigators/auditors from the Department of Health Professions (“DHP”) and an insurance program with which she participated. Specifically:

i. An unannounced office inspection by DHP Investigators on July 9, 2013 revealed the following deficiencies (all of which are documented with photographs): a freezer located in Dr. West-Johnson’s employee staff lounge contained both frozen employee food and frozen medical specimens, specimen tubes, and specimen transport bags; three closed boxes and one open box of biohazardous waste material were located in a storage room, along with used patient gowns, broken furniture, an open full sharps container, and closed full sharps containers; no chlorox wipes or other cleaning/disinfecting materials were found in exam rooms 2, 3, 4, or 5; exam room #5 lacked hot water; an expired sterile collection swab was found in exam room #3; there was no hand soap in exam room #2; triage/exam room #1 was dirty and cluttered with boxes, papers, urine kits, blood draw tubes, and other medical supplies; multiple expired (opened and unopened) sterile packets containing surgical instruments were
found in the surgical supplies drawer in triage/exam room #1 (with expiration dates going back to 2006 and 2008); specimen collection supplies in triage/exam room #1 included sterile water that expired on June 1, 2010; triage/exam room #1 had a full sharps container sitting on the window sill and an unlocked medication drawer with medications in it, including an open multi-dose vial of cyanocobalamin and a bottle of lidocaine; the billing office contained multiple boxes of vaccinations that had expired on December 5, 2011; the autoclave located in the electrical closet was not in use; multiple boxes of Lipitor samples expired as of February 2013 were found in Dr. West-Johnson’s medication sample room; and multiple expired medications were found in two refrigerators located in the office manager’s room, including two pre-filled 5 ml influenza virus vaccine syringes (expired on June 30, 2013), boxes of Byetta Exanadide injections pens (two expired in December 2013 and one expired in March 2013), two Novolog prefilled insulin flex pens (expired in February 2013), a Humalog (insulin) kwik pen (expired in December 2011), ten pouches of Trichomonas vaginitis tests (expired on June 30, 2012), a prefilled Le vemir flex pin (expired April 2013), Novolog flex pen insulin injections (one expired in November 2012 and two expired in December 2012), 10 ml Novolog insulin injections (three expired in June 2013 and two expired in April 2013), a 100 Sun Dex Glucose Tolerance beverage (expired on July 19, 2012), and an Esyde 50 x Glucose Tolerance beverage (expired on July 19, 2012.)

ii. On-site quality review visits performed on April 10 and 11, 2013, by auditors from a Medicaid insurance plan provider in which Dr. West-Johnson participated, revealed the following deficiencies: examination rooms were dirty; triage/exam room
1, including the examination table, was cluttered with numerous boxes, unfiled papers, urine kits, and expired blood draw tubes (as evidenced by photographs taken on April 11, 2013); exam room #3 had expired blood draw tubes; numerous boxes and bags with biohazardous waste material were maintained in a storage room; an epi-pen expired in 2012 was found; and no process for checking or disposing of expired medications was in place or being followed.

iii. Dr. West-Johnson’s office manager reports that she maintained vials containing old blood drawn from patients within her stock of unused blood draw tubes; exam rooms were not wiped down nor was the paper on examination tables changed in between patients; hazardous waste accumulated over the course of several months was not properly and promptly disposed of but instead was stored in a “junk area” of the office (that also contained patient and insurance records), as evidenced by a photograph taken by Dr. West-Johnson’s former office manger on March 21, 2013; two refrigerators and a freezer containing medicines, vaccines, injectibles, patient samples, and other medical supplies were not consistently maintained at temperatures required by Virginia Department of Health guidelines; and Dr. West-Johnson maintained expired vaccines, medications, solutions, and other medical supplies in her office, including sterilized, bagged instruments with expiration dates going back to 2004, expired EKG and ICG leads, and expired blood tubes and needles (as evidenced by photographs of these items taken by Dr. West-Johnson’s former office manager on March 21, 2013 and April 15, 2013).
iv. By Dr. West-Johnson’s own admission, biohazardous waste material was not picked up and removed from her office from approximately February 2013 until July 11, 2013 (a few days after her office was inspected by DHP Investigators). Instead, those materials accumulated in Dr. West-Johnson’s office storage room. Dr. West-Johnson reported that the waste management company with whom she had a contract did not pick up her biohazardous waste during that interim because her account with them became past due in October 2012.

b. Dr. West-Johnson’s filing system for patient medical records was/is so chaotic, and in such a state of general disarray as to make it extremely difficult, if not virtually impossible, for her or her staff to consistently and timely locate specific patient records, as evidenced by the following:

i. Patient records are located throughout Dr. West-Johnson’s office in many different places with no unified or logical system for determining where specific records are filed or how they can be found. For example, inspections of Dr. West-Johnson’s office by DHP Investigators and insurance auditors on July 9, 2013 and April 10-11, 2013, respectively, photographs taken by Dr. West-Johnson’s former office manager, and interviews with Dr. West-Johnson and her staff revealed that patient charts and medical information needing to be filed in patient charts can be found:

- In multiple filing cabinets located in the front desk/reception area;
- In disorganized clutter on a table in the employee staff lounge;
- In boxes in the office storage room (where many months worth of biohazardous waste was also stored);
- Stacked in piles in the patient check-out window in the front desk/receptionist area and on and underneath the desk at the check-out window (some in boxes and some not);
• In multiple accordion redwells on tables in the front receptionist area and in a bag underneath those tables;
• In shelving next to a small desk that Dr. West-Johnson maintains in the front receptionist area where she performs/reviews patient billing, with files and loose billing data arranged in monthly piles (going back for over a year) on these shelves;
• In stacks located below Dr. West-Johnson’s billing desk and on her billing desk (some in boxes and some not);
• On the floor in boxes in front of the daily plastic bins located in the front desk/reception area;
• Scattered throughout the billing office on shelves, in boxes stacked on top of each other, in piles on the floor, in and under the desk, and on top of the shelving;
• In filing cabinets and boxes located in the hallway;
• In boxes on top of the shredder machine in the hallway;
• In Dr. West-Johnson’s office/samples room; and
• On multiple shelves and other surface areas in the office manager’s room.

ii. By West-Johnson’s own admission, she often takes patient records home, and some files for her Richmond office patients are located in another practice in Petersburg that she owns (but where she does not actively practice). Dr. West-Johnson does not have a reliable system for her or her Richmond office staff to know which records are located at her home or at the Petersburg office.

iii. Dr. West-Johnson’s filing system co-mingles active and inactive files.

iv. At various locations throughout Dr. West-Johnson’s office, she maintains “temporary” charts consisting of loose papers/documentation containing patient medical information, usually held together by a paperclip or binder clip (sometimes on a clipboard). These temporary charts are created when the corresponding patient records cannot be located.
v. Dr. West-Johnson’s patient records are not consistently filed alphabetically (or in any other logical and accessible manner), as was observed by a DHP Investigator during inspection of the premises on July 9, 2013. In addition, this inadequate filing system resulted in Dr. West-Johnson’s failure to respond in a timely fashion to multiple written requests for records of deceased Patient B made on or about April 19, 2012 and May 16, 2012 (and thereafter) by a life insurance company on behalf of the patient’s beneficiary. Although Dr. West-Johnson acknowledged that these patient records were properly requested by an individual/entity legally entitled to receive them, she failed to provide them within the statutorily-mandated 15 days and instead did not send these records until on or about July 31, 2012, after she had been contacted by a DHP Investigator regarding a complaint filed with respect to this matter. Dr. West-Johnson explained that this delay was caused by her inability to locate the requested records, which were not found until an intensive search of her office revealed that the patient record had been misfiled under Patient B’s first, rather than last, name.

vi. In February 2013, an insurance company with which Dr. West-Johnson participated requested that she provide 15-20 patient records for their review, a request that was reiterated during an on-site visit by insurance program auditors on April 10-11, 2013; however, neither Dr. West-Johnson nor her staff was able to locate any of these requested records. Further, when the insurance auditors requested fifty additional patient records on April 10, 2013, Dr. West-Johnson was only able to produce 21 of them. Moreover, when the insurance auditor requested 9-10 randomly selected patient records on April 11, 2013, one of Dr. West-Johnson’s office staff
informed the auditor that eight of the charts requested were located in the Petersburg office (though these were patients at Dr. West-Johnson’s Richmond office).

vii. During an inspection of Dr. West-Johnson’s office on July 9, 2013 by DHP Investigators, Dr. West-Johnson (or her staff) was unable to produce six of the records that were requested.

c. Dr. West-Johnson failed to maintain timely, accurate, complete, and legible documentation within her patient records, including with respect to Patients C-R. Examples of Dr. West-Johnson’s deficient and chaotic medical recordkeeping include the following:

i. Patient medical information is routinely filed in the wrong patient chart and patient charts are inappropriately co-mingled. Moreover, Dr. West-Johnson recycles paper taken from old, allegedly inactive, patient charts, for use as copying and faxing paper, for use as superbills, and also as a source of paper on which to document information in her active patient charts. This practice results in medical information from one patient being filed in the medical records of other patients (see, e.g., the medical records of Patients E, F, G, J, and L), a practice that is confusing and also conducive to the release of patients’ confidential and protected health information to other patients or individuals to whom such “recycled” medical documentation is not legally disclosable.

ii. Due to repeated computer crashes of Dr. West-Johnson’s electronic medical recordkeeping system on/in June 2012, October 21, 2012, and January 31, 2013, she has lost all medical data recorded electronically in patient charts (including billing/insurance information) from approximately June 2012 to January 2013. Dr.
West-Johnson indicated to a DHP Investigator that she is attempting to recreate this lost data from old superbills, her Reason for Visit flowsheets, appointment logs, and memory.

iii. By Dr. West-Johnson’s own admission, before any patient record is released pursuant to a bona fide release/request, she reviews the record to make sure the appropriate documentation is “recreated” (if it is missing due to the computer crashes) and to determine if the record otherwise needs anything else to be “fixed.” This process often is not completed in a timely fashion, resulting in delayed responses to record requests, as shown in Dr. West-Johnson’s untimely response to record requests for Patients G (records requested on November 26, 2012, but not provided until March 16, 2013) and Patient I (records requested on August 21, 2012, but not provided until October 2, 2012).

iv. Dr. West-Johnson has frequently failed to document any progress notes with respect to patient visits. By her own admission, there have been periods of time when she failed to complete “formal” office progress notes, and instead documented patient medical information on the face of superbills or on the Reason for Visit flowsheet/log. Moreover, information that Dr. West-Johnson has documented on superbills is often illegible due to the fact that it is written on top of preprinted information, see, e.g., records for Patients C, D, E, F, and H.

v. When documented, Dr. West-Johnson’s patient progress notes often fail to include necessary information, such as the patient’s chief complaint and history of
present illness; review of systems; examinations, evaluations, and assessments;
diagnoses; treatment plan; and/or prescribed medications.

vi. Dr. West-Johnson’s patient records are often incomplete in that information that
should be filed in individual patient charts is unfiled and located in looseleaf form in
many different places throughout her office.

d. Dr. West-Johnson has failed to implement or maintain office procedures and practices
that ensure timely review and notification to her patients of laboratory, radiology, and other
testing results and medical information received, thereby causing or creating an unnecessary
delay in evaluation, diagnosis, treatment, and follow-up. Further, Dr. West-Johnson
frequently failed to make (or document) timely patient referrals to specialists when indicated
by such testing results/information or, when such referrals were made, to timely follow-up
with respect thereto. Specifically:

i. Lab, radiology, and other similar reports dating back for several years (as far
back as 2002) routinely are not filed in patient charts, often because these charts cannot
be located. Instead, these reports are filed looseleaf in multiple accordion redwell
folders maintained in no apparent order in Dr. West-Johnson’s front office area.
According to Dr. West-Johnson’s staff, medical reports and information on individuals
whom she has never treated are also co-mingled with the unfiled lab/radiology reports
maintained in these front office redwells.

ii. Dr. West-Johnson failed to timely review and appropriately respond to
laboratory and other test results, including those reporting abnormal values, for
Patient P, a 50-year-old male for whom she was the primary health care provider
("PCP") from 2006 until the patient's death from AIDS on July 11, 2008. Specifically:

- Dr. West-Johnson (and/or or her office staff) failed to notify Patient P of and to discuss with him multiple abnormal laboratory results obtained from blood collected on August 30, 2006 for more than two months, when the patient returned for an office visit on November 6, 2006.

- Although Dr. West-Johnson informed a DHP Investigator that she was concerned at Patient P's November 6, 2006 office visit that he might have cancer, she made no documentation to this effect in her progress note and instead noted a gastroenterologist referral. However, Dr. West-Johnson did not actually sign the form for such a GI referral until December 20, 2006, more than a 1½ months after it was documented as being ordered.

- At Patient P's office visit on January 5, 2007, Dr. West-Johnson informed the patient of the abnormal results of his abdominal ultrasound performed on December 28, 2006 and signed a referral for the patient to be seen by a hepatologist for liver disease evaluation; however, Dr. West-Johnson's staff failed to fax this referral to MCV until February 6, 2007, more than a month after she had made and signed the referral.

- Although Dr. West-Johnson signed a prescription dated March 8, 2007 ordering a colonoscopy for Patient P based on a diagnosis of heme + stool, a referral/consult form to VCU for this was not signed and faxed until July 25, 2007, a delay of over four months. Further, Dr. West-Johnson failed to follow up when she did not receive a copy of this colonoscopy report; had Dr. West-
Johnson done so, she would have learned that such testing (which was performed on August 21, 2007) revealed lymphocyte depletion indicative of possible immunocompromise.

- Although Dr. West-Johnson documented in a progress note for a November 19, 2007 visit that Patient P saw a gastroenterologist for Celiac disease and had a biopsy done that was inconclusive, she failed to request or obtain this or any other information/documentation from said gastroenterologist; had she done so, she would have been aware that the biopsy indicated no evidence of Celiac disease.

- On or about November 19, 2007, Dr. West-Johnson ordered bloodwork, to include a CBC with differential and iron panel, for Patient P. Although these results contained numerous abnormalities, Dr. West-Johnson failed to review this laboratory report until July 21, 2008, at which time she noted that these labs should be repeated. Patient P was not informed of these results and the need to schedule repeat labs until he was notified by mail on September 25, 2008 to contact Dr. West-Johnson’s office; however, the patient had died from AIDS, more than 2 ½ months earlier on July 11, 2008.

- On January 15, 2008, a physician employed in Dr. West-Johnson’s practice ordered urinalysis and bloodwork for Patient P. Although these lab results were completed the next day and revealed multiple abnormalities, neither the ordering physician (who left Dr. West-Johnson’s employment at the end of January 2008), Dr. West-Johnson, nor her staff reviewed these
results until July 21, 2008, at which time she noted on the lab reports to schedule an abdominal ultrasound, advise the patient to quit drinking, and to repeat the labs in three months. Patient P, however, was not informed of these results and the need to schedule repeat labs until he was notified by mail on September 25, 2008, approximately 2 1/2 months after he had expired.

- On or about June 3, 2008, Dr. West-Johnson’s office received faxed hospital documentation from MCV concerning Patient P’s May 25-30, 2008 admission there. Although this documentation indicated Patient P had been newly diagnosed with HIV during that admission and indicated that an appointment had been made for the patient with Dr. West-Johnson on June 10, 2008, she failed to follow up with the patient regarding this information. Instead, Dr. West-Johnson’s office inexplicably faxed an urgent request to MCV on June 3, 2008 requesting copies of MRI and colonoscopy reports for tests performed on Patient P in 2007, results that were not present in Dr. West-Johnson’s file for Patient P.

iii. With respect to Patient N, a female in her 60’s with multiple medical problems whom Dr. West-Johnson treated as her PCP from approximately 2002 to 2008:

- Dr. West-Johnson failed to review a lab report from October 23, 2007 asking her to resubmit a specimen for testing for H. pylori (since no specimen had accompanied the test submitted for Patient N on October 15, 2007), until June 6, 2008, over seven months after such request had been made. At that time, Dr. West-Johnson (or one of her staff) noted the need to send Patient N to
Labcorp for this test; however, the patient was not notified of this until June 18, 2008 (by mail). The test, performed on July 2, 2008, was positive for H. pylori; however, Dr. West-Johnson did not address this result with Patient N until July 29, 2008 (almost nine months after the H. pylori test was initially ordered), at which time she called in several prescriptions to treat this condition.

- On May 9, 2008, the day after Dr. West-Johnson refused to see Patient N for follow-up subsequent to an emergency room visit (due to her alleged outstanding account balance), Dr. West-Johnson requested from the ER a copy of abdominal CT scans taken during the patient’s May 2, 2008 visit there. Although these scans revealed abnormal, subpleural 7 mm nodules in the patient’s right lower lobe and recommended further CT evaluation of the thorax, Dr. West-Johnson waited almost a month, until June 6, 2008, to schedule a thorax CT scan for Patient N on July 2, 2008. Further, Dr. West-Johnson did not inform the patient of this appointment until mailing her notice thereof on June 18, 2008.

- Dr. West-Johnson failed to inform Patient N of the results of her July 2, 2008 CT thorax scan (which revealed small lung nodules) until July 28, 2008, at which time she also informed Patient N, among other things, that she would need to undergo this test again, with contrast, on August 21, 2008. According to Patient N, she made numerous phone calls to Dr. West-Johnson’s office to learn the results of the August 21, 2008 CT scan, but no one returned her calls.
Consequently, she made an appointment with Dr. West-Johnson to address the CT results on October 3, 2008.

- According to Patient N, at her October 3, 2008 office visit, Dr. West-Johnson could not find the CT report in her file (or anywhere else in her office) and had to ask the hospital to re-fax the report to her while Patient N waited. After receiving the CT report from the hospital (now almost 43 days since the CT was performed), Dr. West-Johnson informed Patient N that this scan again showed 4 small pleural based nodules and referred her to a pulmonologist (with an appointment scheduled for October 13, 2008).

iv. With respect to Patient O, the minor teenage daughter of Patient N, whom Dr. West-Johnson treated as her PCP from 2004 to 2008:

- On April 28, 2006, Dr. West-Johnson’s nurse practitioner reviewed abnormal results for Patient O from a PAP smear performed on April 24, 2006 (which indicated atypical squamous cells of undetermined significance) and documented the need to follow up with another PAP smear in 4-6 months. Although Dr. West-Johnson’s Reason for Office Visit flow sheet indicates that Patient O subsequently presented to the office on two occasions within approximately 4-6 months of the abnormal April 24, 2006 PAP smear, i.e., on August 23, 2006 and December 20, 2006 (though no progress notes are documented for either of these encounters), a PAP smear was not performed or ordered on either of these occasions.
• Another PAP smear was not performed until Patient O’s next annual gynecological examination on May 4, 2007, at which time Dr. West-Johnson’s progress note documented (incorrectly) that Patient O’s prior PAP smear from April 2006 was normal. The results from Patient O’s May 4, 2007 PAP smear (reported to Dr. West-Johnson’s office on May 17, 2007) indicated continued abnormality, i.e., high-grade squamous intraepithelial lesions and moderate dysplasia and suggested a colposcopy and biopsy.

• Although Dr. West-Johnson asserts that she (or her nurse practitioner or other staff) notified Patient O of her abnormal results in a timely fashion after both the April 24, 2006 and May 4, 2007 PAP smear reports were received, both Patient O and her mother (Patient N) state that these results were not communicated to them until a follow-up visit on August 6, 2007, at which time Dr. West-Johnson referred Patient O to a gynecologist for follow-up (over 15 months from when abnormal squamous cells were first detected in this patient).

v. With respect to Patient Q, a 46-year-old female whom Dr. West-Johnson treated from approximately November 2012 to June 2013:

• Although Dr. West-Johnson informed a DHP Investigator that referrals of Patient Q to VCU’s rheumatology department documented in her notes for January 29, 2013 and February 6 and 26, 2013 (made in connection with her diagnosis of lupus) had been transmitted telephonically and a follow-up call was made by her office to VCU rheumatology on April 2, 2013, there is no written documentation in Patient Q’s file confirming that such telephonic
referrals or follow-up were made. Further, Patient Q informed a DHP Investigator that, sometime after April 2, 2013, when one of Dr. West-Johnson's medical assistants called her to suggest that she try making an appointment with VCU rheumatology directly, she went in person to VCU to do so and was told that they had never received a referral from Dr. West-Johnson's office for her.

- When the DHP Investigator made further inquiries concerning these rheumatology referrals, Dr. West-Johnson produced additional documentation that had not previously been included in the patient file provided to the investigator, i.e., a fax dated April 24, 2013 from VCU requesting that Dr. West-Johnson complete their attached "Cover Sheet Request For Consult Or Referral" form (which Dr. West-Johnson completed and faxed back to VCU on April 25, 2013). However, this faxed referral cover sheet also has handwritten notations on it indicating that it was re-faxed to VCU on May 9, 2013 and "0 appt. yet" on June 4, 2013, notwithstanding the fact that Dr. West-Johnson was informed on or about April 26, 2013 that Patient Q would not be accepted by VCU as a rheumatology referral (see next bullet). Further, this fax form has additional notations on August 6, 2013 stating "awaiting call back from nurse" and on August 13, 2013 stating "due to rheumatology appt. schedule being full this dept. is not taking new pt. at this time with this dx."

- Patient Q's medical records from VCU contain a letter dated April 26, 2013, from a VCU rheumatologist to Dr. West-Johnson declining to accept her referral
of Patient Q due to a lengthy backlog of patients, noting that her referral did not provide enough information to determine whether the patient would benefit from rheumatology services since the positive ANA ratio of 1:80 Dr. West-Johnson reported (based on Patient Q’s January 29, 2013 labwork) was “a very nonspecific result and can be seen in 10-20% of normal healthy people.” Dr. West-Johnson’s medical record for Patient Q, however, contains no copy of this letter from VCU.

• Dr. West-Johnson informed a DHP Investigator that Patient Q told her (at a June 4, 2013 visit) that she had been hospitalized for depression on May 25, 2103 and was seen in the ER 2-3 weeks previously for a pulmonary embolus, but never mentioned to Dr. West-Johnson any attempted suicide or her misdiagnosis of lupus. However, hospital records in Dr. West-Johnson’s file for Patient Q (with a print-out date of June 4, 2013) documented her hospital admission from May 13 - 24, 2013 for a suicide attempt by overdose, noted a new diagnosis of chronic pulmonary embolus made during her stay, and indicated that hospital work-up determined Patient Q did not have lupus.

v. Other patients with respect to whom Dr. West-Johnson provided untimely notification of lab results or other medical information include the following:

• Although Dr. West-Johnson ordered lab work for Patient I on October 18, 2012, the lab requisition form in the patient’s file has the handwritten notation “Find Lab”; however, these lab results are not contained in Patient I’s chart.
• Patient L was not notified of abnormal lab results obtained on or about May 21, 2007 until February 8, 2008.

• Abnormal results from a specimen for Patient M reported by the lab to Dr. West-Johnson’s office on September 15, 2006 were not addressed with Patient M until February 2, 2007, at which time Dr. West-Johnson prescribed antibiotics for the condition indicated.

• Patient R was not notified of abnormal laboratory results reported to Dr. West-Johnson’s office on or about September 9, 2011 until December 16, 2011.

3. Dr. West-Johnson reported that some of the pictures of the medical record files taken by DHP Investigators during their July 9, 2013 inspection were actually “inactive” records and were in stacks to be purged or shredded. Dr. West-Johnson informed the Committee that her electronic medical record (“EMR”) is now up and running and that new computer equipment was actually being installed the day the DHP Investigators came to the office. She states that she also purchased a new Dragon dictation system which has made it easier for her to document when she sees patients.

4. Dr. West-Johnson reported to the Committee that she has recreated the medical records that were lost during the computer crashes of her EMR in 2012-2013 by accessing paper billing information (e.g., superbills) going as far back as June 2012 (approximately nine months before the last crash) for over two hundred patients.

5. Dr. West-Johnson explained that she stopped “recycling” old patient paper records for new patient records once the Board notice was received in February 2014. At the time she engaged in this practice, she thought it was a good way to save on paper. Dr. West-Johnson now realizes that this was inappropriate and a potential HIPAA violation.
6. In discussing her care of Patient P, Dr. West-Johnson stated that she felt her total office system for notifying this patient failed. She explained that she found it difficult to manage Patient P’s care due to his many health issues, the complications of the Virginia Coordinated Care (“VCC”) referral system, and the multiple physicians who were involved in the patient’s care. Dr. West-Johnson also stated that she did not get copies of certain reports, e.g., a colonoscopy performed on Patient P in August 2007, even though she requested them from VCC. These issues have been rectified by new VCC program implementations, and Dr. West-Johnson stated that she will now directly call physicians to get needed information/reports. Additionally, she has taken measures to ensure that requests for labs and other reports are documented, while before they may not have always been documented even when requests may have been made.

7. Another new process that Dr. West-Johnson reports she has implemented is that she has interfaced with two labs so her process of notifying patients of lab results is now more accurate and timely.

8. Dr. West-Johnson stated that the allegations regarding Patient N are essentially true, and as stated previously, she has implemented a new process for lab results.

9. Regarding her care of Patient O, Dr. West-Johnson says that there is documentation the patient was notified of her abnormal PAP smear results from April 2006, even though Patient O and her mother (Patient N) deny this. Dr. West-Johnson has no explanation for why Patient O’s PAP smear was not repeated at one of her follow-up office visits within six months of the abnormal PAP results from April 2006, as per her nurse practitioner’s documented plan. A follow-up PAP smear for Patient O was performed approximately a year later (on or about May 4, 2007).
10. Dr. West-Johnson disagreed with the allegation that she failed to document multiple referrals of Patient Q to VCU rheumatology, explaining that the relevant documentation was in a different folder. Dr. West-Johnson also stated that, although a dismissal letter was prepared for Patient Q, it was never signed or mailed.


a. Dr. West-Johnson prescribed Patient G #90 Percocet 5/325 from October 4, 2012 to November 30 2012 for his reported neck and lower back pain subsequent to a motor vehicle accident that occurred on October 2, 2012. However, during that interim, she failed to obtain x-rays or other diagnostic studies of Patient G’s neck and/or back to determine if any fractures were present or to otherwise determine the etiology of the patient’s ongoing pain.

b. Although Dr. West-Johnson ordered and Patient G submitted to urine drug screens (“UDS”) performed on October 5, 2012, November 9, 2012, and November 19, 2012, she took no appropriate responsive action when each of these drug screens produced results that were inconsistent with medications prescribed to Patient G. Specifically:

i. A UDS performed on Patient G on October 5, 2012 was negative for all drugs tested, including benzodiazepines, opiates and oxycodone; however, Patient G had been prescribed diazepam 5 mg, bid, #12, and Percocet 5/325, qid, #12 at the emergency room on October 2, 2012 (which he filled on October 3, 2012) and Dr. West-Johnson had just prescribed Patient G #30 Percocet 5/325 on October 4, 2012 (which he filled on the date written).
ii. A UDS performed on Patient G on November 9, 2012 was positive for unspecified opiates and acetaminophen; however, Patient G should have been out of the Percocet that Dr. West-Johnson had last prescribed him on October 4, 2012 for almost six days (if he took the medication as it was prescribed).

iii. A UDS performed on Patient G on November 19, 2012 was negative for all drugs tested, including opiates and oxycodone; however, Patient G filled (on November 10, 2012) a prescription for a 30-day supply of Percocet that Dr. West-Johnson had written him on November 9, 2012.

c. Despite the evidence of possible medication misuse/abuse presented by the foregoing inconsistent UDS results, Dr. West-Johnson nevertheless provided Patient G with a prescription for Percocet on November 30, 2012, ten days earlier than the date on which such prescription should have been renewed if Patient G was taking the Percocet as she had prescribed it to him.

d. Patient G returned to Dr. West-Johnson’s practice on May 29, 2013 after a six-month hiatus. However, Dr. West-Johnson did not obtain an updated history or inquire regarding Patient G’s medical treatment during that interim. Instead, Dr. West-Johnson prescribed Patient G #120 oxycodone (5 mg), to be taken as frequently as 12/day, without performing or documenting any physical examination, review of systems, history of symptoms, assessment, or any other relevant information that might shed light on her diagnosis of abdominal pain--generalized. Further, although Dr. West-Johnson noted that this visit was a follow-up from a hospitalization, there is no documentation regarding that hospitalization (including the reason therefor or the treatment rendered therein), nor are there any corresponding hospital
records located in Patient G’s record.

e. At Patient G’s next office visit on June 25, 2013, the only information Dr. West-Johnson documented is that the patient complained of right hip pain and that he had an ongoing prescription for oxycodone 5 mg, 1-3 qid, #120 for severe pain (along with the patient’s vitals). It is impossible from this note to know exactly what was wrong with the patient, what symptoms and history of illness/injury he reported, physical exam findings, and/or Dr. West-Johnson’s treatment plan, since no such information is documented.

12. Dr. West-Johnson considered Patient G to be an acute pain patient, not a chronic pain patient. Dr. West-Johnson stated to the Committee that she ordered a C-spine x-ray for Patient G at his October 4, 2012 visit; however, the patient did not follow-up and get the x-ray. Dr. West-Johnson pointed out that she referred Patient G for physical therapy, which the patient did follow through on.

13. Dr. West-Johnson explained to the Committee that any motor vehicle accident patient, such as Patient G, has a separate chart. Consequently, Patient G, who was already an established patient at the time of his accident, had another chart. Dr. West-Johnson stated it was a staff mistake that only Patient G’s motor vehicle accident chart was provided to the DHP Investigator. Dr. West-Johnson elaborated that Patient G was seen at a time when many medical records were lost, which is why her staff made this mistake.

14. Dr. West-Johnson stated she did not check the PMP the first time she prescribed Percocet to Patient B, but did check the PMP at his next appointment. Additionally, Dr. West-Johnson stated she believed Patient G when he reported he had lost medications prescribed to him at the emergency room a few days before his October 4, 2012 office visit since his UDS came back negative and he seemed to be in a lot of pain. The second in-office UDS screen for Patient G on
November 9, 2012 was negative for any controlled substances (as would be expected since the patient should have been out of narcotics), so Dr. West-Johnson felt comfortable issuing another prescription; however, the out-of-office confirmatory laboratory UDS was positive for opiates when it came back a few days later.

15. Dr. West-Johnson violated Section 54.1-2915.A(3), (12), (16), and (18) of the Code, and 18 VAC 85-20-26.C of the Board’s General Regulations, in that:

a. A review by a third-party certified medical coder of 21 patient records obtained from Dr. West-Johnson’s office on or about April 11, 2013 pursuant to an insurance company audit revealed that only five out of the 21 records (24%) were coded and documented correctly for billing purposes, citing (among other things) deficiencies for no or inadequately documented histories of physical illness, review of systems, and physical examinations, as well as dates of service and patient names in the medical records that did not match the information on the claims submitted. Subsequently, on or about April 19, 2013, Dr. West-Johnson’s contract with this insurance provider was terminated based on her continued unacceptable practice of balance billing Medicaid patients for covered insurance services for which she had been denied payment due to untimely claims filing.

b. By Dr. West-Johnson’s own admission, she has been attempting to recreate billing information from June 2012 to January 2013 that was lost due to computer crashes based on her review of superbills, treatment visit logs, and information in patients’ paper records; however, Dr. West-Johnson acknowledges that this process has been slow and has prevented her from timely submitting many insurance claims and resulted in confusion over amounts payable by patients, including her office staff asking patients for co-payments that they have
already paid or which they do not owe under their insurance coverage.

16. Dr. West-Johnson stated staff issues and turnover presented chaos and problems in her office; however, Dr. West-Johnson now has three temporary agencies on call in case of any last minute staff changes or absences. Dr. West-Johnson also provided photographs of the corrective actions she has taken in the cleanup of her office.

17. Dr. West-Johnson retained Yevonne J. Childers, MBS, FACMPE, of Medical Management Consulting, which is a consulting firm that offers medical management consulting. At the conclusion of her consultation on May 6, 2014, during which Ms. Childers reviewed the office, billings, and organizational and overall practice management issues, she reported the office was operating smoothly and in good order, including the condition of examination rooms, staff areas, office areas, the patient waiting area, and the front desk. Ms. Childers also reported that Shred-it and Wastes Management were picking up protected health information and red-bag biohazardous waste material, respectively, on a regular basis. Dr. West-Johnson reports that she is in the process of contracting for on-going consultation with Ms. Childers for the future review of her office practice.

18. Dr. West-Johnson stated that she cares for her patients, loves her job and profession, and wants to be able to continue to help her patients. She feels she is a good physician and will continue to improve.

**ORDER**

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is ORDERED that the license of Zelda West-Johnson, M.D., is placed on INDEFINITE PROBATION subject to the following TERMS and CONDITIONS:
1. Within thirty (30) days from entry of this Order, Dr. West-Johnson shall present evidence satisfactory to the Board that she has executed a contract for ongoing practice management consultation services with a Board-approved medical management consultant, which services shall include oversight and consultation regarding billing procedures, office procedures, medical recordkeeping, and communication with patients and other providers. Dr. West-Johnson shall ensure that the Board-approved medical management consultant provides the Board with quarterly reports concerning Dr. West-Johnson's status in each of the foregoing areas, as well as the overall state of her office and medical practices, procedures, and protocols. Dr. West-Johnson shall provide a copy of this Order to the Board-approved consultant at or before the execution of said contract. For purposes of this requirement, Yevonne J. Childers, MBS, FACMPE, of Medical Management Consulting, shall be considered approved by the Board.

2. Within sixty (60) days of entry of this Order, Dr. West-Johnson shall sign an authorization providing for unrestricted communication between the Board and the foregoing practice management consultant. Dr. West-Johnson shall be responsible for all costs associated with this management consultant contract and reports required to be filed with the Board by the consultant pursuant to this Order.

3. Within sixty (60) days from entry of this Order, Dr. West-Johnson shall provide the Board with a written statement certifying that she has read and will comply with:
   a. the laws governing the practice of medicine and other healing arts (Title 54.1, Chapter 29 of the Code);
   b. the Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, and Chiropractic (18 VAC 85-20-10 et seq);
c. the Drug Laws for Practitioners; and


4. Within twelve (12) months from entry of this Order, Dr. West-Johnson shall submit evidence satisfactory to the Board verifying that she has completed at least twelve (12) hours of Board-approved continuing medical education ("CME") in each of the following subjects:

   a. proper prescribing of controlled substances and chronic pain management;

   b. medical recordkeeping;

   c. billing and coding;

   d. professionalism and ethics; and

   e. general medicine.

Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal, or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board’s continuing education requirements for license renewal.

5. Within twelve months from entry of this Order, Dr. West-Johnson’s practice shall be the subject of an unannounced inspection by an inspector/investigator of DHP. Such inspection shall be conducted during normal business hours and shall include a review and photographs of all areas of Dr. West-Johnson’s office (including, without limitation, examination/triage rooms, medical equipment, supply closets, administrative/billing offices, front desk/reception area, medication sample storage areas, medical recordkeeping files, biohazardous waste disposal receptacles, refrigerators, etc.), and may include interviews with Dr. West-Johnson and/or her staff. Further, the
DHP inspector/investigator shall obtain from Dr. West-Johnson a copy of her complete medical and billing records for not less than twenty (20) randomly selected patients who have been treated/seen by Dr. West-Johnson subsequent to entry of this Order for review by the Board. Dr. West-Johnson shall be responsible for the cost of such inspection.

6. Upon the Board’s receipt of evidence that Dr. Johnson has complied with all of the foregoing terms and conditions, the Committee authorizes the Executive Director to terminate the indefinite probation imposed hereunder and close this matter or refer it to a special conference committee for review.

Dr. West-Johnson shall maintain a course of conduct in her practice of medicine commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Violation of this Order may constitute grounds for suspension or revocation of Dr. West-Johnson’s license. In the event that Dr. West-Johnson violates this Order, an administrative proceeding may be convened to determine whether such action is warranted.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Dr. West-Johnson may, not later than 5:00 p.m., on June 23, 2014, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.
Therefore, this Order shall become final on June 23, 2014, unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

[Signature]
William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

Entered: 5/21/14