IN THE MATTER OF	*	**BEFORE THE**
RENEE VAN WIE, P.T.	*	**MARYLAND BOARD OF**
Respondent	*	**PHYSICAL THERAPY**
	*	**EXAMINERS**
License No.: 15365	*	**Case No. PT-20-01**

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

CONSENT ORDER

On December 1, 2022, the Maryland Board of Physical Therapy Examiners (the "Board") charged **RENEE VAN WIE, P.T.** (the "Respondent"), License Number 15365, with violating the Maryland Physical Therapy Act (the "Act"), codified at Md. Code Ann., Health Occupations ("Health Occ.") §§ 13-101 *et seq.* (2021 Repl. Vol.) and Code of Maryland Regulations ("COMAR") 10.38 *et seq.*

Specifically, the Board charged the Respondent with violations of the following provisions of Health Occ. § 13-316:

> **§ 13-316. Denials, reprimands, probations, suspensions, and revocations - Grounds.**
>
> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, or suspend or revoke a license or restricted license if the applicant, licensee, or holder:
>
> (4) In the case of an individual who is authorized to practice physical therapy, is grossly negligent:
>
> (i) In the practice of physical therapy;
>
> (12) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy;

(14) Submits a false statement to collect a fee;

(15) Violates any provision of this title or rule or regulation adopted by the Board;

(19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy;

(20) Grossly overutilizes health care services;

(25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy care [;].

The Board also promulgated certain regulations, COMAR 10.38.03:

.02 Standards of Practice

A. Physical Therapists.

(1) The physical therapist who establishes or changes the plan of care shall be ultimately responsible for patient care until another physical therapist:

(a) Provides services to the patient; or

(b) Provides supervision to the treating physical therapist assistant.

(2) The physical therapist shall:

(a) Exercise sound professional judgment in the use of evaluation and treatment procedures;

(b) Provide:

(i) Physical therapy services to not more than an average of three patients per clinical treatment hour per calendar day, excluding group therapy; and

(ii) Each patient with adequate treatment time consistent with accepted standards in delivering physical therapy care;

(c) Provide the patient with accurate information about the physical therapy services provided;

(d) Respect the right of the patient to refuse treatment;

(e) Evaluate the patient and develop a plan of care before the patient is treated;

(f) Work within the physical therapist's competency in physical therapy evaluation and treatment;

(g) Reevaluate the patient as the patient's condition requires, but at least every 30 days, unless the physical therapist, consistent with accepted standards of physical therapy care, documents in the treatment record an appropriate rationale for not reevaluating the patient;

(j) Delegate to the physical therapist assistant only treatment that is within the competency and scope of practice of the physical therapist assistant;

(k) Provide direction and instruction for the physical therapist assistant that is adequate to ensure the safety and welfare of the patient; and

(l) Document ongoing communication with the physical therapist assistant regarding changes in a patient's status and treatment plan.

§ 10.38.03.02-1. Requirements for Documentation

A. The physical therapist shall document legibly the patient's chart each time the patient is seen for:

(1) The initial visit, by including the following information:

(a) Date;

(b) Condition, or diagnosis, or both, for which physical therapy is being rendered;

(c) Onset;

(d) History, if not previously recorded;

(e) Evaluation and results of tests (measurable and objective data);

(f) Interpretation;

(g) Goals;

(h) Modalities, or procedures, or both, used during the initial visit and the parameters involved including the areas of the body treated;

(i) Plan of care including suggested modalities, or procedures, or both, number of visits per week, and number of weeks; and

(j) Signature, title (PT), and license number.

(2) Subsequent visits, by including the following information (progress notes):

(a) Date;
(b) Cancellations, no-shows;
(c) Modalities, or procedures, or both, with any changes in the parameters involved and areas of body treated;
(d) Objective status;
(e) Response to current treatment, if any;
(f) Changes in plan of care; and
(g) Signature, title (PT), and license number, although the flow chart may be initialed.

(3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit:

(a) Date;
(b) Number of treatments since the initial evaluation or last reevaluation;
(c) Reevaluation, tests, and measurements of areas of body treated;
(d) Changes from previous objective findings;
(e) Interpretation of results;
(f) Goals met or not met and reasons;
(g) Updated goals;
(h) Updated plan of care including recommendations for follow-up; and
(i) Signature, title (PT), and license number;

(4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist:

(a) Date;

(b) Reason for discharge;

(c) Objective status;

(d) Recommendations for follow-up; and

(e) Signature, title (PT), and license number.

B. Notwithstanding §A (4) of this regulation, a physical therapist may direct a physical therapist assistant to treat a patient on a final visit.

C. The physical therapist assistant shall document the patient's chart each time the patient is seen by the physical therapist assistant following the physical therapist's initial evaluation or reevaluation by including the following:

(1) Date;

(2) Cancellations and no-shows;

(3) Modalities, procedures, or both, including parameters involved, and areas of body treated;

(4) Objective status;

(5) Response to treatment, if any;

(6) Continuation of plan as established by the physical therapist or change of plan as authorized by the physical therapist; and

(7) Signature, title (PTA), and license number, although the flow chart may be initialed.

D. Subsequent visits, as referred to in §A (2) of this regulation, in the same day by the same physical therapist do not require separate progress notes unless there is a change in the patient's status.

E. Ongoing Communications. Both the physical therapist and the physical therapist assistant shall document ongoing communication between the physical therapist and physical therapist assistant regarding changes in a patient's status and treatment plan.

On February 21, 2023, a conference with regard to this matter was held before the Board's Case Resolution Conference ("CRC") Committee. As a result of the CRC, the Respondent agreed to enter this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

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

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice physical therapy in Maryland. The Respondent was first issued a Maryland PT license on August 31, 1982. The Respondent's license expires on May 31, 2023.

2. At all times relevant herein, the Respondent was the owner of, and operator of a physical therapy practice located in Severna Park, Anne Arundel County, Maryland, hereinafter, the "Facility". The Respondent also had her employees see patients at an off-site pool as part of her physical therapy practice.

3. On June 29, 2019, the Board received a complaint regarding the Respondent's practice. Specifically, the Complainant, another physical therapist and former employee of the Respondent, alleged that the Respondent directed a physical

therapist assistant (PTA) to treat Medicare patients off-site in a pool without supervision and that she continued to do so after the Complainant informed her that this was improper. The Complainant further advised the Board that the Respondent was double booking Medicare patients, but billing treatments as if the patient was treated alone.

4. When the Board's Investigator interviewed the Complainant, the Complainant also stated that she was concerned about the Respondent's billing for services provided by an aide or tech and continuing care past the Medicare cap without justification. With regard to Medicare regulations, the Complainant explained that a PT must be present during aquatic therapy, but the Respondent's office is "down the road" from the pool. The Complainant stated that the Respondent signed notes for patients she did not oversee in the pool.

5. The Complainant further informed the Investigator that on her first day of treating patients at the Facility, several of them had not been re-evaluated in a year.

6. The Board obtained treatment records from the Respondent, which it then sent to an expert for review. The following is the Expert's analysis:

CASE SUMMARIES

Patient A

7. Patient A was treated at the Facility from August 16, 2018, until November 2018 for "low back pain" and "sciatica." She was treated at both the Facility and in the pool. The PTA's aquatic therapy was signed off on by the Respondent, who admitted that

she did not directly supervise the PTA at the pool facility. Those therapy notes were signed on by the Respondent weeks or even months after the treatment.

8. The Respondent's documentation for November 5, 2018, is labeled "Lumbar SOAP note" by the Respondent. According to the Expert, reevaluation was billed although the content of the documentation does not support a complete reevaluation pursuant to the Maryland rules. The Expert stated that, although the PTA re-started aquatic therapy, there is no change in goals or plan of care from the August or September 2018 visits.

9. The last documentation note in the file is a "Lumbar SOAP note" completed by the PTA on December 18, 2018, but the note was not co-signed by the Respondent until January 2, 2019. Flow sheets have evidence of aquatic therapy occurring on January 3, 2019, January 10, 2019, and January 24, 2019, but no daily notes were included in Patient A's file for those dates.

10. The Respondent failed to document the total timed code treatment minutes and total treatment time as required by Medicare.

11. Therapy flow sheets at the Facility include the initials "AMS" and "SB." These individuals were identified as therapy aides. Medicare does not consider "aides" as "qualified providers" for billing purposes as they do not provide "skilled care." For example, AMS signed the flow sheet on September 21, 2018, and noted 45 minutes of exercise, for which the Respondent billed Medicare for three units of skilled care. The flow sheet for August 16, 2018, was missing both clinician initials and time seen.

12. On December 6, 2018, the note mentioned a "home program," but there was no evidence of one in the records.

13. As set forth above, the Respondent failed to provide the required amount of supervision or timely, ongoing communication to the PTA with regard to the aquatic therapy, yet billed for same, in violation of § 13-316 (4) (In the case of an individual who is authorized to practice physical therapy, is grossly negligent): (i) (In the practice of physical therapy); (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee) [;].

14. As set forth above, the Respondent failed to maintain timely, ongoing communication with the PTA regarding Patient A's status, as demonstrated by the delayed signatures, in violation of § 13-316 (4) (In the case of an individual who is authorized to practice physical therapy, is grossly negligent: (i) In the practice of physical therapy); (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee); (19) (Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy) [;].

15. The Respondent's reevaluations failed to include all of the required elements noted in the Maryland regulations, such as number of treatments since the initial evaluation or last reevaluation, changes from previous objective findings and goals met or not met, which also violated § 13-316 (15) (Violates any provision of this title or rule

or regulation adopted by the Board), as follows: (COMAR 10.38.03: .02 Standards of Practice. A. Physical Therapists. (2) The physical therapist shall:(a) Exercise sound professional judgment in the use of evaluation and treatment procedures; (e) Evaluate the patient and develop a plan of care before the patient is treated; (g) Reevaluate the patient as the patient's condition requires, but at least every 30 days, unless the physical therapist, consistent with accepted standards of physical therapy care, documents in the treatment record an appropriate rationale for not reevaluating the patient; and (k) Provide direction and instruction for the physical therapist assistant that is adequate to ensure the safety and welfare of the patient) [;].

16. The Respondent submitted billing for therapy provided by aides, failed to include the total timed code treatment minutes and total treatment time in the medical record, as required, and failed to correct the omissions in the medical records, such as lack of initials on flow sheets, in violation of § 13-316 (14) (Submits a false statement to collect a fee); and (25) (Fails to meet accepted standards in delivering physical therapy or limited physical therapy care) [;]. The Respondent also violated § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), as follows: COMAR10.38.03: .02 Standards of Practice. (A. Physical Therapists. (1) The physical therapist who establishes or changes the plan of care shall be ultimately responsible for patient care until another physical therapist: (a) Provides services to the patient; or (2) The physical therapist shall:(a) Exercise sound professional judgment in the use of evaluation and treatment procedures) [;].

Patient B

17. Patient B began treatment in the Facility with Physical Therapist B on June 18, 2018, for spastic left hemiplegia (paralysis of one side of the body). Aquatic therapy was included in the plan of care, without details or specific guidance.

18. Aquatic therapy services were started with the PTA on June 25, 2018 and the Respondent signed the dates of service, although she had never seen the patient. According to the Expert, it appears that the PTA designed and executed the aquatic therapy treatments and that the Respondent failed to supervise or provide ongoing, timely communication to the PTA in providing these treatments. The Expert concluded that the Respondent billed for these services even though they were not properly supervised.

19. Flow sheet entries for care at the Facility on July 11, July 18, July 25, and August 28, 2018 had no initials or time noted. The entry for August 30, 2018 had the initials "SB", a therapy aide, who was not qualified to provide skilled care, yet the Respondent billed for it as such.

20. Notes signed by the PTA were co-signed by the Respondent weeks or even months after the treatment. For example, the PTA provided aquatic therapy to Patient B on July 16, 2018 and the Respondent cosigned the note on August 4, 2018. The PTA

provided the therapy on July 26, 2018 and the Respondent cosigned the note on April 17, 2019.

21. A home exercise program is noted in the documentation, but there is no evidence of the program in the chart. No discharge note is available: the last daily note is October 4, 2018.

22. The Respondent failed to provide in her reevaluations the requirements, such as the number of treatments since the initial evaluation or the last reevaluation, changes from previous objective findings, goals met/not met, with reasons. The Expert determined that the objective measurement information is extremely limited.

23. The Expert stated that the Respondent failed to ensure that omissions on flow sheets were corrected, such as lack of initials on the flow sheets.

24. As set forth above, the Respondent failed to provide the required amount of supervision or timely, ongoing communication to the PTA with regard to the aquatic therapy, yet billed for same, in violation of § 13-316 (4) (In the case of an individual who is authorized to practice physical therapy, is grossly negligent: (i) In the practice of physical therapy); (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee) [;].

25. As set forth above, the Respondent failed to maintain timely, ongoing communication with the PTA regarding Patient A's status, as demonstrated by the delayed signatures, in violation of § 13-216 (4) (In the case of an individual who is authorized to

practice physical therapy, is grossly negligent: (i) In the practice of physical therapy); (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee); (19) (Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy) [;].

26. The Respondent's reevaluations failed to include all of the required elements noted in the Maryland regulations, such as number of treatments since the initial evaluation or last reevaluation, changes from previous objective findings and goals met or not met, which also violated § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), as follows: (COMAR § 10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (1) The initial visit, by including the following information: (g) Goals; (h) Modalities, or procedures, or both, used during the initial visit and the parameters involved including the areas of the body treated; (3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit: (a) Date; (b) Number of treatments since the initial evaluation or last reevaluation; (c) Reevaluation, tests, and measurements of areas of body treated; (d) Changes from previous objective findings; (e) Interpretation of results; (f) Goals met or not met and reasons; (g) Updated goals; (h) Updated plan of care including recommendations for follow-up; and (i) Signature, title

(PT), and license number; (4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up; and (e) Signature, title (PT), and license number).

27. In addition to the above, the Respondent also violated § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), as follows: (COMAR .02 Standards of Practice. (k) Provide direction and instruction for the physical therapist assistant that is adequate to ensure the safety and welfare of the patient; and (l) Document ongoing communication with the physical therapist assistant regarding changes in a patient's status and treatment plan).

Patient C

28. Patient C began treatment at the Facility on September 12, 2018 for lumbar radiculopathy[1] with the Respondent. The Expert determined that the Respondent failed to complete the initial evaluation under the "Pain Scale" by failing to complete information on what "aggravates" pain.

29. The Expert further noted that the progress note for October 15, 2018 includes measures in table format; however, these are not carried forward into multiple

[1] Radiculopathy is commonly referred to as a pinched nerve. Radiculopathy is injury or damage to nerve roots in the area where they leave the spine. This condition can affect anyone and can be the result disc degeneration, disc herniation or other trauma.

follow-up daily notes. Flow sheets describing treatment held at the Facility on September 14, October 5, October 25, and November 2, 2018 lack initials and/or minutes.

30. On the note of September 17, 2018, the initials "SB" appear. SB is an aide and is not a qualified provider. However, the Respondent billed Medicare for her services as skilled care.

31. The last date of service appears to be November 2, 2018, but there is no discharge note.

32. As set forth above, the Respondent's documentation is incomplete and failed to comply with the standards of practice. The Respondent also falsely billed for services provided by aides as skilled care. As such, the Respondent violated § 13-316 (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee); (19) (Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy…) [;].

33. As set forth above with regard to Patient C, the Respondent also violated § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), in the following manner: (COMAR § 10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (1) The initial visit, by including the following information: (4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final

visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up; and (e) Signature, title (PT), and license number).

Patient D

34. It is unclear when Patient D began therapy at the Facility for a diagnosis of "closed displaced fracture of the right medial malleolus (ankle)."

35. Although the Respondent treated Patient D on the following dates: January 24, 25, February 1, 6, 7, 13, 20, 22 and 27, 2018, the Respondent did not sign the notes until 3/1/18. The Respondent failed to complete the required reevaluations in February and June 2018.

36. The Respondent added aquatic therapy to Patient D's treatment on March 6, 2018, but the note was not signed until 5/8/18. The Respondent failed to design and supervise the aquatic therapy which the PTA performed starting on March 8, 2018. Aquatic therapy notes signed by the PTA were cosigned by the Respondent weeks or months after treatment. For example, treatment provided by the PTA on March 15, 2018 was not signed by the Respondent until May 17, 2018.

37. On April 10, 2018, Patient D reported "more pain" to the PTA. There is no evidence that the PTA consulted with the Respondent about this change in pain status. On 5/10/18, Patient D reported "calf pain"[2] to the PTA, but there is no evidence that this was communicated to the Respondent, who did not sign the note until July 5, 2018.

[2] Calf pain is an important clinical finding because it may mean a potential blood clot.

38. On the July 24, 2018 note, the Respondent added the diagnostic/billing code for "cervicalgia"[3] (neck pain). However, the Respondent's Progress Evaluation referred to only Patient D's "knees," even though hot packs, ultrasound, and massage were applied to the neck that date.

39. The July 26, 2018 daily note, completed by the PTA, was signed by the Respondent on December 3, 2019, more than a year later. The Respondent's last daily note is dated July 31, 2018. The Respondent failed to include a discharge note.

40. The flow sheets for November and December 2018 contain omissions of initials and of one date. Progress notes for those visits were also missing. Flow sheets for January, February and July 2018 contain the initials "SB", the aide. The Respondent billed and received payment for skilled care services provided by the aide.

41. As set forth above, by billing for services provided by an aide, by failing to properly supervise and communicate with the PTA and by submitting billing for services provided by the unsupervised PTA, the Respondent violated § 13-316 (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee); (19) (Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy…)[;].

42. As set forth above, by failing to accurately document patient records, the Respondent violated § 13-316 (15) (Violates any provision of this title or rule or

[3] Cervicalgia is pain in the neck and shoulder that varies in intensity and may feel achy or like an electric shock from the neck to the arm.

regulation adopted by the Board), in the following manner: (COMAR 10.38.03: .02 Standards of Practice. (2) The physical therapist shall: (g) Reevaluate the patient as the patient's condition requires, but at least every 30 days, unless the physical therapist, consistent with accepted standards of physical therapy care, documents in the treatment record an appropriate rationale for not reevaluating the patient; (k) Provide direction and instruction for the physical therapist assistant that is adequate to ensure the safety and welfare of the patient; and (l) Document ongoing communication with the physical therapist assistant regarding changes in a patient's status and treatment plan; COMAR Sec. 10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit: (a) Date; (b) Number of treatments since the initial evaluation or last reevaluation; (c) Reevaluation, tests, and measurements of areas of body treated; (d) Changes from previous objective findings; (e) Interpretation of results;(f) Goals met or not met and reasons; (g) Updated goals; (h) Updated plan of care including recommendations for follow-up; and (i) Signature, title (PT), and license number; (4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up; and (e) Signature, title (PT), and license number).

Patient E

43. It is unclear when Patient E began receiving services at the Facility. An initial evaluation signed by the Respondent was dated June 4, 2018, but that note references an initial evaluation of 5/9/18 under the "Functional Deficits" section.

44. There are aquatic services dated February 15, 2015, February 22, 2015, and November 2, 2017 on the same flow sheet as those dated February 1 and March 1, 2018. It is unclear whether these are errors. However, the June 4, 2018 initial evaluation does not include aquatic evaluation as part of the plan of care. A home care program is mentioned, but there is none outlined in the records. The Respondent signed off on the initial evaluation on 5/9/19—almost a year later. The Respondent also delayed signing notes, some as much as almost 12 months. For example, the Respondent signed the note of June 4, 2018 on May 9, 2019.

45. The Expert concluded that the Respondent failed to properly supervise and communicate with the PTA regarding aquatic therapy because the PTA added the aquatic therapy note on Jun 25, 2018 and the Respondent signed off on it one year later. Patient E complained of "more pain" to the PTA on July 18, 2018 and July 24, 2018. However, the Expert stated that it does not appear that this information was communicated to the Respondent because of the Respondent's delayed signatures. The PTA added "deep water spinal decompression" to the aquatic exercises on July 26, 2018, but the Expert stated that there is no evidence that the Respondent was aware of this modification.

46. The Respondent failed to reevaluate Patient E in July 2018, as required, according to the Expert.

47. The PTA added manual therapy and massage to Patient E's program on September 17, 2018 after she complained of cervical pain and stiffness. The Expert stated that there is no evidence that the Respondent was consulted because the Respondent signed off on the note one year later.

48. On November 2, 2018, the PTA reported that an MRI revealed a lumbar herniated disc. However, there is no mention of a discussion between the Respondent and the PTA. The PTA initiated lumbar traction on November 5, 2018. The Respondent signed off on the note on October 16, 2019.

49. The Expert noted that many of the aquatic therapy flow sheets have no initials or identifiers of the providers. There is no discharge note in the records.

50. As set forth above, the Respondent failed to properly communicate with or supervise the PTA, yet the Respondent billed for services as though she had provided the supervision, in violation of § 13-316 (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee); (19) (Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy…)[;].

51. As set forth above, by failing to accurately document patient records, the Respondent violated § 13-316 (15) (Violates any provision of this title or rule or

regulation adopted by the Board), in the following manner: (COMAR 10.38.03: .02 Standards of Practice. (2) The physical therapist shall: (k) Provide direction and instruction for the physical therapist assistant that is adequate to ensure the safety and welfare of the patient; and (l) Document ongoing communication with the physical therapist assistant regarding changes in a patient's status and treatment plan. COMAR §10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (1) The initial visit, by including the following information: (c) Onset; and (g) Goals; (3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit: (a) Date; (b) Number of treatments since the initial evaluation or last reevaluation; (c) Reevaluation, tests, and measurements of areas of body treated; (d) Changes from previous objective findings; (e) Interpretation of results; (f) Goals met or not met and reasons; (g) Updated goals; (h) Updated plan of care including recommendations for follow-up; and (i) Signature, title (PT), and license number; (4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up; and (e) Signature, title (PT), and license number).

Patient F

52. On June 19, 2018, Patient F began treatment at the Facility for left lateral epicondylitis (elbow tendonitis). The Respondent signed off on the initial treatment note one year later. In the "Functional Deficits" section of the initial evaluation, the name of the outcomes test is missing according to the Expert. The note contains more information about the right arm than the left arm, although the latter is the one in treatment. The left arm examination is incomplete, according to the Board's Expert.

53. A home care program is part of the therapy plan but is not documented in the note. There is no discharge note. The Respondent billed for two units of therapy, which were not supported by the documentation, according to the Expert.

54. As set forth above, the Respondent failed to complete an adequate initial evaluation and billed for services not supported by the record, in violation of § 13-316 (14) (Submits a false statement to collect a fee); and (25) (Fails to meet accepted standards in delivering physical therapy or limited physical therapy care) [;].

55. By delaying sign-off of records and failing to complete an adequate initial examination, the Respondent violated § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), in the following manner: (COMAR § 10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (1) The initial visit, by including the following information: (e) Evaluation and results of tests (measurable and objective data); and (f) Interpretation) [;].

Patient G

56. Patient G began treatment at the Facility on February 14, 2018 for post-cardiac valve replacement, general fatigue, and deconditioning. The second page of the initial evaluation is missing. According to the Expert, the goals listed on the evaluation are not measurable. The Expert also stated that no specific functional limitation testing tool is reported despite the notation that the G-Code modifiers for Medicare's functional limitation program were reported. Vital signs were not noted by Physical Therapist B, though he stated that they were "monitored."

57. On documentation between February 2018 and April 2018, three units of therapeutic exercise were billed. However, beginning on April 25, 2018, four units of therapeutic exercise were billed, but the documentation did not change, noted the Expert.

58. A flow sheet includes the initials "SB," an aide, for which therapy was billed even though "SB" is not a skilled provider. Other entries on the flow sheet are illegible. Time and initials are missing.

59. The last date of service is 7/30/18 and signed by the Respondent. There is no discharge note.

60. As set forth above, billing is not supported by the record and billing for an aide is not allowed, in violation of; (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee); (19) (Commits an act of unprofessional conduct in the practice

of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy) [;].

61. As set forth above, the Respondent failed to ensure the accuracy of the records in that the initial evaluation dates were repeatedly misstated in the notes, and the Respondent failed to complete a discharge note, in violation § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), in the following manner: (COMAR §10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up; and (e) Signature, title (PT), and license number).

Patient H

62. Patient H began treatment at the facility on February 14, 2018 with Physical Therapist B. Flow sheets from 2018 have initials “SB”, “AV”, and “VM” on them—all aides. Medicare does not consider aides as “qualified providers” for purposes of billing, yet the Respondent billed Medicare for their services for therapeutic exercises.

63. As set forth above, the Respondent submitted false billing in violation §§ 13-316 (12) (Willfully makes or files a false report or record in the practice of physical

therapy or limited physical therapy;) and (14) (Submits a false statement to collect a fee) [;].

Patient I

64. Patient I began treatment at the Facility on February 19, 2018 with PT B for a diagnosis of osteoarthritis of the knees. On July 2, 2018, the Respondent became the therapist of record but did not complete a complete reevaluation, according to the Expert. The Respondent added massage to the treatment modalities and noted "improvement in knee extension," but no range of motion measurements were taken stated the Expert. On multiple dates of services, minutes are not included in the notes, but the Respondent billed multiple units of timed-coded services.

65. The initials, "VM," "AV," and "SB," therapy aides, appear on flow sheets that the Respondent billed for as skilled care.

66. As set forth above, the Respondent's billing is not supported by the notes, as she billed for services rendered by unqualified providers and she failed to complete a reevaluation, in violation of §§ 13-316 (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee; (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy…)[;].

67. By failing to perform a reevaluation, the Respondent violated § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), as

follows: (COMAR § 10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit: (a) Date; (b) Number of treatments since the initial evaluation or last reevaluation; (c) Reevaluation, tests, and measurements of areas of body treated; (d) Changes from previous objective findings; (e) Interpretation of results; (f) Goals met or not met and reasons; (g) Updated goals; (h) Updated plan of care including recommendations for follow-up; and (i) Signature, title (PT), and license number [;]).

Patient J

68. Patient J began treatment at the Facility with the Respondent on March 19, 2018 for "leg weakness." The plan of care included therapeutic exercises and a home exercise program; however, there is no evidence of a home exercise program in the record. Patient J reported "ambulation limitations," but the Respondent listed ambulation as "normal." According to the Board's Expert, "not all of the listed goals are measurable." The Expert further states that the Respondent used a "Berg disability index" but believes the proper test is a "Berg Balance Scale."

69. The Expert stated that for many notes, there are no minutes associated with the therapeutic exercises. The Expert further stated that, although the Respondent repeatedly states that the "Patient is progressing with lower extremity strength, there are no objective measures in the notes to support that claim. The exercises remain the same."

70. Flow sheets with the initials "AV" and "SB," identified previously as therapy aides, conducted therapeutic exercises, which the Respondent billed as being performed by "skilled providers."

71. Patient J was discharged on August 15, 2018, but the Respondent failed to produce a discharge note.

72. Patient J returned to the Facility for a shoulder problem on December 12, 2018 with a note signed by the Respondent. No flow sheets were provided for this visit and, although a home exercise program was part of the plan, it was not included in the record.

73. As set forth above, by falsely billing for services provided by aides and the patient notes appear to be copied and pasted—not reflecting the patient's accurate status, in violation of §§ 13-316 (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee); (19) (Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy…)[;].

74. The Respondent failed to comply with the requirements of documentation regarding her initial notes, progress notes and discharge notes, in violation of violated § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), as follows: (COMAR § 10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen

for: (1) The initial visit, by including the following information: (e) Evaluation and results of tests (measurable and objective data); (f) Interpretation; (3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit: (a) Date; (b) Number of treatments since the initial evaluation or last reevaluation; (c) Reevaluation, tests, and measurements of areas of body treated; (d) Changes from previous objective findings; (e) Interpretation of results; (f) Goals met or not met and reasons; (g) Updated goals; (h) Updated plan of care including recommendations for follow-up; and (4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up [;]).

Patient K

75. It is unclear when Patient K began therapy at the Facility for "unsteady gait," as no initial evaluation was located in the file. The first available typed note is dated January 10, 2018, which notes a Medicare certification period from November 17, 2017 – February 15, 2018.

76. The Respondent dated a progress note for January 24, 2018 which refers to a "reevaluation of February 19, 2018." The notes were signed by the Respondent on March 18, 2018. The PTA began aquatic therapy with Patient K on February 15, 2018, which indicates that the Respondent failed to supervise or provide guidance for the

aquatic therapy. In addition, the Respondent cosigned many of the PTA's aquatic therapy notes in a delayed manner, sometimes more than a month later. For example, the Respondent cosigned the PTA's June 19, 2018 note on August 2, 2018.

77. The initials "SB" and "VM," previously identified as non-skilled therapy aides, are on many flow sheets, which the Respondent billed the insurer as "skilled providers."

78. There were no minutes for therapeutic exercises contained in the daily notes. Some of the flow sheets lack documentation of minutes involved.

79. There is no progress evaluation/reevaluation for May 2018 or July 2018. The Progress reevaluation for June 2018 notes the balance testing is unchanged since November 2017, yet the Respondent failed to change the plan of care to address the lack of progress, according to the Expert.

80. On July 17, 2018, Patient K reported "vertigo, loss of balance and shakiness" in the prior week, but no reevaluation was requested by the PTA or performed by the Respondent, who cosigned the note three weeks later. The PTA continued aquatic therapy and repeatedly made comments about "improved performance," but there are no measures of this, noted the Expert.

81. The last daily note is dated July 24, 2018 but aquatic therapy continued on July 26, July 31, and August 2, 2018. It appears that treatment ended August 2, 2018, but there is no discharge note.

82. As set forth above, by falsely billing for therapy provided by aides and by failing to supervise and communicate with the PTA, the Respondent violated of §§ 13-316 (12) (Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy); (14) (Submits a false statement to collect a fee; (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy); and (25) (Fails to meet accepted standards in delivering physical therapy…)[;].

83. As set forth above, the Respondent failed to comply with documentation requirements regarding initial evaluation, progress notes and failure to provide a discharge note, or to provide minutes for each date of service in violation § 13-316 (15) (Violates any provision of this title or rule or regulation adopted by the Board), as follows: (COMAR § 10.38.03.02-1. Requirements for Documentation A. The physical therapist shall document legibly the patient's chart each time the patient is seen for: (1) The initial visit, by including the following information: (e) Evaluation and results of tests (measurable and objective data); (f) Interpretation; (3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit: (a) Date; (b) Number of treatments since the initial evaluation or last reevaluation; (c) Reevaluation, tests, and measurements of areas of body treated; (d) Changes from previous objective findings; (e) Interpretation of results; (f) Goals met or not met and reasons; (g) Updated goals; (h) Updated plan of care including recommendations for follow-up; and (4) Discharge, by including the following

information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up; e) Interpretation of results; (f) Goals met or not met and reasons; (g) Updated goals; (h) Updated plan of care including recommendations for follow-up; and (4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist: (a) Date; (b) Reason for discharge; (c) Objective status; (d) Recommendations for follow-up; and E. Ongoing Communications. Both the physical therapist and the physical therapist assistant shall document ongoing communication between the physical therapist and physical therapist assistant regarding changes in a patient's status and treatment plan).

84. By referring the above patients for unsupervised aqua therapy and billing Medicare for services provided by unqualified personnel, the Respondent overutilized health services, in violation of section 13-316 (20) Grossly overutilizes health care services [;].

85. As set forth above, by failure to supervise and communicate with the PTA, by falsely billing for services provided by aides, and by failing to comply with the Board's documentation requirements, the Respondent violated the Act and regulations thereunder.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Board concludes as a matter of law that the Respondent violated Health Occ. § 13-316(12), (14), (15), (19), (25), and COMAR 10.38.03.02A(1)(a), 10.38.03.02A(1)(b), 10.38.03.02A(2)(a), 10.38.03.02A(2)(b)(i), 10.38.03.02A(2)(b)(ii), 10.38.03.02A(2)(c), 10.38.03.02A(2)(d), 10.38.03.02A(2)(e), 10.38.03.02A(2)(f), 10.38.03.02A(2)(g), 10.38.03.02A(2)(j), 10.38.03.02A(2)(k), 10.38.03.02A(2)(l), 10.38.03.02-1A(1)(a), 10.38.03.02-1A(1)(b), 10.38.03.02-1A(1)(c), 10.38.03.02-1A(1)(d), 10.38.03.02-1A(1)(e), 10.38.03.02-1A(1)(f), 10.38.03.02-1A(1)(g), 10.38.03.02-1A(1)(h), 10.38.03.02-1A(1)(i), 10.38.03.02-1A(1)(j), 10.38.03.02-1A(2)(a), 10.38.03.02-1A(2)(b), 10.38.03.02-1A(2)(c), 10.38.03.02-1A(2)(d), 10.38.03.02-1A(2)(e), 10.38.03.02-1A(2)(f), 10.38.03.02-1A(2)(g), 10.38.03.02-1A(3)(a), 10.38.03.02-1A(3)(b), 10.38.03.02-1A(3)(c), 10.38.03.02-1A(3)(d), 10.38.03.02-1A(3)(e), 10.38.03.02-1A(3)(f), 10.38.03.02-1A(3)(g), 10.38.03.02-1A(3)(h), 10.38.03.02-1A(3)(i), 10.38.03.02-1A(4)(a), 10.38.03.02-1A(4)(b), 10.38.03.02-1A(4)(c), 10.38.03.02-1A(4)(d), 10.38.03.02-1A(4)(e), 10.38.03.02-1B, 10.38.03.02-1C(1), 10.38.03.02-1C(2), 10.38.03.02-1C(3), 10.38.03.02-1C(4), 10.38.03.02-1C(5), 10.38.03.02-1C(6), 10.38.03.02-1C(7), 10.38.03.02-1D, 10.38.03.02-1E.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by the affirmative vote of a majority of the Board considering this case:

ORDERED that the Respondent be placed on **PROBATION** for a period of **ONE (1) YEAR** under the following terms and conditions:

1. The Respondent shall be assigned a Board-approved supervisor and meet monthly to review the Respondent's documentation and billing practices. The Board-approved supervisor shall be required to submit quarterly reports to the Board.

2. The Respondent shall be responsible for ensuring that the Board-approved supervisor submits the quarterly reports timely. The Board-approved supervisor's last quarterly report should be a final report where, if appropriate, recommends that supervision is no longer required.

3. The Respondent is fined in the amount of **ONE THOUSAND FIVE HUNDRED DOLLARS ($1500)**, due within sixty (60) days to the board;

4. Within six (6) months of the date of execution of the Consent Order, the Respondent shall successfully complete a Board-approved six (6) hour **course(s) in billing and documentation**, which shall not be counted toward continuing education requirements for license renewal;

5. Within six (6) months of the date of execution of the Consent Order, the Respondent shall complete, closed book, the Maryland Physical Therapy Jurisprudence Examination with at least a Ninety (90) Percent Score.

And it is further

ORDERED that after the conclusion of the **ONE (1) YEAR** probationary period, the Respondent may submit a written petition to the Board requesting termination of

probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, shall grant the termination of the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints of similar nature; and it is further

ORDERED that if the Board has reason to believe that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-approved supervisor, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and

conditions of this Consent Order; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that the Effective Date of this Consent Order is the date on which the Consent Order is executed by the Board Chair, and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2021 Repl. Vol.).

March 8, 2023

Karen L Gordes

Date

Karen Gordes, PT, PhD, DScPT, Chair
Maryland Board of
Physical Therapy Examiners

CONSENT

By this Consent, I, Renee Van Wie, P.T. agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

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

I sign this Consent Order after having had the opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order and understand its effect.

3/15/2023
Date

Renee Van Wie P.T.
Renee Van Wie, P.T.
Respondent

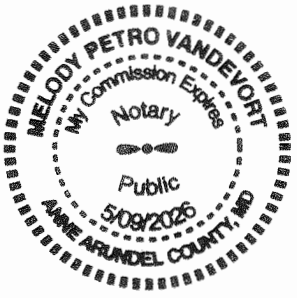
NOTARY PUBLIC

STATE OF Maryland

CITY/COUNTY OF: Anne Arundel

I HEREBY CERTIFY that on this 15th day of March 2023, before me, a Notary Public of the State and County aforesaid, personally appeared Renee Van Wie, P.T., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.



Notary Public Melody Petro Vandevort

My commission expires: 5/9/2026