BEFORE THE ARIZONA STATE BOARD OF BEHAVIORAL HEALTH EXAMINERS

In the Matter of: **Arline M. Lemeshewsky, LCSW-3634,** **Licensed Clinical Social Worker,** **In the State of Arizona.** **RESPONDENT**	**CASE NO. 2011-0009** **RELEASE FROM** **CONSENT AGREEMENT AND ORDER**

The Board received a request from Respondent to release her from the terms and conditions of the Consent Agreement and Order dated September 13, 2013. After consideration, the Board voted to release Respondent from the terms and conditions of the Consent Agreement and Order dated September 13, 2013.

ORDER

GOOD CAUSE APPEARING, IT IS THEREFORE ORDERED THAT:

Respondent is hereby released from all terms and conditions of the Consent Agreement and Order dated September 13, 2013.

Dated this 10th day of March, 2016.

By: Tobi Zavala
TOBI ZAVALA, Executive Director
Arizona Board of Behavioral Health Examiners

ORIGINAL of the foregoing filed
This 10th day of March, 2016, with:

Arizona Board of Behavioral Health Examiners
3443 N. Central Ave., Suite 1700
Phoenix, AZ 85012

COPY of the foregoing mailed via
Certified mail no. 70142870000189575624,
This 10th day of March, 2016, to:

Arline M. Lemeshewsky
Address of Record
Respondent

COPY of the foregoing mailed via Mail
This 10th day of March, 2016 to:

Larry Cohen
P.O. Box 10056
Phoenix, AZ 85064
Attorney for Respondent

BEFORE THE ARIZONA BOARD

OF BEHAVIORAL HEALTH EXAMINERS

In the Matter of: **ARLINE M. LEMESHEWSKY, LCSW-3634, Licensed Clinical Social Worker,** **In the State of Arizona.** **RESPONDENT**	**CASE NO. 2011-0009** **CONSENT AGREEMENT**

In the interest of a prompt and speedy settlement of the above captioned matter, consistent with the public interest, statutory requirements and responsibilities of the Arizona State Board of Behavioral Health Examiners ("Board"), and pursuant to A.R.S. §§ 32-3281(H) and 41-1092.07(F)(5), Arline M. Lemeshewsky ("Respondent") and the Board enter into this Consent Agreement, Findings of Fact, Conclusions of Law and Order ("Consent Agreement") as a final disposition of this matter.

RECITALS

Respondent understands and agrees that:

1. Any record prepared in this matter, all investigative materials prepared or received by the Board concerning the allegations, and all related materials and exhibits may be retained in the Board's file pertaining to this matter.

2. Respondent has the right to a formal administrative hearing at which Respondent can present evidence and cross examine the State's witnesses. Respondent hereby irrevocably waives her right to such formal hearing concerning these allegations and irrevocably waives her right to any rehearing or judicial review relating to the allegations contained in this Consent Agreement.

. . .

3. Respondent has the right to consult with an attorney prior to entering into this Consent Agreement.

4. Respondent acknowledges and agrees that upon signing this Consent Agreement and returning it to the Board's Executive Director, Respondent may not revoke her

acceptance of this Consent Agreement or make any modifications to it. Any modification of this original document is ineffective and void unless mutually approved by the parties in writing.

5. Although Respondent does not agree that all the Findings of Fact set forth in this Consent Agreement are supported by the evidence, Respondent acknowledges that it is the Board's position that, if this matter proceeded to formal hearing, the Board could establish sufficient evidence to support a conclusion that certain of Respondent's conduct constituted unprofessional conduct. Therefore, Respondent has agreed to enter into this Consent Agreement as an economical and practical means of resolving the issues associated with the complaint(s) filed against her. Further, Respondent acknowledges that the Board may use the evidence in its possession relating to this Consent Agreement for purposes of determining sanctions in any further disciplinary matter.

6. This Consent Agreement is subject to the Board's approval, and will be effective only when the Board accepts it. In the event the Board in its discretion does not approve this Consent Agreement, this Consent Agreement is withdrawn and shall be of no evidentiary value, nor shall it be relied upon or introduced in any disciplinary action by any party hereto, except that Respondent agrees that should the Board reject this Consent Agreement and this case proceeds to hearing, Respondent shall assert no claim that the Board was prejudiced by its review and discussion of this document or of any records relating thereto.

7. Respondent understands that once the Board approves and signs this Consent Agreement, it is a public record that may be publicly disseminated as a formal action of the Board, and that it shall be reported as required by law to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

8. Respondent further understands that any violation of this Consent Agreement constitutes unprofessional conduct pursuant to A.R.S. § 32-3251(n) and may result in disciplinary action pursuant to A.R.S. § 32-3281.

9. The Board therefore retains jurisdiction over Respondent and may initiate disciplinary action against Respondent if it determines that she has failed to comply with the terms of this Consent Agreement or of the practice act.

The Board issues the following Findings of Fact, Conclusions of Law and Order:

FINDINGS OF FACT

1. Respondent is the holder of License No. LCSW-3634 for the practice of clinical social work in Arizona.

2. Respondent initially treated a client ("Client") from 2004-2005.

3. In 07/08, Client reinitiated counseling services with Respondent on a referral by Client's psychiatrist ("Psychiatrist").

4. Upon Client's initial contact with Respondent on 07/17/08, Client reported the following:

   a. She was very depressed.

   b. She had "been snowing Psychiatrist" that she was fine.

   c. She "tried to slit [her] wrist three times in the past year" and did not tell Psychiatrist.

5. A one page "Wellness Assessment" questionnaire Client completed on 07/18/08 indicated the following:

   a. Client felt "somewhat" sad/blue and that everything was an effort.

   b. She experienced some trouble sleeping.

   c. She did not feel good about herself or that she could deal with her problems.

   d. Client had a chronic pain condition.

   e. In the past week, she consumed 5 alcohol drinks.

   f. Client recently felt she should cut down on her drinking.

6. Respondent documented the following regarding her first session with Client on 07/18/08:

   a. Client's father began sexually abusing her at age 8.

   b. Client had a history of "passive [suicide ideation without] intent or plan" 6 months earlier.

   c. Client had a history of "cutting arm" 3 times in the last 2 years to get her husband's attention.

   d. She drinks to change her mood.

   e. She has a history of 5 blackouts.

f. Her husband complains that Client binge drinks.

g. One of her prescribed medications was Ambien.

7. Following the 07/18/08 session, Respondent diagnosed Client as follows:

a. Bipolar Disorder

b. ADHD

c. Complex PTSD

d. Alcohol abuse

e. Adult Child of Alcoholic

f. Personality disorder, NOS, borderline traits.

8. Recognized suicide assessment guidelines reflect that PTSD, depression, previous self-harm gestures, substance abuse, mood disorders, and a history of childhood abuse all increase a patient's risk for suicidal behavior.

9. These guidelines specifically indicate that any person who shows evidence of depressed mood, anxiety, or substance abuse should be assessed for suicidal risk.

10. Given that Client had a number of issues that increased her risk for suicide, it was Respondent's responsibility to conduct a comprehensive suicide risk assessment in order to:

a. Elicit sufficient information to properly evaluate Client's risk for suicide.

b. Develop safety plans as needed to ensure Client's safety.

c. Conduct ongoing risk assessments to ascertain Client's level of risk during treatment.

11. Despite the fact that Client presented for treatment with a number of recognized suicide risk factors, Respondent's records do not reflect that Respondent:

a. Conducted any type of comprehensive risk assessment in order to elicit sufficient information to properly evaluate Client's risk for suicide.

b. Considered whether a safety plan was needed to ensure Client's safety.

c. Conducted any type of ongoing risk assessments to ascertain Client's level of risk on an ongoing basis.

12. Given that Client presented with several well-recognized suicide risk factors, Respondent's failure to recognize the necessity of completing both an initial comprehensive risk assessment and ongoing risk assessments in order to ensure Client's safety was inappropriate.

13. On 07/18/08, Client signed a "Patient Coordination of Care Notice" authorizing Respondent to communicate with Psychiatrist for the purpose of sharing Client's treatment recommendations.

14. Given that Client reported a number of issues that significantly increased her risk of suicide and that Client was not fully disclosing these issues to Psychiatrist, it was incumbent upon Respondent to communicate with Psychiatrist regarding these issues in order to both:

a. Optimize Client's treatment.

b. Coordinate Client's care as needed to ensure her safety.

15. Although Respondent represents that she shared information about Client with Psychiatrist, there is no documentation in Client's record indicating that Respondent:

a. Communicated in any way with Psychiatrist regarding Client.

b. Made any attempt to coordinate Client's care with Psychiatrist.

16. Given that Client presented with a number of serious presenting issues, several of which significantly increased Client's risk of suicide, and that Client reported she had not fully disclosed these issues to Psychiatrist, Respondent's failure to document that she communicated with Psychiatrist regarding Client's care and the results of those communications was inappropriate.

17. Respondent's failure to document her ongoing efforts to coordinate Client's care with Psychiatrist is particularly problematic where, at a minimum, it was incumbent upon Respondent to clearly communicate with Psychiatrist regarding Client's alcohol abuse in order to ensure that Psychiatrist had the information needed to properly monitor Client's medications.

a. This was particularly critical given that the manufacturer of Ambien clearly advises prescribers as follows:

- If used in combination with other CNS depressants, dose reductions may be needed due to additive effects. Do not use with alcohol.
- "Use with alcohol causes additive psychomotor impairment."
- "Because persons with a history of addiction to, or abuse of, drugs or alcohol are at increased risk for misuse, abuse and addiction of [Ambien], they should be monitored carefully..."

b. There is no documentation in Client's record indicating that Respondent recognized or gave any consideration to:

- Her responsibility as a licensed behavioral health professional to appropriately transmit information regarding Client's alcohol abuse problems to Psychiatrist.
- The potentially serious negative consequences of Respondent's failure to ensure that Psychiatrist had the information needed to avoid prescribing medication that was contra-indicated given Client's ongoing alcohol abuse problems.

18. When Client initiated treatment in 07/08, Respondent documented that Client made the following statements:

a. Client did not feel that she could deal with her problems.

b. Client recently felt she should cut down on her drinking.

c. Client recently felt annoyed by people criticizing her drinking.

d. Client had a history of cutting her arm to get her husband's attention when she was drinking.

e. Client had experienced 5 blackouts and engaged in binge drinking to change her mood.

f. Client's husband had complained that Client was a binge drinker.

19. Client's self-reported alcohol abuse issues, which included blackouts and binge drinking, clearly put Respondent on notice of the following:

a. Client potentially had a serious alcohol abuse problem.

b. A comprehensive substance abuse assessment was necessary in order to better evaluate the nature and extent of Client's problem and to develop appropriate treatment goals and objectives.

20. Despite the fact that all of the information received indicated that Client was experiencing a significant ongoing alcohol abuse problem, there is no information in Client's record indicating that Respondent conducted a comprehensive substance abuse assessment of Client.

21. As a result, there is no information in Client's record identifying:

a. Client's alcohol use/abuse history.

b. Client's use/abuse of other drugs.

c. Prior attempts to stop drinking.

d. Prior substance abuse treatment.

e. Prior substance abuse treatment providers.

f. Negative behavioral and medical effects on Client resulting from her alcohol abuse.

22. Given the serious nature of Client's reported alcohol abuse problem, Respondent's failure to either conduct a comprehensive substance abuse assessment, or immediately refer Client out for such an assessment, in order to obtain the information needed to evaluate the nature and extent of Client's problem and to develop appropriate treatment goals and objectives was inappropriate.

23. Following her intake assessment, Respondent developed a treatment plan for Client.

24. None of the objectives in Client's treatment plan addressed Client's alcohol abuse issues.

25. Following the development of a treatment plan, Respondent conducted 6 individual therapy sessions with Client.

26. Respondent did not document any information in her progress notes indicating that she directly addressed Client's alcohol abuse issues during treatment.

27. The only reference to Client's alcohol abuse in Respondent's session progress notes indicated that Client's "homework" included exercising "abstinence".

28. Given the severity of Client's self-reported alcohol abuse, Respondent's failure to include any goals or objectives in Client's treatment plan to address this problem or to directly address this problem during treatment was inappropriate.

29. Client attended 6 weekly sessions with Respondent from 07/08 - 09/08.

30. When a billing issue arose regarding Client's insurance carrier ("Insurance"), Client contacted Respondent on 09/18/08 indicating that she wanted to discontinue therapy until the billing issue was resolved.

31. Respondent did not document any information indicating that, following Client's decision to terminate therapy, Respondent took any steps to ensure an appropriate continuation of care for Client.

32. When she terminated treatment with Respondent due to the billing issue:

a. Client had several serious behavioral health diagnoses, including Bipolar Disorder, Complex PTSD, alcohol abuse, and a personality disorder with borderline traits.

b. Client presented with a number of suicide risk factors

c. Client reported that she was binge drinking and experiencing blackouts.

33. Despite this, there is no evidence that Respondent:

a. Created any type of written safety plan for Client.

b. Provided any crisis line information to Client.

c. Provided information in writing to Client with contact information for at least 3 other therapists.

d. Advised Psychiatrist that Client had terminated therapy.

34. Given the severity of Client's symptoms and issues, Respondent's failure to document that she took reasonable steps to provide for Client's continuing therapy needs was inappropriate.

35. On 07/18/08, Client signed an Application for Service form that authorized, "the release of any medical information necessary to process claims to any insurer, third party payor or other underwriter."

36. At that same time, Client signed a Consent to Release Information form authorizing Respondent to share diagnosis and treatment plan information with Insurance.

37. On/about 09/03/08, Insurance denied Respondent's claims for reimbursement for fees related to Client's treatment.

38. In that denial, Respondent was advised that she had 180 days (by 03/14/09) to submit a written appeal.

39. Based on information in Client's record and information provided by Respondent, the following occurred after Respondent's receipt of the denial notice from Insurance:

a. In 10/08, Respondent determined the following:
   - She needed to submit Client's progress notes to Insurance with her appeal.
   - Neither of the 2 release of information authorizations already in her possession could be used to release Client's progress notes.
   - Another signed release of information authorization would be required in order to release Client's progress notes.

b. From 10/08 – 03/09, there is no evidence in Client's record that Respondent or her billing service (Billing Service) made any effort to develop the necessary release for Client to sign.

c. On 03/16/09, Client sent Respondent a letter authoring Billing Service to release her progress notes to Insurance.

d. Respondent determined that Client's letter could not be used as an authorization to release Client's progress notes to Insurance because Client authorized Billing Service, not Respondent, to release Client's progress notes to Insurance.

e. Respondent did not submit any type of appeal regarding the denial of her claims regarding Client by the identified appeal deadline of 03/14/09.

f. On 04/09/09, Respondent sent Client a release of information form that authorized Respondent to release "diagnosis", "assessment", "treatment plan", and "treatment summary" information to Insurance.

g. Client signed the release on 04/15/09 and immediately returned it to Respondent.

h. On 06/25/09, Respondent submitted an appeal of the denial to Insurance along with Client's progress notes.

i. On 07/20/09, Insurance advised Respondent that her appeal could not be processed because it was received after the identified deadline.

40. Respondent's attempts to obtain reimbursement for her fees from Insurance were inadequate where:

a. The claim denial Insurance sent to Respondent clearly put her on notice that she had 180 days (by 03/14/09) to appeal the denial.

b. There is no information in Client's record supporting Respondent's assumption that Insurance ever asked for Client's progress notes.

c. Even if Respondent had been required to submit Client's progress notes, there is no justification for the processing delays that occurred in this matter when all that was required was for Respondent to modify her existing release authorization to specifically allow Respondent to release progress notes, obtain Client's signature, and send the revised authorization and progress notes to Insurance.

41. Respondent's delay was particularly problematic where the revised release authorization she finally sent to Client for signature on 04/15/09 only authorized the release of "diagnosis", "assessment", "treatment plan", and "treatment summary" information to Insurance.

42. Nothing in that release specifically indicates that "progress notes" would be released to Insurance.

43. Under these circumstances, Respondent's inability to obtain reimbursement from Insurance for fees related to services provided to Client were solely due to Respondent's failure to properly process the required appeal.

44. When Client returned for treatment with Respondent in 07/08:

a. She signed an "Application for Service" form indicating that she "agrees to pay $20 per session, payable at the time of service."

b. While this form indicated that Respondent's "usual and customary fee" is $125-$150 per session, nothing in the agreement indicated that Client would be responsible for any fees in excess of $20.

c. This was the only documented payment agreement between Respondent and Client.

45. On/about 09/03/08, Respondent received notice that Insurance would not reimburse Respondent for any of her fees.

46. Respondent's subsequent efforts to obtain reimbursement from Insurance were unsuccessful.

47. On 02/19/09, Billing Service sent an invoice to Client seeking payment in the amount of $468 for the balance due on Respondent's "usual and customary fee".

48. On 03/12/09, 04/09/09, 08/24/09, 08/31/09, and 09/21/09, Billing Service left telephone messages for Client regarding the billing issue.

49. In response to Respondent's/Billing Services' efforts to collect additional payment from her, on 09/23/09, Client sent a letter to Respondent indicating the following:

a. Client refused to pay the balance due because she felt Insurance denied the claims as a result of Respondent's billing errors.

b. Client asked that Respondent/Billing Service stop contacting her regarding this issue.

50. Despite the fact that the only documented payment agreement between Respondent and Client indicated that Client would only be responsible for paying $20 per session, and despite the fact that Client asked that further efforts to collect payment from her stop, Respondent and/or Billing Service continued efforts to obtain payment from Client as follows:

a. On 12/16/09, Billing Service called to keep Client updated.

b. On 02/17/10, Billing Service notified Client that it was sending a second appeal to Insurance.

c. On 04/14/10, Billing Service informed Client that the second appeal had been sent to Insurance.

d. On 05/12/10, Billing Service notified Client that Insurance denied the second appeal.

e. On 06/21/10, Billing Service left a phone message for Client.

51. Respondent acknowledges the following:

a. The only written fee arrangement she had with Client was the 07/18/08 Application for Services form where Client agreed to pay $20 per session.

b. This was Client's copay.

c. Although Respondent believes Client understood that Respondent would bill Insurance for the balance of her fees, this understanding is not documented.

d. Respondent has no documentation indicating that Client was informed, or agreed, that she would be responsible for any fees not paid by Insurance.

52. Respondent's decision to pursue Client for the outstanding balance that Insurance refused to pay was inappropriate where:

a. Client was only responsible for the $20 fee per session she agreed in writing to pay.

b. Because Respondent's form failed to clarify that the client would be responsible for fees not reimbursed by the client's insurance company, Respondent had no basis for pursuing Client for the fees Insurance refused to pay.

53. Respondent's decision to repeatedly contact Client regarding this issue and to actively pursue Client for the fees Insurance refused to pay, was particularly problematic given the following:

a. The financial arrangement between Respondent and Client was clear that Client was only responsible for paying $20 per session.

b. Respondent was unable to collect any payment from Insurance because Respondent failed to submit a timely appeal regarding Insurance's denial of her claims.

c. On 09/23/09, Client clearly advised Respondent in writing that she did not wish to receive any further communications regarding the billing issue.

d. There is no evidence indicating that, following receipt of this letter, Respondent ever reviewed the issue to determine whether continuing efforts to obtain payment from Client, a former client with significant behavioral health issues, were appropriate.

e. Instead, following receipt of Client's written request not to be contacted, Respondent and/or Billing Service telephoned and/or mailed Client at least 5 times in a continuing effort to extract payment for fees that Client had no contractual obligation to pay.

54. Respondent's Application for Services form serves as her informed consent for treatment.

55. This forms lacks the following required elements:

a. The purpose of treatment.

b. General procedures to be used in treatment.

c. Methods for a client to obtain information about the clients' records.

d. A client's right to refuse recommended treatment or withdraw informed consent to treatment and to be advised of the consequences of such refusal or withdrawal.

e. The client's right to be informed of all fees that the client is required to pay and the licensee's refund and collection policies and procedures.

56. Respondent has indicated that she shared information and conferred with Psychiatrist regarding Client.

57. Respondent did not document any communications she had with Psychiatrist regarding Client.

58. If Respondent did, in fact, communicate with Psychiatrist regarding Client's treatment, Respondent's failure to appropriate document the date and substance of these communications was inappropriate.

59. Respondent failed to date her signature on the 6 progress notes she maintained for Client's therapy sessions.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent pursuant to A.R.S. § 32-3251 *et seq.* and the rules promulgated by the Board relating to Respondent's professional practice as a licensed behavioral health professional.

2. The conduct and circumstances described in the Findings of Fact constitute a violation of A.R.S. § 32-3251(12)(k), any conduct or practice that constitutes a danger to the health, welfare or safety of a client.

3. A.R.S. § 32-3251(12)(l), any conduct, practice or condition that impairs the ability of the licensee to safely and competently practice.

4. A.R.S. § 32-3251(12)(p), failing to conform to minimum practice standards as developed by the Board, as it relates to the following:

A.A.C. R4-6-1101 Consent for Treatment

A licensee shall:

1. Provide treatment to a client only in the context of a professional relationship based on valid informed consent for treatment;

2. Document in writing for each client served the following elements of informed consent for treatment:

a. Purpose of treatment;
b. General procedures to be used in treatment, including benefits, limitations, and potential risks;
e. Methods for a client to obtain information about the client's records;
g. A client's right to refuse any recommended treatment or to withdraw informed consent to treatment and to be advised of the consequences of such refusal or withdrawal; and
h. The client's right to be informed of all fees that the client is required to pay and the licensee's refund and collection policies and procedures.

A.A.C. R4-6-1103 Client Record

(A)(5) A licensee shall ensure that a client record is current and accurate.

(B)(9) A licensee shall ensure that a client record contains documentation of telephone, written, or face-to-face contact with the client or another individual that relates to the clients' health, safety, welfare, or treatment.

(H)(4) A licensee shall ensure that a progress note includes the signature and date signed by the licensee who provided the behavioral health service.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, the parties agree to the provisions and penalties imposed as follows:

1. Respondent's license, LCSW-3634, will be placed on probation, effective from the date of entry as signed below.

2. Respondent shall not practice under her license, LCSW-3634, unless she is fully compliant with all terms and conditions in this Consent Agreement. If, for any reason, Respondent is unable to comply with the terms and conditions of this Consent Agreement, she shall immediately notify the Board in writing and shall not practice under her license until she submits a written request to the Board to re-commence compliance with this Consent Agreement. All such requests shall be pre-approved by the Social Work Credentialing Committee Chair or designee.

3. In the event that Respondent is unable to comply with the terms and conditions of this Consent Agreement, all remaining time frames shall be tolled and remain tolled until such time as she is granted approval to re-commence compliance with the Consent Agreement.

Continuing Education

4. In addition to the continuing education requirements of A.R.S. § 32-3273, within 12 months of the effective date of this Consent Agreement, Respondent shall complete 6 clock hours of the NASW Staying Out of Trouble continuing education course or its 6 hour equivalent. All required continuing education shall be pre-approved by the Social Work Credentialing Committee Chair or designee. Upon completion, Respondent shall submit a certificate of completion of the required continuing education.

5. In addition to the continuing education requirements of A.R.S. § 32-3273, within 12 months of the effective date of this Consent Agreement, Respondent shall complete 3 clock hours of continuing education addressing clinical record keeping standards in Arizona and 3 clock hours of continuing education addressing appropriate billing practices. All required continuing education shall be pre-approved by the Social Work Credentialing Committee Chair or designee. Upon completion, Respondent shall submit a certificate of completion of the required continuing education.

6. In addition to the continuing education requirements of A.R.S. § 32-3273, within 18 months of the effective date of this Consent Agreement, Respondent shall take and pass an in-person three semester credit hour graduate level course in assessment and diagnosis from an accredited college or university, pre-approved by the Social Work Credentialing Committee Chair or designee. Upon completion, Respondent shall submit to the Board an official transcript establishing completion of the required course.

7. Respondent may submit continuing education completed since the complaint was for filed for consideration by the Social Work Credentialing Committee Chair or designee.

Audit

8. While on probation, Respondent shall submit to an audit of all of her private practice records by a pre-approved auditor. Within 30 days of this consent agreement, Respondent shall submit the name of an auditor and a plan for conducting the audit for pre-approval by the Social Work Credentialing Committee Chair or designee. The audit shall be completed within 60 days of the effective date of this consent agreement. Also within 60 days of the effective date of this consent agreement, the auditor shall provide an audit report and a proposed audit plan addressing any deficiencies found during the audit to the Social Work Credentialing Committee Chair or designee for review and approval.

Practice Monitor

9. While on probation, Respondent shall establish and maintain a relationship with a practice monitor who is a masters or higher level behavioral health professional licensed at the independent level. The practice monitor shall provide training and assistance to Respondent regarding setting up appropriate forms and formats for Respondent's clinical records, implementing current behavioral health standards of practice related to behavioral health assessment and treatment planning, providing treatment consistent with the documented treatment plan, and documenting the treatment provided in accordance with current behavioral health standards. Additionally, the practice monitor shall focus on record keeping, billing, and diagnosis. Respondent and the practice monitor shall review the clinical documentation produced for each and every active client Respondent sees at least once per month. The practice monitor shall ensure that Respondent complies with the audit plan approved by the

Social Work Credentialing Committee Chair or designee. Respondent shall meet with the practice monitor a minimum of twice a month for the first 12 months of probation and monthly for the second 12 months of probation.

10. Within 30 days of the effective date of this Consent Agreement, Respondent shall submit the name of a practice monitor for pre-approval by the Social Work Credentialing Committee Chair or designee. Also within 30 days of the effective date of this Consent Agreement, the proposed Practice Monitor shall submit a letter disclosing his/her prior relationship to Respondent. In that letter, the practice monitor shall address why he/she should be approved, acknowledge that he/she has reviewed the Consent Agreement and include the results of an initial assessment and a monitoring plan regarding the proposed practice monitoring of Respondent. The letter from the proposed Practice Monitor auditor shall be submitted to the Board.

Monitoring Quarterly Reports

11. Once approved, the practice monitor shall submit quarterly reports for review and approval by the Social Work Credentialing Committee Chair or designee. The quarterly reports shall include issues presented in this consent agreement that need to be reported and the practice monitor shall notify the Board if more frequent monitoring is needed. The practice monitor shall submit a final summary report for review and approval by the Social Work Credentialing Committee Chair or designee. The final summary report submitted by the practice monitor shall address Respondent's competency to engage in independent practice in accordance with current standards of practice.

Change of Practice Monitor During Probation

12. If, during the period of Respondent's probation, the practice monitor determines that he/she cannot continue as the practice monitor, she/she shall notify the Board within 10 days of the end of monitoring and provide the Board with an interim final report. Respondent shall advise the Social Work Credentialing Committee Chair or designee within 30 days of cessation of monitoring by the approved practice monitor of the name of a new proposed practice monitor. The proposed practice monitor shall provide the same documentation to the Board as was required of the initial practice monitor.

GENERAL PROVISIONS

Provision of Clinical Supervision

13. Respondent shall not provide clinical supervision while subject to this Consent Agreement.

Civil Penalty

14. Subject to the provisions set forth in paragraph 14, the Board imposes a civil penalty against the Respondent in the amount of $1,000.00.

15. Respondent's payment of the civil penalty shall be stayed so long as Respondent remains compliant with the terms of this Consent Agreement. If Board staff determines that Respondent is noncompliant with the terms of this Consent Agreement in any respect, with the exception of the tolling provision under Paragraph 3, the stay of the civil penalty payment shall be automatically lifted and payment of the civil penalty shall be made by certified check or money order payable to the Board within 30 days after being notified in writing of the lifting of the stay.

16. Within 10 days of being notified of the lifting of the stay, Respondent may request that the matter be reviewed by the Board for the limited purpose of determining whether the automatic lifting of the stay was supported by substantial evidence. If the Board receives the written request within 10 days or less of the next regularly scheduled Board meeting, the request will not be heard at that meeting, but will be heard at the next regularly scheduled Board meeting. The Board's decision on this matter shall not be subject to further review.

17. The Board reserves the right to take further disciplinary action against Respondent for noncompliance with this Consent Agreement after affording Respondent notice and an opportunity to be heard. If a complaint is filed against Respondent for failure to comply with this Consent Agreement, the Board shall have continuing jurisdiction until the matter is final and the period of probation shall be extended until the matter is final.

18. Respondent currently sees clients in her own private practice. If Respondent obtains any other type of behavioral health position, either as an employee or independent contractor, where she provides behavioral health services to clients of another individual or agency, she shall comply with requirements set forth in Paragraphs 18 through 19 below.

19. Within 10 days of the effective date of this Order, if Respondent is working in a position where Respondent provides any type of behavioral health related services are provided, Respondent shall provide the Social Work Credentialing Committee Chair or designee with a signed statement from Respondent's employer(s) confirming Respondent provided the employer(s) with a copy of this Consent Agreement. If Respondent does not provide the employer's statement to the Board within 10 days of the effective date, the Board will provide Respondent's employer(s) with a copy of the Consent Agreement.

20. If Respondent is not employed as of the effective date of this Order, within 10 days of accepting employment in a position where Respondent provides any type of behavioral health related services, Respondent shall provide the Social Work Credentialing Committee Chair or designee with a written statement providing the contact information of her new employer and a signed statement from Respondent's new employer confirming Respondent provided the employer with a copy of this Consent Agreement. If Respondent does not provide the employer's statement to the Board within 10 days, as required, Respondent's failure to provide the required statement to the Board shall be deemed a violation of A.R.S. § 32-3251(12)(n) and the Board will provide Respondent's employer(s) with a copy of the Consent Agreement.

21. If, during the period of Respondent's probation, Respondent changes employment, resigns, is involuntarily terminated, resigns in lieu of termination, or goes on extended leave of absence for whatever reason that may impact her ability to timely comply with the terms of probation, Respondent shall, within 10 days of the aforementioned acts, inform the Board of her change of employment status. After the change and within 10 days of accepting employment in a position where Respondent provides any type of behavioral health related services, Respondent shall provide the Social Work Credentialing Committee Chair or designee a written statement providing the contact information of her new employer(s) and a signed statement from Respondent's new employer(s) confirming Respondent provided the employer(s) with a copy of this Consent Agreement. If Respondent does not provide the employer's statement to the Board within 10 days, as required, Respondent's failure to provide the required statement to the Board shall be deemed a violation of A.R.S. § 32-3251(12)(n) and the Board will provide Respondent's employer(s) with a copy of the Consent Agreement.

22. Respondent shall practice clinical social work using the name under which she is licensed. If Respondent changes she name, she shall advise the Board of the name change as prescribed under the Board's regulations and rules.

23. Prior to the release of Respondent from probation, Respondent must submit a written request to the Board for release from the terms of this Consent Agreement at least 30 days prior to the date she would like to have this matter appear before the Board. Respondent may appear before the Board, either in person or telephonically. Respondent must provide evidence that she has successfully satisfied all terms and conditions in this Consent Agreement. The Board has the sole discretion to determine whether all terms and conditions of this Consent Agreement have been met and whether Respondent has adequately demonstrated that she has addressed the issues contained in this Consent Agreement. In the event that the Board determines that any or all terms and conditions of this Consent Agreement have not been met, the Board may conduct such further proceedings as it determines are appropriate to address those matters.

24. Respondent shall bear all costs relating to probation terms required in this Consent Agreement.

25. Respondent shall be responsible for ensuring that all documentation required in this Consent Agreement is provided to the Board in a timely manner.

26. This Consent Agreement shall be effective on the date of entry below.

27. This Consent Agreement is conclusive evidence of the matters described herein and may be considered by the Board in determining appropriate sanctions in the event a subsequent violation occurs.

PROFESSIONAL ACCEPTS, SIGNS AND DATES THIS CONSENT AGREEMENT

Arline Lemeshewsky

8-28-2013
Date

BOARD ACCEPTS, SIGNS AND DATES THIS CONSENT AGREEMENT

Dated this 18th day of September, 2013.

By: Debra Rumsey

DEBRA RINAUDO, Executive Director
Arizona Board of Behavioral Health Examiners

. . . .

ORIGINAL of the foregoing filed
This 13th day of September, 2013 with:

Arizona Board of Behavioral Health Examiners
3443 N. Central Ave., Suite 1700
Phoenix, AZ 85012

COPY of the foregoing mailed via
Certified mail no. 7012 2920 0001 8751 0546,
This 13th day of September, 2013, to:

Arline Lemeshewsky
Address of Record
Respondent

COPY of the foregoing mailed via Mail
This 13th day of September, 2013 to:

Larry Cohen
P.O. Box 10056
Phoenix, AZ 85064
Attorney for Respondent

COPY of the foregoing mailed via Interagency Mail
This 13th day of September, 2013, to:

Marc H. Harris
Assistant Attorney General
1275 West Washington
Phoenix, Arizona 85007

Tobi Zavala

Tobi Zavala, Compliance Officer
602-542-1617